Suicide Risk Assessment & Safety Planning as a Stand Alone Intervention

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Agenda

• Introduction
• Facts about Veteran Suicide
• Suicide Risk Assessment
• Safety Planning
• Role-play
• Questions and Comments
Acknowledgments

• Lisa Brenner, PhD, ABPP (Rp)
• Bridget Matarazzo, PsyD
• Patricia Alexander, PhD
• Hal Wortzel, MD
Facts about Veteran Suicide
Facts about Veteran Suicide

• ~34,000 US deaths from suicide/ year
  (Centers for Disease Control and Prevention)

• ~20% are Veterans
  (National Violent Death Reporting System)

• ~18 deaths from suicide/day are Veterans
  (National Violent Death Reporting System)

• ~ 5 deaths from suicide/day among Veterans receiving care in VHA.
  (VA Serious Mental Illness Treatment, Research and Evaluation Center)
Facts about Veteran Suicide

- More than 60% of suicides among those who utilize VHA services are among patients with a known diagnosis of a mental health condition. (VA Serious Mental Illness Treatment Research and Education Center)

- Veterans are more likely to use firearms as a means. (National Violent Death Reporting System)

- ~1000 attempts/month among Veterans receiving care in VHA as reported by suicide prevention coordinators. (VA National Suicide Prevention Coordinator)
OEF/OIF/OND Veterans

• In FY2008, the suicide rate for Veterans enrolled in VHA was:
  – **38.6** per 100,000 OEF/OIF
  – **36.5** per 100,000 non OEF/OIF

• In FY2009, the suicide rate was:
  – **31.4** per 100,000 OEF/OIF
  – **36.4** per 100,000 non OEF/OIF
  (Blow & Jemp, 2011)

• In 2009, the suicide rate for the general US population was **13.68** per 100,000
  (Center for Disease Control and Prevention)
VA Suicide Prevention Efforts

• Annual depression and PTSD screens
• For each Veteran determined to be at high risk:
  – A VA Safety Plan is created
  – A suicide risk flag is placed in their medical record
• Every VAMC is staffed with a suicide prevention coordinator
• VA Crisis Line (1-800-273-TALK)
• Online chat (www.veteranscrisisline.net/chat)
• Text option (838255)
Suicide Risk Assessment
We assess risk to...

- Take good care of our patients and to guide our interventions
- Identify modifiable and treatable risk factors that inform the patient’s overall treatment and management requirements (Simon 2001)
- Best way to care for our potential suicidal patients and ourselves are one in the same (Simon 2006)
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
Good Clinical Practice is the Best Medicine

- **Evaluation**
  - Accurate diagnosis
  - Systematic suicide risk assessment
  - Get/review prior treatment records

- **Treatment**
  - Formulate, document, and implement a cogent treatment plan
  - Continually assess risk

- **Management**
  - Safety management (hospitalize, safety plans, precautions, etc)
  - Communicate and enlist support of others for patient’s suicide crisis

"Never worry alone." (Gutheil 2002)
Suicide Risk Assessment

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

• Standard of care does require suicide risk assessment whenever indicated
• Best assessments will attend to both risk and protective factors
• Risk assessment is an ongoing process
• Goal is to generate specific patient data to guide clinical judgment, treatment, and management
Suicide Assessment Indications

• Emergency department or crisis evaluation
• Intake evaluation
• Prior to change in observation status or treatment setting
• Abrupt change in clinical presentation
• Lack of improvement or gradual worsening with treatment
• Anticipation/experience of loss or stressor
• Onset of physical illness
Important Domains of a Suicide-Focused Psychiatric Interview

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

Specific Inquiry of Thoughts, Plans, and Behaviors

• Elicit any suicidal ideation
  – Focus on nature, frequency, extent, timing
  – Assess feelings about living

• Presence or Absence of Plan
  – What are plans, what steps have been taken
  – Investigate patient’s belief regarding lethality
  – Ask what circumstances might lead them to enact plan
  – Ask about firearms and address the issue
Specific Inquiry of Thoughts, Plans, and Behaviors

• Assess patient’s degree of suicidality, including intent and lethality of the plan
  – Consider motivations, seriousness and extent of desire to die, associated behaviors and plans, preparations, lethality of method, accessibility

• Strive to know your patient and their specific or idiosyncratic warning signs
Identify Suicide Risk Factors

• Specific factors that may generally increase risk for suicide or other self-directed violent behaviors

• A major focus of research for past 30 years

• Categories of risk factors
  – Demographic
  – Psychiatric
  – Psychosocial stressors
  – Past history
Warning Signs

• Warning signs – person-specific emotions, thoughts, or behaviors precipitating suicidal behavior

• Proximal to the suicidal behavior and imply imminent risk

• The presence of suicide warning signs, especially when combined with suicide risk factors generates the need to conduct further suicide risk assessment

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

<table>
<thead>
<tr>
<th>Characteristic Feature</th>
<th>Risk Factor</th>
<th>Warning Sign</th>
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<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>
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Rudd et al. 2006
### Risk Factors vs. Warning Signs

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

<table>
<thead>
<tr>
<th>Non-modifiable Risk Factors</th>
<th>Modifiable Risk Factors</th>
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<tbody>
<tr>
<td>Family History</td>
<td>Treat psychiatric symptoms</td>
</tr>
<tr>
<td>Past history</td>
<td>Increase social support</td>
</tr>
<tr>
<td>Demographics</td>
<td>Remove access to lethal means</td>
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</table>
Develop a Treatment Plan

• For the suicidal patient, particular attention should be paid to modifiable risk and protective factors

• Static risk factors help stratify level of risk, but are typically of little use in treatment; can’t change age, gender, or history

• Modifiable risk factors are typically many: medical illness (pain), psychiatric symptoms (psychosis), active substance abuse, cognitive styles, access to means, etc
Don’t Neglect Modifiable Protective Factors

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

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

A 29 y/o female with hx of 5 suicide attempts and chronic suicidal ideation, numerous psychiatric admissions, family hx of suicide, gun ownership, TBI, intermittent homelessness, alcohol dependence, and BPD presents to ER with c/o SOB; asked to conduct psychiatric evaluation given her well-known history. What is her risk?

- Formulation and plan for such individuals necessitates separate consideration of chronic and acute risk
Static v. Dynamic Risk Factors

Static Risk Factors
- Hx of suicide attempts
- Hx of psychiatric admissions
- Family hx of suicide
- TBI

Dynamic Risk Factors
- Chronic, ongoing suicidal ideation
- Access to firearms
- Intermittent homelessness
- Alcohol dependence
- BPD
Status of Dynamic Risk Factors

- **Dynamic Risk Factors**
  - Chronic, ongoing suicidal ideation
  - Access to firearms
  - Intermittent homelessness
  - Alcohol dependence
  - BPD

- **Current Status**
  - Thoughts of dying but no intent or plan for self harm
  - Firearm is in sister’s gunsafe
  - Stable housing and employment for the past 6 months
  - Sustained sobriety past 12 months
  - Engaged in treatment and regularly attending DBT groups
Acute v. Chronic Risk

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

“Although patient carries many static risk factors placing her at high chronic risk for engaging in suicidal behaviors, her present mood, stable housing, sustained sobriety, and SI below baseline (no intent or plan) suggest low acute/imminent risk for suicidal behavior.”
Status of Dynamic Risk Factors

• What is her acute risk now?
  – Active SI with some intent and plan to overdose on psychotropic meds and alcohol
  – Firearm is in sister’s gun safe
  – Stable housing but threat to employment
  – Recent relapse and several episodes of binge drinking in past two weeks
  – Missed last two DBT groups and poor adherence to medications
Assessment Measures
Elements of Useful Assessment Tools

- Clear operational definitions of construct assessed
- Focused on specific domains
- Developed through systematic, multistage process
  - empirical support for item content, clear administration and scoring instructions, reliability, and validity
- Range of normative data available
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
Suicide Specific Self-Report Measures

• Self-Harm Behavior Questionnaire (SHBQ; Gutierrez et al., 2001)

• Reasons for Living Inventory (RFL; Linehan et al., 1983)

• Suicide Cognitions Scale-Revised (SCS-R; Rudd, 2004)

• Beck Scale for Suicidal Ideation (BSS; Beck, 1991)
2. Have you ever attempted suicide? **YES** **NO**
   If no, go on to question # 4.
   If yes, how? ____________________
   (Note: if you took pills, what kind? ___________; how many? _____; over how long a period of time did you take them? __________)
   a. How many times have you attempted suicide? ________
   b. When was the most recent attempt? (write your age) __________
   c. Did you tell anyone about the attempt? **YES** **NO**
      Who? ___________________________________________________________________
   d. Did you require medical attention after the attempt? **YES** **NO**
      If yes, were you hospitalized over night or longer? **YES** **NO**
      How long were you hospitalized? ___________________________________________________________________
   e. Did you talk to a counselor or some other person like that after your attempt? **YES** **NO**
      Who? _______________
Sample RFL Items

1. I have a responsibility and commitment to my family.
2. I believe I can learn to adjust or cope with my problems.
3. I believe I have control over my life and destiny.
4. I have a desire to live.
5. I believe only God has the right to end a life.
6. I am afraid of death.
7. My family might believe I did not love them.
8. I do not believe that things get miserable or hopeless enough that I would rather be dead.
9. My family depends upon me and needs me.
10. I do not want to die.
Sample SCS-R Items

1) The world would be better off without me.
2) Suicide is the only way to solve my problems.
3) I can’t stand this pain anymore.
4) I am an unnecessary burden to my family.
5) I’ve never been successful at anything.
6) I can’t tolerate being this upset any longer.
7) I can never be forgiven for the mistakes I have made.
8) No one can help solve my problems.
9) It is unbearable when I get this upset.
10) I am completely unworthy of love.
Safety Planning: A Stand Alone Intervention
Major Challenges

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

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

“No-Suicide Contracts”

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

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

• DON’T USE THEM!
### SAFETY PLAN: VA VERSION

<table>
<thead>
<tr>
<th>Step 1: Warning signs:</th>
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<tbody>
<tr>
<td>1. ____________________________</td>
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<td>2. ____________________________</td>
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<td>3. ____________________________</td>
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<thead>
<tr>
<th>Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:</th>
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<tbody>
<tr>
<td>1. ____________________________</td>
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<td>2. ____________________________</td>
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<td>3. ____________________________</td>
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<tr>
<th>Step 3: People and social settings that provide distraction:</th>
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<tbody>
<tr>
<td>1. Name_________________________________ Phone____________________</td>
</tr>
<tr>
<td>2. Name_________________________________ Phone____________________</td>
</tr>
<tr>
<td>3. Place_________________________________ 4. Place __________________________</td>
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<table>
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<tr>
<th>Step 4: People whom I can ask for help:</th>
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<tbody>
<tr>
<td>1. Name_________________________________ Phone____________________</td>
</tr>
<tr>
<td>2. Name_________________________________ Phone____________________</td>
</tr>
<tr>
<td>3. Name_________________________________ Phone____________________</td>
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<tr>
<th>Step 5: Professionals or agencies I can contact during a crisis:</th>
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<tbody>
<tr>
<td>1. Clinician Name_________________________________ Phone____________________</td>
</tr>
<tr>
<td>Clinician Pager or Emergency Contact #________________________</td>
</tr>
<tr>
<td>2. Clinician Name_________________________________ Phone____________________</td>
</tr>
<tr>
<td>Clinician Pager or Emergency Contact #________________________</td>
</tr>
<tr>
<td>3. Local Urgent Care Services __________________________________</td>
</tr>
<tr>
<td>Urgent Care Services Address_________________________________________________________________________</td>
</tr>
<tr>
<td>Urgent Care Services Phone __________________________________________________________________________</td>
</tr>
<tr>
<td>4. VA Suicide Prevention Resource Coordinator Name________________________</td>
</tr>
<tr>
<td>VA Suicide Prevention Resource Coordinator Phone________________________</td>
</tr>
<tr>
<td>5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician</td>
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<th>Step 6: Making the environment safe:</th>
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<tbody>
<tr>
<td>1. ____________________________</td>
</tr>
<tr>
<td>2. ____________________________</td>
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Tips for Developing a Safety Plan

• Ways to increase collaboration
  – Sit side-by-side
  – Use a paper form
  – Allow the patient to write
• Brief instructions using the patient’s own words
• Easy to read
• Address barriers and use a problem-solving approach

6 Steps of Safety Planning

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

- Purpose: To help the patient identify and pay attention to his or her warning signs
- Recognize the signs that immediately precede a suicidal crisis
- Personal situations, thoughts, images, thinking styles, mood or behavior
- “How will you know when the safety plan should be used?”
- Specific and personalized examples
Step 1: Recognizing Warning Signs

Examples

- **Automatic Thoughts**
  - “I am a nobody”

- **Images**
  - “Flashbacks”

- **Mood**
  - “Feeling hopeless”

- **Behavior**
  - “Crying”
  - “Not answering the phone”
  - “Using drugs”
Step 2: Using Internal Coping Strategies

- **Purpose:** To take the patient’s mind off of problems to prevent escalation of suicidal thoughts
  - **NOT** to solve the patient’s problems
- **List activities the patient can do without contacting another person**
- This step helps patients see that they can cope with their suicidal thoughts on their own, even if only for a brief period of time
- **Examples:** Go for a walk, listen to inspirational music, take a hot shower, play with a pet
Step 2: Using Internal Coping Strategies

- Ask “How likely do you think you would be able to do this step during a time of crisis?”
- Ask “What might stand in the way of you thinking of these activities or doing them if you think of them?”
- Use a collaborative, problem solving approach to address potential roadblocks.
Step 3: People and Social Settings that Provide Distraction

- Purpose: To engage with people and social settings that will provide *distraction*
- Also increases social connection
- The client is not telling someone they are in distress during this step
- Importance of including phone numbers and multiple options
- Avoid listing any controversial relationships
Step 3: Socializing with Family Members or Others

• Ask “Who helps you take your mind off your problems at least for a little while? You don’t have to tell them about your suicidal feelings.”

• Ask “Who do you enjoy socializing with?”

• Ask “Where can you go where you’ll have the opportunity to be around people in a safe environment?”

• Ask patients to list several people, in case they cannot reach the first person on the list.
Step 4: Contacting Family Members or Friends Who May Offer Help

- Purpose: To explicitly tell a family member or friend that he or she is in crisis and needs support

- Can be the same people as Step 3, but different purpose

- If possible, include a family member or friend in the process by sharing the safety plan with them
Step 4: Contacting Family Members or Friends Who May Offer Help

• Coach patients to use Step 4 if Step 3 does not resolve the crisis or lower risk.

• Ask “Among your family or friends, who do you think you could contact for help during a crisis?” or

• “Who is supportive of you and who do you feel that you can talk with when you’re under stress?”
Step 5: Contacting Professionals and Agencies

- **Purpose:** The client should contact a professional if the previous steps do not work to resolve the crisis.

- **Include name, phone number and location**
  - Primary mental health provider
  - Other providers
  - Urgent care or emergency psychiatric services
  - National Crisis Hotline 800-273-TALK (8255)
  - 911
Step 6: Reducing the Potential for Use of Lethal Means

• Complete this step even if the client has not identified a suicide plan
• Eliminate or limit access to any potential lethal means
• Always ask about access to firearms
• Discuss medications and how they are stored and managed
• Consider alcohol and drugs as a conduit to lethal means
Step 6: Reducing the Potential for Use of Lethal Means

• Ask “What means do you have access to and are likely to use to make a suicide attempt or to kill yourself?”

• Ask “How can we go about developing a plan to limit your access to these means?”

• The clinician should always ask whether the client has access to a firearm.
Step 6: Reducing the Potential for Use of Lethal Means

- For methods with low lethality, clinicians may ask clients to remove or restrict their access to these methods themselves.
  - For example, if clients 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 clients are considering shooting themselves, suggest that they ask a trusted family member to store the gun in a secure place.
Implementation

• Assess how likely it is that the patient will use the safety plan
• Problem-solve around any barriers
• Examples of barriers
  – Difficult to reach out to others
  – Don’t like the name
• Discuss where the patient will keep the safety plan
  – Multiple copies; wallet-size versions
• Review and update the safety plan frequently
Implementation

• Decide with whom and how to share the safety plan

• Discuss the location of the safety plan
  – Accessibility is key

• Discuss how it should be used during a crisis
It’s Always About the Relationship

• Be familiar enough with the Safety Planning steps that you don’t have to go through it by rote
• Have a conversation with the patient as you develop the plan
• Recognize strengths and skills and help apply those to the safety plan
• Draw on the patient’s history, as he or she is telling it, to support the positive side of the ambivalence
Most Suicidal People...

• do not want to end their lives, they want an end to their psychological pain and suffering
• tell others that they are thinking about suicide as an option for coping with pain
• have psychological problems, social problems and limiting coping skills – all things mental health professionals are usually well trained to tackle.

(Jobes, 2006)
What You Bring to the Relationship

• Degree of comfort in talking about suicide.
• Awareness of the intensity of your own feelings in dealing with suicidal patients.
• Awareness of the role ambivalence is playing.
• Understand and have compassion for the role suicidal thoughts are playing in the person’s life.
• Bring options as most suicidal patients are searching for ways to end their pain.
• Familiarity with Warning Signs, Risk and Protective Factors but don’t limit yourself to checklists or algorithms or assessment measures alone.
Bring Hope to the Relationship

“It is clear that the capacity to think about the future with a sense of hope is absolutely protective against suicide. It follows that a sense of hopefulness within our future thinking and key beliefs help us weather the rough spots that we invariably encounter in life. Alternatively, the absence of hopefulness-particularly in the absolute sense of hopelessness- is an extremely pernicious risk factor for suicide... there is perhaps no single construct that has been more highly correlated with completed suicide than hopelessness”.

(Beck, 1986; Brown, Beck, Steer ,& Grisham, 2000)
Role-Play
Resources

• VISN 19 MIRECC
  http://www.mirecc.va.gov/visn19/

• VA Safety Planning Manual
  www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.doc
It takes the courage and strength of a warrior to ask for help.....

If you're in an emotional crisis call 1-800-273-TALK "Press 1 for Veterans"

www.suicidepreventionlifeline.org
Use Your Smartphone to Visit the VISN 19 MIRECC Website

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

www.mirecc.va.gov/visn19
Thank you!

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