



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

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Disclosure

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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

We assess risk to...

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

Simon 2001

Take care of our patients

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

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

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Morton M. Silverman, M.D.

Lisa M. Betthausen, M.B.A.

Ryan E. Breshears, Ph.D.

Katherine K. Bellon, Ph.D.

Herbert. T. Nagamoto, M.D.



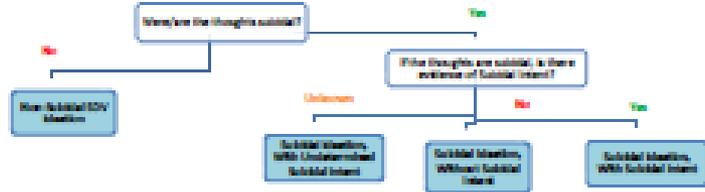
Type	Sub-Type	Definition	Modifiers	Terms
Thoughts	Non-Suicidal Self-Directed Violence Ideation	<p>Self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent.</p> <p>For example, persons engage in Non-Suicidal Self-Directed Violence Ideation in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).</p>	N/A	<ul style="list-style-type: none"> •Non-Suicidal Self-Directed Violence Ideation
	Suicidal Ideation	<p>Self-reported thoughts of engaging in suicide-related behavior.</p> <p>For example, intrusive thoughts of suicide without the wish to die would be classified as Suicidal Ideation, Without Intent.</p>	<ul style="list-style-type: none"> •Suicidal Intent -Without -Undetermined -With 	<ul style="list-style-type: none"> •Suicidal Ideation, Without Suicidal Intent •Suicidal Ideation, With Undetermined Suicidal Intent •Suicidal Ideation, With Suicidal Intent
Behaviors	Preparatory	<p>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).</p> <p>For example, hoarding medication for the purpose of overdosing would be classified as Suicidal Self-Directed Violence, Preparatory.</p>	<ul style="list-style-type: none"> • Suicidal Intent -Without -Undetermined -With 	<ul style="list-style-type: none"> •Non-Suicidal Self-Directed Violence, Preparatory •Undetermined Self-Directed Violence, Preparatory •Suicidal Self-Directed Violence, Preparatory
	Non-Suicidal Self-Directed Violence	<p>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.</p> <p>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).</p>	<ul style="list-style-type: none"> • Injury -Without -With -Fatal • Interrupted by Self or Other 	<ul style="list-style-type: none"> •Non-Suicidal Self-Directed Violence, Without Injury •Non-Suicidal Self-Directed Violence, Without Injury, Interrupted by Self or Other •Non-Suicidal Self-Directed Violence, With Injury •Non-Suicidal Self-Directed Violence, With Injury, Interrupted by Self or Other •Non-Suicidal Self-Directed Violence, Fatal
	Undetermined Self-Directed Violence	<p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> • Injury -Without -With -Fatal • Interrupted by Self or Other 	<ul style="list-style-type: none"> •Undetermined Self-Directed Violence, Without Injury •Undetermined Self-Directed Violence, Without Injury, Interrupted by Self or Other •Undetermined Self-Directed Violence, With Injury •Undetermined Self-Directed Violence, With Injury, Interrupted by Self or Other •Undetermined Self-Directed Violence, Fatal
	Suicidal Self-Directed Violence	<p>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.</p> <p>For example, a person with a wish to die cutting her wrist with a knife would be classified as Suicide Attempt, With Injury.</p>	<ul style="list-style-type: none"> • Injury -Without -With -Fatal • Interrupted by Self or Other 	<ul style="list-style-type: none"> •Suicide Attempt, Without Injury •Suicide Attempt, Without Injury, Interrupted by Self or Other •Suicide Attempt, With Injury •Suicide Attempt, With Injury, Interrupted by Self or Other •Suicide

Self-Directed Violence (SDV) Classification System Clinical Tool

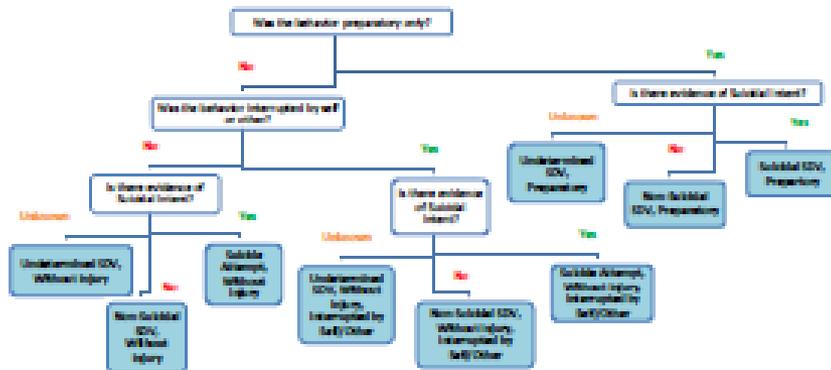
BEGIN WITH THESE 3 QUESTIONS:

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 suggest self-directed violence → NO SDV FORM
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

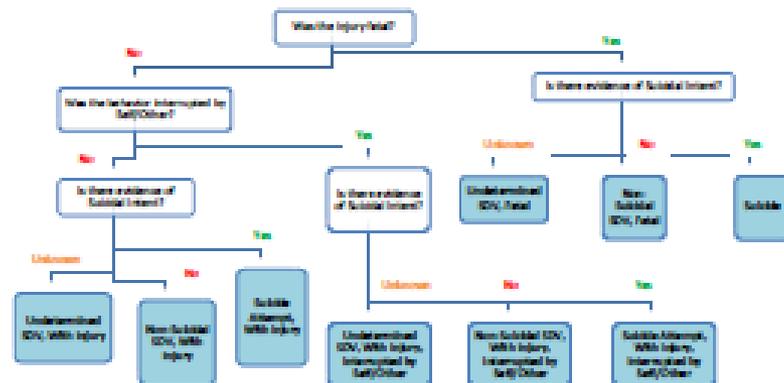
DECISION TREE A: THOUGHTS



DECISION TREE B: BEHAVIORS, WITHOUT INJURY



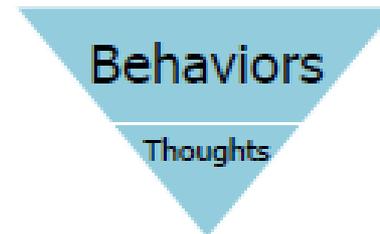
DECISION TREE C: BEHAVIORS, WITH INJURY



Self-Directed Violence (SDV) Classification System Clinical Tool

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:	There is past or present evidence (explicit and/or implicit) that the individual intended to kill him/herself and wished to die, and that he/she understood the probable consequences of his/her actions or potential actions.
Preparatory Behavior:	Acts or preparation towards ultimately 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 one's death by suicide (e.g., writing a suicide note, giving things away).
Physical Injury (paraphrased):	A bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical, or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance (e.g., bodily harm due to suffocation, poisoning or overdoses, lacerations, gunshot wounds, etc.). Refer to the Classification System for the full CDC definition.
Interrupted By Self or Other:	A person takes steps to injure self but is stopped by self/another person prior to fatal injury. The interruption may occur at any point.
Suicide Attempt:	A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior.
Suicide:	Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.



Reminder: Behaviors Trump Thoughts

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

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“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.”

http://www.suicidology.org/c/document_library/get_file?folderId=235&name=DLFE-113.pdf



**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

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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 we 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

Non-Modifiable Risk Factors

- Family History
- Past History
- Demographics

Modifiable Risk Factors

- Psychiatric symptoms
- Social Support
- Access to Lethal Means

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

Risk Factors vs. Warning Signs

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

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



AMERICAN ASSOCIATION OF SUICIDOLOGY

- 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

VA Risk 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 ER/URGENT 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 Psychiatric Disorders Compendium. Arlington VA 2004. (835-1027).
Rudd et.al, Warning signs for suicide: theory, research and clinical applications. Suicide and Life Threatening Behavior, 2006 June36 (3)255-62.

 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. 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.

 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)
- 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).

Suicide and Traumatic Brain Injury Among Individuals Seeking Veterans Health Administration Services

Lisa A. Brenner, PhD, ABPP; Rosalinda V. Ignacio, MS; Frederic C. Blow, PhD

Objective: To examine associations between history of traumatic brain injury (TBI) diagnosis and death by suicide among individuals receiving care within the Veterans Health Administration (VHA). **Method:** Individuals who received care between fiscal years 2001 to 2006 were included in analysis. Cox proportional hazards survival models for time to suicide, with time-dependent covariates, were utilized. Covariate sandwich estimators were used to adjust for the clustered nature of the data, with patients nested within VHA facilities. Analyses included all patients with a history of TBI ($n = 49,626$) plus a 5% random sample of patients without TBI ($n = 389,053$). Of those with a history of TBI, 103 died by suicide. Models were adjusted for demographic and psychiatric covariates. **Results:** Veterans with a history of TBI were 1.26 (95% confidence interval [CI], 1.24-1.92) times more likely to die by suicide than those without a history of TBI. Analyses by TBI severity were also conducted, and they suggested that in comparison to those without an injury history, those with (1) concussion/cranial fracture were 1.98 times more likely (95% CI, 1.39-2.87) to die by suicide and (2) cerebral contusion/traumatic intracranial hemorrhage were 1.34 times more likely (95% CI, 1.09-1.64) to die by suicide. This increased risk was not explained by the presence of psychiatric disorders or demographic factors. **Conclusions:** Among VHA users, those with a diagnosis of TBI were at greater risk for suicide than those without this diagnosis. Further research is indicated to identify evidence-based means of assessment and treatment for those with TBI and suicidal behavior. **Keywords:** suicide, traumatic brain injury, veterans

AMONG MEMBERS of the general population, individuals with a history of traumatic brain injury (TBI) are at increased risk for suicidal behavior as compared with those without an injury history.¹ Silver and colleagues² found that those with a TBI reported a higher frequency of suicide attempts, 8.1% versus 1.9%

in the general population. In a seminal study, Teasdale and Engberg³ reviewed hospital admission records and found that the incidence of suicide among those with concussion, cranial fracture, and cerebral contusion/intracranial hemorrhage were increased relative to the population on whole.

These findings are particularly relevant in light of the high rate of TBI being sustained by military personnel serving in Iraq and Afghanistan,^{4,5} and concerns regarding suicidal behavior among members of the armed forces and veterans.^{3,6} Estimates of military personnel serving in current conflicts who have either screened positive or been diagnosed with clinician-confirmed mild TBI range from 11% to 23%.^{3,6,7,8} In addition, recent studies suggest a high rate of TBI among individuals seeking Veterans Health Administration (VHA) mental health and substance abuse treatment services.^{9,10}

According to a recently published report by the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces,⁵ between 2005 and 2009, more than 1100 individuals in the military died by suicide. These numbers reflect a sharp increase in the rate of suicide among marines and soldiers, with the rate of suicide among army personnel more than doubling.⁵ Moreover, in comparison with members of the general population, suicide rates among

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Preliminary data regarding traumatic brain injury (TBI), all combined, and suicide were presented at the International Brain Injury Association's Eighth World Congress on Brain Injury. An abstract of the presentation will appear in the journal Brain Injury. This abstract is approximately 400 words. A full manuscript with complete information is available at <http://dx.doi.org/10.1093/HTK/001.0012.0014>.

Dr. Brenner and Blow and Ms. Ignacio report no competing interests. The authors thank Drs. Joe Koenig and John M. Carthy for their assistance in obtaining and analyzing data presented in this manuscript.

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DOI: 10.1093/HTK/001.0012.0014

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)



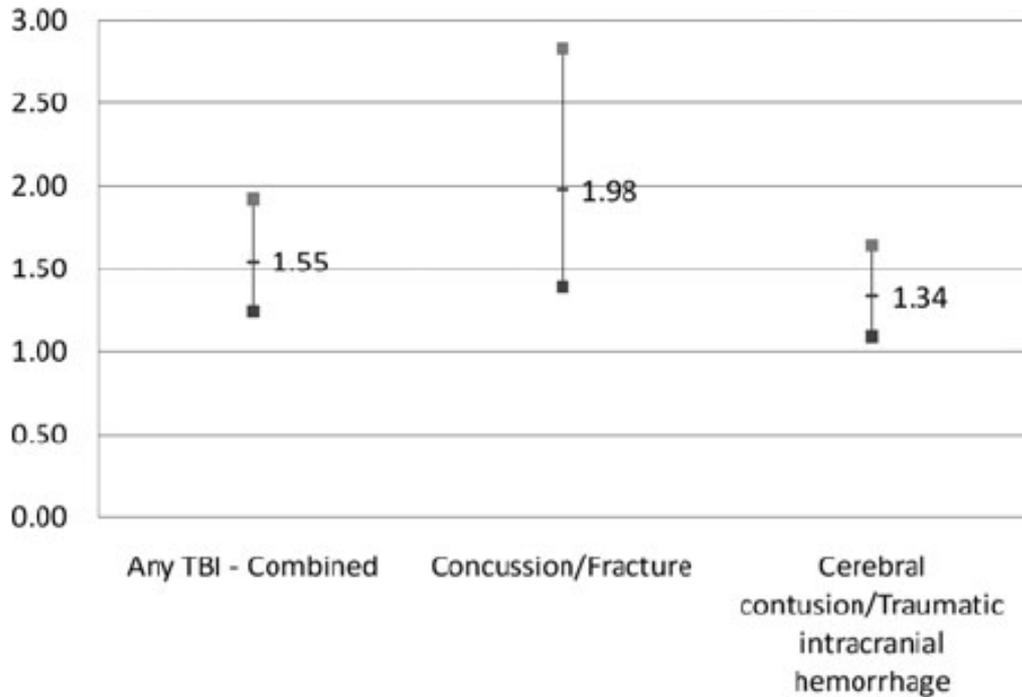


Figure 2. Hazard ratios for suicide by traumatic brain injury severity adjusted for sex, age, and psychiatric conditions.

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).



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.

Diagnosis	All		Those who died by suicide		Those who did not die by suicide		P
	N	Col%	N	Col%	N	Col%	
VHA users with any TBI (combined)							
All	49 626	100	105	100	49 521	100	
Substance abuse	8368	16.86	32	30.48	8336	16.83	.0002
Bipolar I/II	2265	4.56	10	9.52	2255	4.55	.0292
MDD	4,464	9	24	22.86	4440	8.97	<.0001
Other depression, no MDD	7616	15.35	23	21.9	7593	15.33	.062
Other anxiety	4326	8.72	16	15.24	4310	8.7	.0177
PTSD	4880	9.83	23	21.9	4857	9.81	<.0001
Schizophrenia/schizoaffective disorder	2287	4.61	6	5.71	2281	4.61	.4875
VHA users with concussion/fracture ←							
All	12 159	100	33	100	12 126	100	
Substance abuse	2087	17.16	9	27.27	2078	17.14	.123
Bipolar I/II	588	4.84	2	6.06	586	4.83	.6731
MDD	1198	9.85	10	30.3	1188	9.8	.00092 ←
Other depression, no MDD	1831	15.06	7	21.21	1824	15.04	.3271
Other anxiety	1148	9.44	7	21.21	1141	9.41	.0316 ←
PTSD	1376	11.32	7	21.21	1369	11.29	.0912
Schizophrenia/schizoaffective disorder	519	4.27	1	3.03	518	4.27	.9999
VHA users with cerebral contusion/traumatic intracranial hemorrhage ←							
All	39 545	100	78	100	39 467	100	
Substance abuse	6728	17.01	25	32.05	6703	16.98	.0004 ←
Bipolar I/II	1802	4.56	8	10.26	1794	4.55	.0256 ←
MDD	3490	8.83	17	21.79	3473	8.8	<.0001 ←
Other depression, no MDD	6142	15.53	17	21.79	6125	15.52	.1263
Other anxiety	3377	8.54	11	14.1	3366	8.53	.0785
PTSD	3757	9.5	17	21.79	3740	9.48	.0002 ←
Schizophrenia/schizoaffective disorder	1869	4.73	5	6.41	1864	4.72	.4199

Suicide and Traumatic Brain Injury Among Individuals Seeking Veterans Health Administration Services

Lisa A. Brenner, PhD, ABPP; Rosalinda V. Ignacio, MS; Frederic C. Blow, PhD

Objective: To examine associations between history of traumatic brain injury (TBI) diagnosis and death by suicide among individuals receiving care within the Veterans Health Administration (VHA). **Method:** Individuals who received care between fiscal years 2001 to 2006 were included in analyses. 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. Analyses included all patients with a history of TBI ($n = 49\,626$) plus a 5% random sample of patients without TBI ($n = 389\,053$). Of those with a history of TBI, 105 died by suicide. Models were adjusted for demographic and psychiatric covariates. **Results:** Veterans with a history of TBI were 1.55 (95% confidence interval [CI], 1.24–1.92) times more likely to die by suicide than those without a history of TBI. Analyses by TBI severity were also conducted, and they suggested that in comparison to those without an injury history, those with (1) concussion/cranial fracture were 1.98 times more likely (95% CI, 1.39–2.82) to die by suicide and (2) cerebral contusion/traumatic intracranial hemorrhage were 1.34 times more likely (95% CI, 1.09–1.64) to die by suicide. This increased risk was not explained by the presence of psychiatric disorders or demographic factors. **Conclusions:** Among VHA users, those with a diagnosis of TBI were at greater risk for suicide than those without this diagnosis. Further research is indicated to identify evidence-based means of assessment and treatment for those with TBI and suicidal behavior. **Keywords:** suicide, traumatic brain injury, veterans

AMONG MEMBERS of the general population, individuals with a history of traumatic brain injury (TBI) are at increased risk for suicidal behavior as compared with those without an injury history.¹ Silver and colleagues² found that those with a TBI reported a

higher frequency of suicide attempts, 8.1% versus 1.9% in the general population. In a seminal study, Teasdale and Engberg¹ reviewed hospital admission records and found that the incidence of suicide among those with concussion, cranial fracture, and cerebral contusion/intracranial hemorrhage were increased relative to the population as a whole.

These findings are particularly relevant in light of the high rate of TBI being sustained by military personnel serving in Iraq and Afghanistan^{3,4} and concerns regarding suicidal behaviors among members of the armed forces and veterans.^{5,6} Estimates of military personnel serving in current conflicts who have either screened positive or been diagnosed with clinician-confirmed mild TBI range from 11% to 23%.^{3,4,7,8} In addition, recent studies suggest a high rate of TBI among individuals seeking Veterans Health Administration (VHA) mental health and substance abuse treatment services.^{9,10}

According to a recently published report by the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces,⁷ between 2005 and 2009, more than 1100 individuals in the military died by suicide. These numbers reflect a sharp increase in the rate of suicide among marines and soldiers, with the rate of suicide among army personnel more than doubling.⁷ Moreover, in comparison with

“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).”

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Preliminary data regarding traumatic brain injury (TBI), all combined, and suicide were presented at the International Brain Injury Association's Eighth World Congress on Brain Injury. An abstract of the presentation will appear in the journal Brain Injury. This abstract is approximately 412 words. A VA memo containing similar information was distributed and discussed with clinicians. The data regarding TBI by severity have not been previously presented.

Drs Brenner and Blow and Ms Ignacio report no competing interests. The authors thank Drs Ira Katz, Jan Kemp, and John McCarthy for their assistance in obtaining and analyzing data presented in this manuscript.

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- 22 Subjects
- Total Number of Admissions: 114
- Median Number of Admissions: 3
- Range of Admissions: 1-20

A Preliminary Investigation of Suicidality in Psychiatrically Hospitalized Veterans with Traumatic Brain Injury

Peter M. Gutierrez, Lisa A. Brenner, and Joseph A. Huggins

The objective of this study was to explore suicidal behaviors documented at time of discharge from acute psychiatric hospitalization. Data from 114 acute psychiatric admissions were reviewed for 22 veterans with a history of traumatic brain injury (TBI). Information extracted included presence of suicidal ideation, nature of suicide attempts, and TBI characteristics. The Lethality of Suicide Attempt Rating Scale was used to classify veterans' non-lethal self-harm behavior. Post-TBI, 6 patients (27.3%) made a total of 14 suicide attempts. Half of those attempts required wounds being sutured, stomach lavage, or other medical attention. Clinicians and researchers are strongly encouraged to focus increased attention on suicide prevention in those with a history of TBI.

Keywords suicide, traumatic brain injury, veterans

Suicidal behavior has been identified as a significant problem among those with a history of traumatic brain injury (TBI). Simpson and Tate (2002) found that 23% of individuals with TBI receiving outpatient services endorsed suicidal ideation. TBI survivors also have a significantly higher rate of suicide attempts than those without such injuries (Silver, Kramer, Greenwald et al. 2001; Simpson & Tate, 2007). In a sample of individuals with mild, moderate, and severe injury, an 8.1% post-TBI lifetime rate of suicide attempts was identified, as compared with 1.9% for the general population (Silver, Kramer, Greenwald et al., 2001). Simpson and Tate (2002) reported that of those receiving outpatient services for TBI, 10.4% had pre-injury

and 17.4% had post-injury suicide attempts. Individuals with a history of TBI also die by suicide more frequently than members of the general population (Teasdale & Engberg, 2001). Rates of suicide have been found to be 3.0, 2.7, and 4.1 times higher than the population on whole, depending on the type of injury sustained (i.e., concussion, cranial fracture, or cerebral contusion or traumatic intracranial hemorrhage respectively) (Teasdale & Engberg, 2001).

A possible neuropsychiatric mechanism underlying both the acquisition of TBI and risk for engaging in suicidal behavior is executive dysfunction (Fann, Leonetti, Jaffe et al., 2002; Jollant, Bellivier, Leboyer et al., 2005). The associated brain area

Are individuals with moderate to severe TBI seeking traditional psychiatric services?

TABLE 2. Characteristics of Most Recent Traumatic Brain Injuries

Variable	N	%
Severity		
Mild	1	4.5
Moderate	11	50
Severe	10	45.5
Mechanism of Injury		
Assault	6	27.3
MVA	4	18.2
Falls	3	13.6
Other Accidents	3	13.6
Explosion	2	9.1
MCA	2	9.1
Other ¹	2	9.1

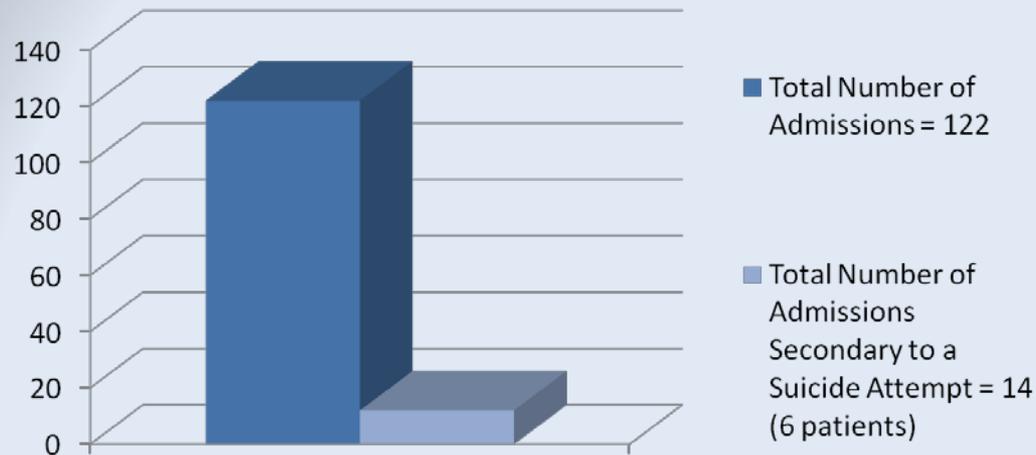
¹Pedestrian hit by car, suicide attempt; MVA = motor vehicle accident, MCA = motorcycle accident.

TABLE 3. Characteristics of Acute Psychiatric Hospitalizations

Variable	%	Range (Mdn)
Number of hospitalizations per patient		1–20 (3)
Total Psychiatric Diagnoses Noted at Discharge ¹		
Substance Abuse	73	
Mood Disorder	59	
Psychosis	24	
Anxiety Disorder	21	
Organic Disorder ²	26	
Length of Stay (Days)		0 ³ –120 (11)

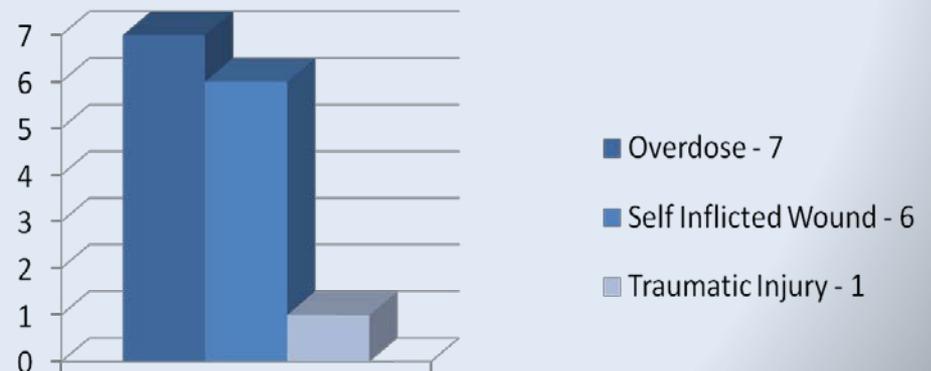
¹Psychiatric diagnoses total to more than 100% due to the majority of patients receiving more than one diagnosis. ²Includes dementia and mood disorders due to general medical condition. ³Two patients were admitted and discharged on the same day.

Number of Admissions Secondary to a Suicide Attempt



“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

Psychological Medicine, 2002, 32, 687–697. © 2002 Cambridge University Press
DOI: 10.1017/S0033291702005561 Printed in the United Kingdom

Suicidality after traumatic brain injury: demographic, injury and clinical correlates

GRAHAME SIMPSON¹ AND ROBYN TATE

*From the Brain Injury Rehabilitation Unit, Liverpool Hospital and Rehabilitation Studies Unit,
Department of Medicine, University of Sydney and Royal Rehabilitation Centre, Sydney, NSW, Australia*

- 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)

Suicidality and Veterans With a History of Traumatic Brain Injury: Precipitating Events, Protective Factors, and Prevention Strategies

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Objective: To increase understanding regarding precipitating and preventative factors of suicidal behavior and to highlight past experiences and recommendations regarding services aimed at suicide prevention among Veterans with a history of traumatic brain injury (TBI). **Study Design:** Qualitative. **Participants:** Sample of 13 Veterans with a history of TBI and history of clinically significant suicidal ideation or behavior. **Methods:** In-person interviews were conducted and data were analyzed using a hermeneutic approach. **Results:** Shared precipitants noted included loss-of-self post-TBI, cognitive sequelae, and psychiatric/adjustment disorders. Common protective factors noted included social supports, a sense of purpose regarding the future, religion, and spirituality, and mental health care. Means of improving care were also identified (e.g., increasing the availability of services and mental health professionals' knowledge regarding TBI, providing more structured treatment). **Conclusions:** Findings highlight potential areas of importance in the assessment and treatment of suicidal Veterans with a history of TBI. Recommendations regarding means of improving care are also presented.

Keywords: suicide, traumatic brain injury, Veterans, qualitative

Populations identified as being at increased risk for suicidal behavior include Veterans (Kaplan, Huguenot, McFarland, & Newcorn, 2007) and individuals with a history of traumatic brain injury (TBI) (Simpson & Tate, 2007). Kaplan et al. (2007) found U.S. male military Veterans, age 18 and older, to be twice as likely to die by suicide as non-Veteran males. Depending on the type of injury sustained, suicide rates among individuals with a history of TBI are estimated to be between 2.7 and 40 times higher as compared to the general population (Teasdale & Engberg, 2001). Findings by Silva, Kramer, Greenwald, and Wetstein (2001)

suggest an 8.1% lifetime rate of suicide attempts post-TBI (mild, moderate, and severe) compared with 1.9% for the general population. Finally, clinically significant suicidal ideation has been identified in 21% to 22% of individuals with a history of TBI (Simpson & Tate, 2007). Nevertheless, limited research has been conducted regarding Veterans with a history of TBI and suicidal behaviors, communications, or thoughts. Increased understanding regarding precipitating and preventative factors associated with suicidal behavior among this high-risk population could be used to identify best assessment and treatment practices.

A recent report suggests that suicide is on the rise among Soldiers, with the year 2005 having the highest number of confirmed cases since 1990 (Lange, 2008). Members of the U.S. Army were asked about current suicidal thoughts, and approximately 1% of the total sample of those who served in Iraq (2,411 of 222,620) endorsed some suicidal ideation (Hoge, Auchincloss, & Milliken, 2006). Moreover, 467 of the 222,620 indicated that they thought about suicide "a lot" (Hoge, Auchincloss, & Milliken, 2006). As individuals transition from active duty to Veteran status, systems of health care also change. During the year 2009, 5,771,000 patients are expected to receive medical care within the Veterans Affairs (VA) system (Pruke, 2008). This number includes approximately 333,000 Veterans who served in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) (Pruke, 2008). The need for research regarding TBI and suicide is further supported by findings that suggest that the rate of TBI among military personnel

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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)*

Level of intervention	Clinical management
<i>Universal</i>	
All people with TBI	<ul style="list-style-type: none"> • Assess hopelessness and suicide ideation proactively, using indirect or direct approaches • Monitor for warning signs that may increase risk level • Recognise that people may be at risk regardless of time post-injury • Make provision for the availability of long-term support • Monitor males and females equally
<i>Selected</i>	
People with TBI in "at-risk" groups	<ul style="list-style-type: none"> • Treat people with depressive or substance misuse conditions • Monitor people with comorbid psychiatric conditions and those injured as the result of a suicide attempt
<i>Indicated</i>	
People with TBI for whom suicide is an identified issue (eg, made attempt, expressed suicide ideation)	<ul style="list-style-type: none"> • Reduce the lethality of the environment • Provide frontline treatments (pharmacotherapy) • In managing someone with a history of any attempts, plan for the possibility that people may use more than one method • Provide support/monitor for at least 12 months after a suicide attempt • Closely monitor in the months after discharge from a psychiatric hospital

* Adapted from the United States Institute of Medicine generic suicide prevention model.²¹



Safety Planning and Suicide Prevention – A Function-Based Intervention

http://vaww.mentalhealth.va.gov/files/suicideprevention/VA_Safety_planning_manual_8-19-08revisions.doc



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

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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.

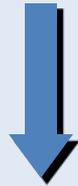
Step 6: Reducing the Potential for Use of Lethal Means

- 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?

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

	Step 1: Warning Signs
1.	<i>Needing to be alone</i>
2.	<i>Having a few too many drinks</i>
3.	<i>Feeling kinda numb</i>

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
1.	<i>Go lift at the gym</i>
2.	<i>Watch sports</i>
3.	<i>Play drums</i>
4.	<i>Go for a walk</i>

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

	Step 3: Socializing with family members or others
1.	<i>Go to the coffee shop</i>
2.	<i>Call my uncle 714-555-3868</i>
3.	<i>Go to the grocery store</i>

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

	Step 4: Contacting family members or friends for help
1.	<i>Call my mom 555-4321</i>
2.	<i>Call my uncle 714-555-3868</i>

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
1.	<i>Call Dr. Bills 555-3434</i>
2.	<i>Go to Local VA Urgent Care</i>
3.	<i>1-800-273-TALK (8255) push 1</i>

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

Written Responses

	Step 6: Reducing the Potential for use of Lethal Means
1.	<i>Ask wife to give the gun to her brother until her father can get it</i>

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

Brief Psychological Intervention after Deliberate Self-Poisoning

Collaborative Assessment and Management for Suicide (CAMS)

Cognitive Behavioral Therapy (CBT) for Suicide Prevention

Dialectic Behavioral Therapy (DBT)

Mentalization Based Treatment (MBT)

Problem Solving Therapy (PST)

Suicide Prevention After Traumatic Brain Injury: A Randomized Controlled Trial of a Program for the Psychological Treatment of Hopelessness

Grahame K. Simpson, PhD; Robyn L. Tate, PhD; Diane L. Whiting MPsychol (Clinical); Rachel E. Cotter, BA (Hons) (Psychol)

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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“...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

