Rehabilitation Psychology and Suicide Prevention: Evidence-Based Assessment and Treatment Strategies

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2/2013
Disclosure

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.
Objectives

• Identify risk for suicidal thoughts and behaviors among key rehab populations
• Identify risk factors/warning signs among rehab populations
• Identify evidence-based assessment strategies to evaluate suicide risk
• Identify evidence-based means of tx for suicide prevention
“I think it took awhile before I realized and then when I started thinking about things and realizing that I was going to be like this for the rest of my life, it gives me a really down feeling and it makes me think like—why should I be around like this for the rest of my life?”

- VA Patient/TBI Survivor
Suicide – General Population

• Worldwide, almost one million people per year die by suicide; a global mortality rate of 16 per 100,000

• In the United States, suicide is the 10th leading cause of death

• 36,909 suicides in the U.S (an annual suicide rate of 12.0 per 100,000) (2009 CDC)

• This translates to 100.8 suicides per day or 1 suicide every 14.3 minutes

• 22 Veterans per day die by suicide
Suicide Attempt – General Population

- Ratio of 8 (suicide):1 (suicide attempt) is conservative (Maris 2000)

- Responses from the National Survey on Drug Use and Health suggest that an estimated one million adults in the US made a suicide attempt in the past year
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

Jacobs 2003
We assess risk to...

Identify modifiable and treatable risk factors [warning signs] that inform treatment

Simon 2001

Take care of our patients

Hal Wortzel, MD
We should also assess to...take care of ourselves

- Risk management is a reality of practice
- 15-68% of psychiatrists have experienced a patient suicide (Alexander 2000, Chemtob 1988)
- About 33% of trainees have a patient die by suicide
- Paradox of training - toughest patients often come earliest in our careers
Is a common language necessary to facilitate suicide risk assessment?

Do we have a common language?
Case Example 1

A 55 year old lawyer was recently diagnosed with MS. Even before being diagnosed, he struggled with feelings of depression and hopelessness. After reading about the condition on the internet, he became distressed and thought about what it would be like to be dead. He went into the bathroom, took 4 sleeping pills and fell asleep. His wife could not awaken him and called 911. In the emergency room he told the ED physician that he has had trouble sleeping since receiving the dx and was just trying to get a good night’s sleep.
The Language of Self-Directed Violence

Identification of the Problem

- Suicidal ideation
- Death wish
- Suicidal threat
- Cry for help
- Self-mutilation
- Parasuicidal gesture
- Suicidal gesture
- Risk-taking behavior
- Self-harm
- Self-injury
- Suicide attempt
- Aborted suicide attempt
- Accidental death
- Unintentional suicide
- Successful attempt
- Completed suicide
- Life-threatening behavior
- Suicide-related behavior
- Suicide
The Language of Self-Directed Violence
A Solution to the Problem

Nomenclature (def.):

• a set of commonly understood
• widely acceptable
• comprehensive
• terms that define the basic clinical phenomena (of suicide and suicide-related behaviors)
• based on a logical set of necessary component elements that can be easily applied

Silverman et al 2006
Nomenclature: **Essential Features**

- enhance clarity of communication
- have applicability across clinical settings
- be theory neutral
- be culturally neutral
- use mutually exclusive terms that encompass the spectrum of thoughts and actions

Peter Brueghel the Elder, 1563
Silverman et al 2006
Self-Directed Violence Classification System in Collaboration with the CDC

Lisa A. Brenner, Ph.D.
Morton M. Silverman, M.D.
Lisa M. Betthauser, M.B.A.
Ryan E. Breshears, Ph.D.
Katherine K. Bellon, Ph.D.
Herbert T. Nagamoto, M.D.
<table>
<thead>
<tr>
<th>Type</th>
<th>Sub-Type</th>
<th>Definition</th>
<th>Modifiers</th>
<th>Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoughts</td>
<td>Non-Suicidal Self-Directed Violence Ideation</td>
<td>Self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence Ideation in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).</td>
<td>N/A</td>
<td>• Non-Suicidal Self-Directed Violence Ideation</td>
</tr>
<tr>
<td></td>
<td>Suicidal Ideation</td>
<td>Self-reported thoughts of engaging in suicide-related behavior.</td>
<td>• Suicidal Intent</td>
<td>• Suicidal Ideation, Without Suicidal Intent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For example, intrusive thoughts of suicide without the wish to die would be classified as Suicidal Ideation, Without Intent.</td>
<td>- Without</td>
<td>• Suicidal Ideation, With Undetermined Suicidal Intent</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Undetermined</td>
<td>• Suicidal Ideation, With Suicidal Intent</td>
</tr>
<tr>
<td></td>
<td>Preparatory</td>
<td>Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one’s death by suicide (e.g., writing a suicide note, giving things away). For example, hoarding medication for the purpose of overdosing would be classified as Suicidal Self-Directed Violence, Preparatory.</td>
<td>• Suicidal Intent</td>
<td>• Non-Suicidal Self-Directed Violence, Preparatory</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Without</td>
<td>• Undetermined Self-Directed Violence, Preparatory</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Undetermined</td>
<td>• Suicidal Self-Directed Violence, Preparatory</td>
</tr>
<tr>
<td>Behaviors</td>
<td>Non-Suicidal Self-Directed Violence</td>
<td>Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).</td>
<td>• Injury</td>
<td>• Non-Suicidal Self-Directed Violence, Without Injury</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Without</td>
<td>• Non-Suicidal Self-Directed Violence, Without Injury, Interrupted by Self or Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- With</td>
<td>• Non-Suicidal Self-Directed Violence, With Injury, Interrupted by Self or Other</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Fatal</td>
<td>• Non-Suicidal Self-Directed Violence, Fatal</td>
</tr>
<tr>
<td></td>
<td>Undetermined Self-Directed Violence</td>
<td>Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based upon the available evidence. For example, the person is unable to admit positively to the intent to die (e.g., unconsciousness, incapacitation, intoxication, acute psychosis, disorientation, or death); OR the person is reluctant to admit positively to the intent to die for other or unknown reasons.</td>
<td>• Injury</td>
<td>• Undetermined Self-Directed Violence, Without Injury</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Without</td>
<td>• Undetermined Self-Directed Violence, Without Injury, Interrupted by Self or Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- With</td>
<td>• Undetermined Self-Directed Violence, With Injury, Interrupted by Self or Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Fatal</td>
<td>• Undetermined Self-Directed Violence, Fatal</td>
</tr>
<tr>
<td></td>
<td>Suicidal Self-Directed Violence</td>
<td>Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent. For example, a person with a wish to die cutting her wrist with a knife would be classified as Suicide Attempt, With Injury.</td>
<td>• Injury</td>
<td>• Suicide Attempt, Without Injury</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Without</td>
<td>• Suicide Attempt, Without Injury, Interrupted by Self or Other</td>
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<td></td>
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<td>- With</td>
<td>• Suicide Attempt, With Injury</td>
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<td>- Fatal</td>
<td>• Suicide Attempt, With Injury, Interrupted by Self or Other</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Suicide</td>
</tr>
</tbody>
</table>
Self-Directed Violence (SDV) Classification System
Clinical Tool

BEGIN WITH THESE 3 QUESTIONS:

1. Is there any indication that the person engaged in self-directed violent behavior, either preparatory or potentially harmful? (Refer to Key Terms on reverse side)  
   If NO, proceed to Question 2; IF YES, proceed to Question 3

2. Is there any indication that the person had self-directed violence related thoughts?  
   If NO to Questions 1 and 2, there is insufficient evidence to support self-directed violence. NO SDV TRSN
   IF YES, proceed to Decision Tree A

3. Did the behavior involve any injury?  
   If NO, proceed to Decision Tree B; IF YES, proceed to Decision Tree C

DECISION TREE A: THOUGHTS

Thoughts are suicidal?

Yes

No

Non-Suicidal SDV

- With or Without Injury

- Attempt or Adversary

- Suicide Attempt

- Suicide

Thoughts are suicidal, is there evidence of Suicidal Intent?

Yes

No

Suicidal Intent, With or Without Injury

- Attempt

- Suicide

Suicidal Intent, Without Injury

- Attempt

- Suicide

Decision Tree B: Behaviors, Without Injury

Was the behavior preparatory only?

Yes

No

Was the behavior interrupted by Self or Other?

Yes

No

Was there evidence of Suicidal Intent?

Yes

No

Undermined SDV, Preparatory

Undermined SDV, Without Injury

Non-Suicidal SDV, Preparatory

Non-Suicidal SDV, Without Injury

Decision Tree C: Behaviors, With Injury

Was the injury fatal?

No

Yes

Was the behavior interrupted by Self or Other?

Yes

No

Was there evidence of Suicidal Intent?

Yes

No

Undermined SDV, With Injury

Non-Suicidal SDV, With Injury

Subacute Injury, With Injury

Subacute Injury, Without Injury

Subacute Injury, Without Injury, Interrupted by Self or Other

Suicide Attempt, With Injury

Suicide

Reminder: Behaviors Trump Thoughts

Key Terms [Centers for Disease Control and Prevention]

Self-Directed Violence: Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

Suicidal Intent: Presence or absence of thoughts or plans to cause self-harm. This can include attempting to kill oneself, planning to kill oneself, or intending to cause serious injury to oneself.

Preparatory Behavior: Acts or preparation towards intentionally making a suicide attempt but before potential for harm has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for near death by suicide (e.g., writing a suicide note, giving away items).

Physical Injury (paraphrased):

A bodily lesion resulting from acute noxious energy to the body in amounts or rates that exceed the threshold of physiological tolerance (e.g., injury due to suffocation, poisoning or overdose, infection, gunshot wounds, etc.) refer to the Definitions System for the full CDC definition.

Suicide Attempt: A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior.
Suicidal Intent

There is past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and in the absence of suicidal behavior.
Now that we are using a common language

How should we be assessing risk?
“Although self-report measures are often used as screening tools, an adequate evaluation of [suicidal thoughts and behaviors] should include both interviewer-administered and self-report measures.”
Elements of Useful Assessment Tools

• Clear operational definitions of construct assessed
• Focused on specific domains (suicidality?)
• Developed through systematic, multistage process
  – empirical support for item content, clear administration and scoring instructions, reliability, and validity
• Range of normative data available
Basic Considerations

• Context specific
  – schools, military, clinical settings

• Available resources
  – time, money, staffing

• Infrastructure to support outcomes
  – available referrals
  – trained clinical staff in-house
Self-Report Measures

• Advantages
  • Fast and easy to administer
  • Patients often more comfortable disclosing sensitive information
  • Quantitative measures of risk/protective factors

• Disadvantages
  • Report bias
  • Face validity
Evidence-Based Measures

- Suicidal Ideation - Beck Scale for Suicide Ideation
- Depressive Symptoms – Beck Depression Inventory II
- Hopelessness - Beck Hopelessness Scale
- Thoughts about the future - Suicide Cognitions Scale
- History of Suicide - Related Behaviors - Self-Harm Behavior Questionnaire
- Protective Factors - Reasons for Living Inventory
“The purpose of this review is to provide a systematic examination of the psychometric properties of measures of suicidal ideation and behavior for younger and older adults.”

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

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

“Many of these measures have demonstrated adequate internal reliability and concurrent validity. ...It is therefore a serious problem that the predictive validity for most suicide measures has not been established. In fact, only a few instruments, such as the Scale for Suicide Ideation and the Beck Hopelessness Scale, have been found to be significant risk factors for ... suicide.”

Evidence-Based Measures: Suicidality in Those With TBI:

1

RESEARCH NEEDED!!!
Predicting Suicidal Behavior in Veterans With Traumatic Brain Injury: The Utility of the Personality Assessment Inventory

Ryan E. Breshears,1 Lisa A. Brenner,1,2,3,4 Jeri E. F. Harwood,1,5 and Peter M. Gutierrez1,2

1VA VISN 19 Mental Illness Research, Education and Clinical Center (MIRECC), Denver VA Medical Center, Denver, Colorado
2Department of Psychiatry, University of Colorado Denver School of Medicine
3Department of Physical Medicine and Rehabilitation, University of Colorado Denver School of Medicine
4Department of Neurology, University of Colorado Denver School of Medicine
5Department of Pediatrics, University of Colorado Denver School of Medicine

In this study, we investigated the Personality Assessment Inventory’s (PAI; Morey, 1991, 2007) Suicide Potential Index (SPI) and Suicide Ideation scale (SUI) as predictors of suicidal behavior (SB) in military Veterans with traumatic brain injury (TBI; N = 154). We analyzed electronic medical records were searched for SB in the 2 years post-PAI administration and data via logistic regressions. We obtained statistical support for the SPI and SUI as predictors of SB. Analyses performed using receiver operating characteristics suggested an optimal SPI cutoff of ≥15 for this sample. Findings suggest that SPI and SUI scores may assist in assessing suicide risk in those with TBI, particularly when population-based cutoffs are considered.
What are the key components?

Suicide focused clinical interview

Psychological/Psychiatric Evaluation
What is a Suicide Risk Factor?

• A major focus of research for past 30 years

• Factors
  – Demographic (e.g., male gender, age over 65, Caucasian)
  – Psychosocial (e.g., diagnosed serious mental illness, loss of significant relationship, impulsivity)
  – Past history (e.g., suicide attempt, sexual or physical abuse)
Risk Factors

• Overall level of clinical concern about an individual
• Guide screening and assessment efforts
• Developing models to explain suicide
• Distal to suicidal behavior
• May or may not be modifiable
• Risk factors do not predict individual behavior
Determine if Factors are Modifiable

<table>
<thead>
<tr>
<th>Non-Modifiable Risk Factors</th>
<th>Modifiable Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Family History</td>
<td>• Psychiatric symptoms</td>
</tr>
<tr>
<td>• Past History</td>
<td>• Social Support</td>
</tr>
<tr>
<td>• Demographics</td>
<td>• Access to Lethal Means</td>
</tr>
</tbody>
</table>
Warning Signs

• Warning signs – person-specific emotions, thoughts, or behaviors precipitating suicidal behavior
  – Thoughts of suicide
  – Thoughts of death
  – Sudden changes in personality, behavior, eating or sleeping patterns

• Proximal to the suicidal behavior and imply imminent risk

Rudd et al. 2006
## Risk Factors vs. Warning Signs

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

Rudd et al. 2006
Risk Factors vs. Warning Signs

**Risk Factors**
- Suicidal ideas/behaviors
- Psychiatric diagnoses
- Physical illness
- Childhood trauma
- Genetic/family effects
- Psychological features (i.e. psychosis, hopelessness)
- Cognitive features
- Demographic features
- Access to means
- Substance intoxication
- Poor therapeutic relationship

**Warning Signs**
- 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
Empirical test of warning signs almost non-existent
• Warning Signs of Acute Risk:
  – Threatening to hurt or kill him or herself, or talking of wanting to hurt or kill him/herself; and/or,
  – Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or,
  – Talking or writing about death, dying or suicide, when these actions are out of the ordinary.
Additional Warning Signs:

- Increased **substance** (alcohol or drug) **use**
- No reason for living; no sense of **purpose** in life
- Rage, uncontrolled **anger**, seeking revenge
- Acting **reckless** or engaging in risky activities, seemingly without thinking

- Dramatic **mood changes**.
- **Anxiety**, agitation, unable to sleep or sleeping all the time
- Feeling **trapped** - like there’s no way out
- **Hopelessness**
- **Withdrawal** from friends, family and society

http://www.suicidology.org/web/guest/stats-and-tools/warning-signs
**RESPONDING TO SUICIDE RISK**

- 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 ER/URGENT CARE CENTER TO PATIENT AND SIGNIFICANT OTHER**

National Suicide Hotline Resource:

1 - 800 - 273 - TALK (8255)

References:
- Rudd et al., Warning signs for suicide: theory, research and clinical applications. Suicide and Life Threatening Behavior, 2006 June36 (3)265-82.

**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. Consider hospitalization for safety until complete assessment may be made.

**Additional Warning Signs**

- Hopelessness
- 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 abuse
- Withdrawing from friends, family and society
- Anxiety, agitation, 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.

Employee Education System

MIRECC
VISN 19 ROCKY MOUNTAIN NETWORK
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)
- Co-morbid health problems, especially a 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
- Spirituality
- Sense of responsibility to family
- Children 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?
Rehabilitation Populations

• There are significant challenges associated with studying suicidal thoughts and behaviors

• Features of suicidal behaviors after neurodisability is extremely variable

• Although the relationships between suicide and some neurodisabilities (e.g., SCI and TBI) are supported by a growing number of methodologically robust studies, there are many areas for which the evidence-based is still extremely limited.

• Many of the population-based studies [death] come from Scandinavia (Sweden, Norway, Denmark, Finland), presumably due to the relatively small populations, the universal access to health care, the capacity to link national health-based data with other national databases (e.g., death registries) and the existence of national registries for various types of neurodisability.

• Many methodological challenges which creates significant risk of bias (e.g., measurement, case ascertainment, secondary or post-hoc analyses).

Simpson and Brenner
Individuals who received care between FY 01 and 06

Analyses included all patients with a history of TBI (n = 49,626) plus a 5% random sample of patients without TBI (n = 389,053)

Suicide - National Death Index (NDI) compiles death record data for all US residents from state vital statistics offices

TBI diagnoses of interest were similar to those used by Teasdale and Engberg
Suicide by TBI Severity – VHA Users FY 01-06

- 12,159 with concussion or cranial fracture, of which 33 died by suicide
- 39,545 with cerebral contusion/traumatic intracranial hemorrhage of which 78 died by suicide
- Of those with a history of TBI, 105 died by suicide

Challenges associated with this type of research and need for collaboration
(~8 million records reviewed)
Cox proportional hazards survival models for time to suicide, with time-dependent covariates, were utilized. Covariance sandwich estimators were used to adjust for the clustered nature of the data, with patients nested within VHA facilities.

ICD-9 codes:
1) concussion (850), cranial fracture—fracture of vault of skull (800), fracture of base of skull (801), and other and unqualified skull fractures (803)
2) cerebral laceration and contusion (851); subarachnoid, subdural, and extradural hemorrhage after injury (852); other and unspecified intracranial hemorrhage after injury (853); and intracranial injury of other and unspecified nature (854).
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>All</th>
<th>Col%</th>
<th>Those who died by suicide</th>
<th>N</th>
<th>Col%</th>
<th>Those who did not die by suicide</th>
<th>N</th>
<th>Col%</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>VHA users with any TBI (combined)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>49,626</td>
<td>100</td>
<td></td>
<td>105</td>
<td>100</td>
<td></td>
<td>49,521</td>
<td>100</td>
<td>.0002</td>
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<td>Substance abuse</td>
<td>8,368</td>
<td>16.86</td>
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<td>32</td>
<td>30.48</td>
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<td>8,336</td>
<td>16.83</td>
<td>.0292</td>
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<tr>
<td>Bipolar I/II</td>
<td>2,265</td>
<td>4.56</td>
<td></td>
<td>10</td>
<td>9.52</td>
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<td>2,255</td>
<td>4.55</td>
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<td>MDD</td>
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<td>9</td>
<td></td>
<td>24</td>
<td>22.86</td>
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<td>4,440</td>
<td>8.97</td>
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<td>Other depression, no MDD</td>
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<td>15.35</td>
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<td>23</td>
<td>21.9</td>
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<td>7,593</td>
<td>15.33</td>
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<td>Other anxiety</td>
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<td>16</td>
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<td>4,310</td>
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<td>PTSD</td>
<td>4,880</td>
<td>9.83</td>
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<td>23</td>
<td>21.9</td>
<td></td>
<td>4,857</td>
<td>9.81</td>
<td>&lt;.0001</td>
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<td>Schizophrenia/schizoaffective disorder</td>
<td>2,287</td>
<td>4.61</td>
<td></td>
<td>6</td>
<td>5.71</td>
<td></td>
<td>2,281</td>
<td>4.61</td>
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<tr>
<td>VHA users with concussion/fracture</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>12,159</td>
<td>100</td>
<td></td>
<td>33</td>
<td>100</td>
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<td>12,126</td>
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<tr>
<td>Substance abuse</td>
<td>2,087</td>
<td>17.16</td>
<td></td>
<td>9</td>
<td>27.27</td>
<td></td>
<td>2,078</td>
<td>17.14</td>
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</tr>
<tr>
<td>Bipolar I/II</td>
<td>588</td>
<td>4.84</td>
<td></td>
<td>2</td>
<td>6.06</td>
<td></td>
<td>586</td>
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<tr>
<td>MDD</td>
<td>1,198</td>
<td>9.85</td>
<td></td>
<td>10</td>
<td>30.3</td>
<td></td>
<td>1,188</td>
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<td>Other depression, no MDD</td>
<td>1,831</td>
<td>15.06</td>
<td></td>
<td>7</td>
<td>21.21</td>
<td></td>
<td>1,824</td>
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<tr>
<td>Other anxiety</td>
<td>1,148</td>
<td>9.44</td>
<td></td>
<td>7</td>
<td>21.21</td>
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<td>1,141</td>
<td>9.41</td>
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<tr>
<td>PTSD</td>
<td>1,376</td>
<td>11.32</td>
<td></td>
<td>7</td>
<td>21.21</td>
<td></td>
<td>1,369</td>
<td>11.29</td>
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<td>Schizophrenia/schizoaffective disorder</td>
<td>519</td>
<td>4.27</td>
<td></td>
<td>1</td>
<td>3.03</td>
<td></td>
<td>518</td>
<td>4.27</td>
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<tr>
<td>VHA users with cerebral contusion/traumatic intracranial hern</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>All</td>
<td>39,545</td>
<td>100</td>
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<td>78</td>
<td>100</td>
<td></td>
<td>39,467</td>
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<td>Substance abuse</td>
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<td>17.01</td>
<td></td>
<td>25</td>
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<td>6,703</td>
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<tr>
<td>Bipolar I/II</td>
<td>1,802</td>
<td>4.56</td>
<td></td>
<td>8</td>
<td>10.26</td>
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<td>1,794</td>
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<tr>
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<td>8.83</td>
<td></td>
<td>17</td>
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<td>3,473</td>
<td>8.8</td>
<td>&lt;.0001</td>
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<tr>
<td>Other depression, no MDD</td>
<td>6,142</td>
<td>15.53</td>
<td></td>
<td>17</td>
<td>21.79</td>
<td></td>
<td>6,125</td>
<td>15.52</td>
<td>.1263</td>
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<tr>
<td>Other anxiety</td>
<td>3,377</td>
<td>8.54</td>
<td></td>
<td>11</td>
<td>14.1</td>
<td></td>
<td>3,366</td>
<td>8.53</td>
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<tr>
<td>PTSD</td>
<td>3,757</td>
<td>9.5</td>
<td></td>
<td>17</td>
<td>21.79</td>
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<td>3,740</td>
<td>9.48</td>
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<tr>
<td>Schizophrenia/schizoaffective disorder</td>
<td>1,869</td>
<td>4.73</td>
<td></td>
<td>5</td>
<td>6.41</td>
<td></td>
<td>1,864</td>
<td>4.72</td>
<td>.4199</td>
</tr>
</tbody>
</table>
Although findings suggested that increased risk for death by suicide was present for those across the injury severity continuum, further work is required to clarify whether those with concussion/cranial fracture versus cerebral contusion/traumatic intracranial hemorrhage are unique populations. It is likely that factors associated with increased risk vary depending on the severity of injury sustained. It may also be that preexisting factors contribute to a greater degree for a subset of the population (eg, those with concussion).
22 Subjects
Total Number of Admissions: 114
Median Number of Admissions: 3
Range of Admissions: 1-20
Are individuals with moderate to severe TBI seeking traditional psychiatric services?

**TABLE 2. Characteristics of Most Recent Traumatic Brain Injuries**

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Severity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Moderate</td>
<td>11</td>
<td>50</td>
</tr>
<tr>
<td>Severe</td>
<td>10</td>
<td>45.5</td>
</tr>
<tr>
<td><strong>Mechanism of Injury</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assault</td>
<td>6</td>
<td>27.3</td>
</tr>
<tr>
<td>MVA</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>Falls</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>Other Accidents</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>Explosion</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>MCA</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>Other¹</td>
<td>2</td>
<td>9.1</td>
</tr>
</tbody>
</table>

¹Pedestrian hit by car, suicide attempt; MVA = motor vehicle accident, MCA = motorcycle accident.
### TABLE 3. Characteristics of Acute Psychiatric Hospitalizations

<table>
<thead>
<tr>
<th>Variable</th>
<th>%</th>
<th>Range (Mdn)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hospitalizations per patient</td>
<td></td>
<td>1–20 (3)</td>
</tr>
<tr>
<td>Total Psychiatric Diagnoses Noted at Discharge$^1$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>Psychosis</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Organic Disorder$^2$</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Length of Stay (Days)</td>
<td></td>
<td>0$^3$–120 (11)</td>
</tr>
</tbody>
</table>

$^1$Psychiatric diagnoses total to more than 100% due to the majority of patients receiving more than one diagnosis. $^2$Includes dementia and mood disorders due to general medical condition. $^3$Two patients were admitted and discharged on the same day.
**Number of Admissions Secondary to a Suicide Attempt**

- **Total Number of Admissions = 122**
- **Total Number of Admissions Secondary to a Suicide Attempt = 14** (6 patients)

“Half of the patients in the current study made suicide attempts by overdose, the majority using medications that were listed as being prescribed at time of discharge.”

11% of total admissions
Number of attempts 1-5
Median - 2
Risk Factors
Hopelessness After TBI

• Hopelessness common after severe TBI

• 35% rate of moderate to severe hopelessness was observed among people with TBI between 1 and 10 years post-injury (Simpson & Tate, 2002)
Participants: Sample of 13 Veterans with a history of TBI, and a history of clinically significant suicidal ideation or behavior.

Method: In-person interviews were conducted and data were analyzed using a hermeneutic approach.
Cognitive Impairment and Suicidality

• “I knew what I wanted to say although I'd get into a thought about half-way though and it would just dissolve into my brain. I wouldn't know where it was, what it was and five minutes later I couldn't even remember that I had a thought. And that added to a lot of frustration going on....and you know because of the condition a couple of days later you can't even remember that you were frustrated.”

• “I get to the point where I fight with my memory and other things...and it’s not worth it.”
Emotional and Psychiatric Disturbances and Suicidality

• I got depressed about a lot of things and figured my wife could use a $400,000 tax-free life insurance plan a lot better than....I went jogging one morning, and was feeling this bad, and I said "well, it's going to be easy for me to slip and fall in front of this next truck that goes by..."
Loss of Sense of Self and Suicidality

- Veterans spoke about a shift in their self-concepts post-injury, which was frequently associated with a sense of loss.
  - "...when you have a brain trauma...it's kind of like two different people that split...it’s kind of like a split personality. You have the person that’s still walking around but then you have the other person who’s the brain trauma."
Intervention
Preventing suicide after traumatic brain injury: implications for general practice

Grahame K Simpson and Robyn L Tate

2 Suicide prevention strategies for general practitioners managing patients with traumatic brain injury (TBI)*

<table>
<thead>
<tr>
<th>Level of intervention</th>
<th>Clinical management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universal</strong></td>
<td></td>
</tr>
<tr>
<td>All people with TBI</td>
<td>• Assess hopelessness and suicide ideation proactively, using indirect or direct approaches</td>
</tr>
<tr>
<td></td>
<td>• Monitor for warning signs that may increase risk level</td>
</tr>
<tr>
<td></td>
<td>• Recognise that people may be at risk regardless of time post-injury</td>
</tr>
<tr>
<td></td>
<td>• Make provision for the availability of long-term support</td>
</tr>
<tr>
<td></td>
<td>• Monitor males and females equally</td>
</tr>
<tr>
<td><strong>Selected</strong></td>
<td></td>
</tr>
<tr>
<td>People with TBI in &quot;at-risk&quot; groups</td>
<td>• Treat people with depressive or substance misuse conditions</td>
</tr>
<tr>
<td></td>
<td>• Monitor people with comorbid psychiatric conditions and those injured as the result of a suicide attempt</td>
</tr>
<tr>
<td><strong>Indicated</strong></td>
<td></td>
</tr>
<tr>
<td>People with TBI for whom suicide is an identified issue (eg, made attempt, expressed suicide ideation)</td>
<td>• Reduce the lethality of the environment</td>
</tr>
<tr>
<td></td>
<td>• Provide frontline treatments (pharmacotherapy)</td>
</tr>
<tr>
<td></td>
<td>• In managing someone with a history of any attempts, plan for the possibility that people may use more than one method</td>
</tr>
<tr>
<td></td>
<td>• Provide support/monitor for at least 12 months after a suicide attempt</td>
</tr>
<tr>
<td></td>
<td>• Closely monitor in the months after discharge from a psychiatric hospital</td>
</tr>
</tbody>
</table>

* Adapted from the United States Institute of Medicine generic suicide prevention model.21
Safety Planning and Suicide Prevention – A Function-Based Intervention
Safety Plan Treatment Manual to Reduce Suicide Risk:

Veteran Version

Barbara Stanley, Ph.D.¹
and
Gregory K. Brown, Ph.D.²

In collaboration with Bradley Karlin, Ph.D.³, Janet E. Kemp, Ph.D.⁴
and Heather A. VonBergen, Ph.D.⁴

¹Suicide Intervention Center, Department of Psychiatry, Columbia University and New York State Psychiatric Institute
²VISN 4 MIRECC, Philadelphia VA Medical Center; Center for the Treatment and Prevention of Suicide, Department of Psychiatry, University of Pennsylvania;
³Office of Mental Health Services, VA Central Office
⁴Center of Excellence at Canandaigua, VA Medical Center
### VA Safety Plan: Brief Instructions

**Step 1: Recognizing Warning Signs**
- Ask “How will you know when the safety plan should be used?”
- Ask, “What 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 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 (6255))
- 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?
Suicide Risk Assessment

Mental Health Referral / Treatment
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
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
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)
Who Develops the Plan?

• Collaboratively developed by the clinician and the patient in any clinical setting
• **Those** 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.
- The clinician should adapt the approach to the individual's needs -- such as involving family members in using the safety plan.
How Do You Do It?

• 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 *form* with the patient
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
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”
### Written Responses

<table>
<thead>
<tr>
<th></th>
<th>Step 1: Warning Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><em>Needing to be alone</em></td>
</tr>
<tr>
<td>2.</td>
<td><em>Having a few too many drinks</em></td>
</tr>
<tr>
<td>3.</td>
<td><em>Feeling kinda numb</em></td>
</tr>
</tbody>
</table>
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 just for a brief time.

• Ask “What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?”
Step 2: Using Internal Coping Strategies

• Examples:
  – Going for a walk
  – Listening to inspirational 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
## Written Responses

### Step 2: Internal Coping Strategies

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><em>Go lift at the gym</em></td>
</tr>
<tr>
<td>2</td>
<td><em>Watch sports</em></td>
</tr>
<tr>
<td>3</td>
<td><em>Play drums</em></td>
</tr>
<tr>
<td>4</td>
<td><em>Go for a walk</em></td>
</tr>
</tbody>
</table>
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.
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
# Written Responses

<table>
<thead>
<tr>
<th>Step 3: Socializing with family members or others</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Go to the coffee shop</strong></td>
</tr>
<tr>
<td>2. <strong>Call my uncle 714-555-3868</strong></td>
</tr>
<tr>
<td>3. <strong>Go to the grocery store</strong></td>
</tr>
</tbody>
</table>
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
## Written Responses

<table>
<thead>
<tr>
<th></th>
<th>Step 4: Contacting family members or friends for help</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><em>Call my mom 555-4321</em></td>
</tr>
<tr>
<td>2.</td>
<td><em>Call my uncle 714-555-3868</em></td>
</tr>
</tbody>
</table>
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
Step 5: Contacting Professionals and Agencies

• List names, numbers and/or locations of:
  – Clinicians
  – Local urgent care services
  – Crisis Prevention Hotline
    • 1-800-273-TALK (8255), press “1” if veteran
# Written Responses

Step 5: Contacting Professionals and Agencies

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td><em>Call Dr. Bills 555-3434</em></td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td><em>Go to Local VA Urgent Care</em></td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td><em>1-800-273-TALK (8255) push 1</em></td>
</tr>
</tbody>
</table>
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 individual 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
<table>
<thead>
<tr>
<th></th>
<th>Step 6: Reducing the Potential for use of Lethal Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Ask wife to give the gun to her brother until her father can get it</strong></td>
</tr>
</tbody>
</table>
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?”
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 patient 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 person's circumstances and needs change over time.
## Promising or Emerging Interventions for those without a History of Neurodegenerative Disease

<table>
<thead>
<tr>
<th>Intervention</th>
</tr>
</thead>
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<tr>
<td>Brief Psychological Intervention after Deliberate Self-Poisoning</td>
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<tr>
<td><strong>Collaborative Assessment and Management for Suicide (CAMS)</strong></td>
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<tr>
<td>Cognitive Behavioral Therapy (CBT) for Suicide Prevention</td>
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<tr>
<td>Dialectic Behavioral Therapy (DBT)</td>
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<tr>
<td>Mentalization Based Treatment (MBT)</td>
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<tr>
<td>Problem Solving Therapy (PST)</td>
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</tbody>
</table>

Primary outcome measure:  Hopelessness

Secondary outcome measures:  Suicidal ideation and depression
                                Hope, self-esteem, problem solving

Participants who completed the WtoH program would report a significant reduction in their levels of hopelessness compared to waitlist controls.

Treatment group would demonstrate significant reductions in suicidal ideation and depression, and increased social problem-solving, self-esteem and hopefulness in comparison to the waitlist controls.
VA Window to Hope Team

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Medicine, Department of Physical Medicine and Rehabilitation, Department of Neurology, University of
Colorado Denver, School of Medicine.

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Consortium through the Department of Defense
“...talk to a professional. That's why you guys are here professionally trained to deal with people with my problem or problems like I have, you know...Left to myself, I'd probably kill myself. But that didn't feel right so I turned to professionals, you guys. “

- VA Patient/TBI Survivor
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