



Documenting suicide risk assessment and management: Making use of the evidence to facilitate decision making

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Disclosure

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“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 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 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 psychiatric 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 healthy 21-year-old female is brought by her boyfriend to the Emergency Department after telling him she ingested 4-6 regular strength acetaminophen [Tylenol] capsules (1300-1950 mg total dose). She reports no ill effects. Lab tests done at the time of admission to the ED reported her acetaminophen level within the therapeutic range. Four hours later, lab tests reported levels within the low therapeutic range. During triage, she states that before she took the capsules, she was upset and wished she was dead. She feels better now and requests to go home.



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 Suicidology

Implications of the Problem

- Clinical
- Research
- Public Health

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

Classification System

Essential Features

- “Exhaustive”
- Builds upon a nomenclature
- Further differentiates between like phenomena

Self-Directed Violence Classification System

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Lisa M. Betthausen, M.B.A.

Ryan E. Breshears, Ph.D.

Katherine K. Bellon, Ph.D.

Herbert. T. Nagamoto, M.D.



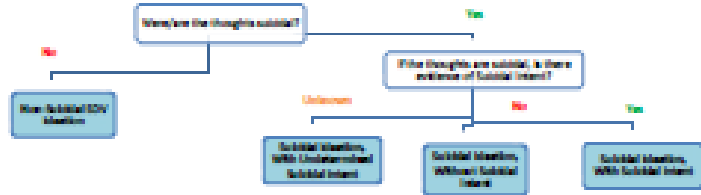
Type	Sub-Type	Definition	Modifiers	Terms
Thoughts	Non-Suicidal Self-Directed Violence Ideation	<p>Self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent.</p> <p>For example, persons engage in Non-Suicidal 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

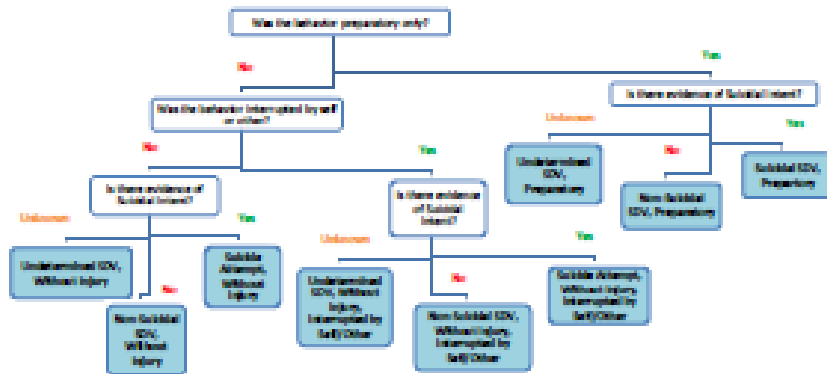
BEGIN WITH THESE 3 QUESTIONS:

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

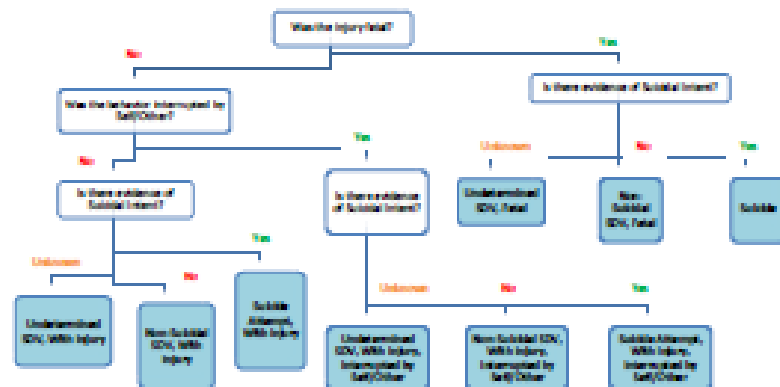
DECISION TREE A: THOUGHTS



DECISION TREE B: BEHAVIORS, WITHOUT INJURY



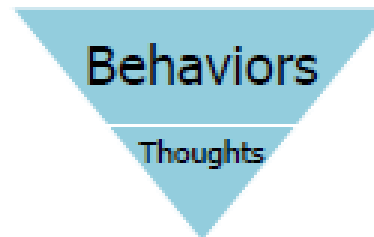
DECISION TREE C: BEHAVIORS, WITH INJURY



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

Now that we are using a
common language

How should we be
assessing risk?

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 completed suicide.”

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



“Although self-report measures are often used as screening tools, an adequate evaluation of suicidality should include both interviewer-administered and self-report measures.”

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

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.



AMERICAN ASSOCIATION OF SUICIDOLOGY

- 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...

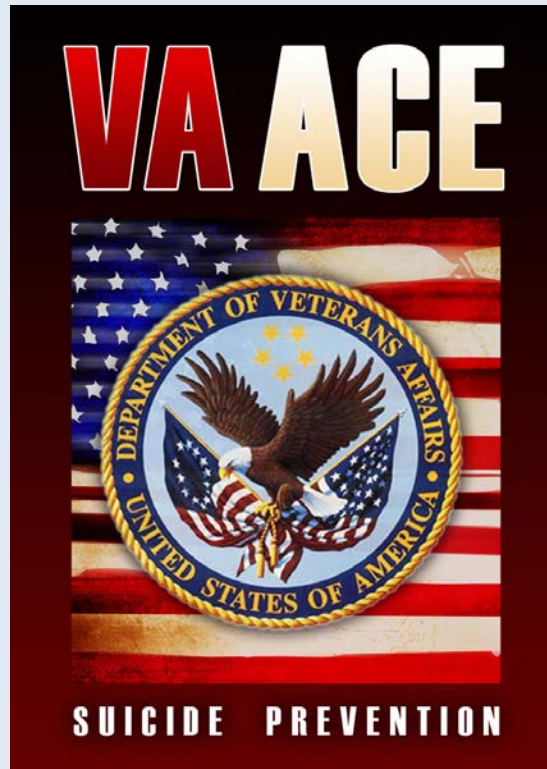
When did you have these thoughts and do you have a plan to take your life?

Have you ever had a suicide attempt?

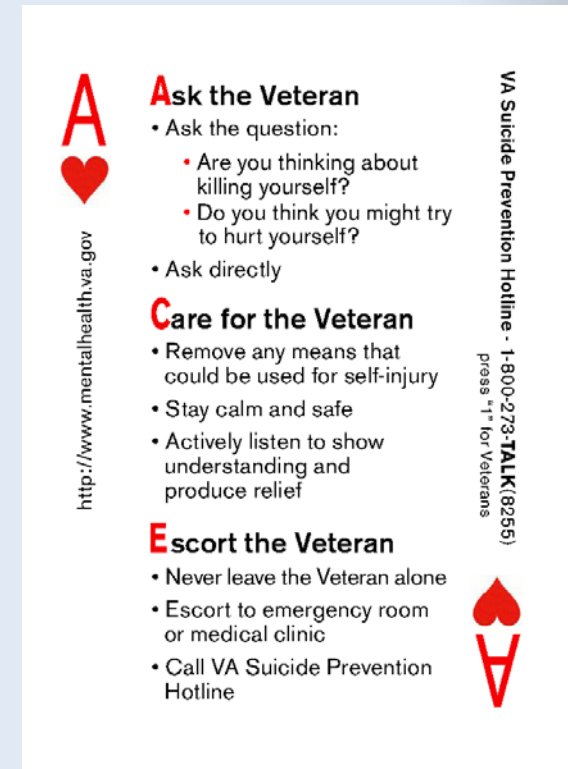


VA ACE CARDS

- These are wallet-sized, easily-accessible, and portable tools on which the steps for being an active and valuable participant in suicide prevention are summarized
- The accompanying brochure discusses warning signs of suicide, and provides safety guidelines for each step



Front view



Back view



Ask your VA provider for an ACE card to carry with you

Recognizing Suicide Warning Signs

Warning signs are early indicators of heightened risk

These signs require immediate attention

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

What Veterans and Their Family Members and Friends Should Know about Suicide

- Asking a Veteran about suicide does not create suicidal thoughts any more than asking about chest pain causes a heart attack
 - The act of asking may give the Veteran permission to talk about thoughts or feelings
- Many people who die by suicide have communicated some intent, wish, or desire to kill themselves
 - Someone who talks about suicide gives you an opportunity to intervene before suicidal behaviors occur
- Many suicidal ideas are associated with the presence of underlying treatable conditions
 - Providing treatment for an underlying condition can save a life
 - Helping the person survive the immediate crisis so that they can seek such treatment is vital
- Suicidal thinking can overwhelm even the most rational person
 - Protective factors may not provide a sufficient buffer during periods of crisis
- Anyone experiencing serious suicidal thoughts should be referred to a health care provider who can evaluate their conditions and provide treatment as appropriate

Additional Warning Signs

The presence of these signs requires contact with a professional

- Inability to sleep or sleeping all the time
- Withdrawing from friends, family and/or society
- Increasing alcohol or drug use
- Acting recklessly or engaging in risky activities
- Rage, anger, seeking revenge
- Avoiding things or reliving past experiences
- Anxiety, agitation
- Dramatic changes in mood
- No reason for living – no sense of purpose in life
- Feeling trapped – like there is no way out
- Hopelessness

Protective Factors

Factors that can protect one from suicidal behavior

Protective factors include:

- Family, friends, social support, close relationships, battle buddy
- Coping/problem-solving skills
- Ongoing health and mental health care relationships
- Reasons for living
- Cultural and religious beliefs that discourage suicide and support living

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

Population of Interest: Operation Enduring Freedom/Operation Iraqi Freedom

At risk for traumatic brain injury (TBI), post
traumatic stress disorder, and suicide

Can we draw from what we know about these
conditions, suicidology, and rehabilitation
medicine to identify novel means of
assessing risk?

OIF and Suicide/Homicide

- **425** patients (Feb – Dec, 2004) – Evaluated by the MH Team at Forward Operational Base Speicher
 - 23% Reserves, 76% Active Duty Army, 1% Active Duty AF
 - 19% Combat Units, 81% Support Units
 - 127 had thought of ending life in the past week
 - 81 had a specific suicide plan
 - 26 had acted in a suicidal manner (e.g. placed weapon to their head)
 - 67 had the desire to kill somebody else (not the enemy)
 - 36 had formed a plan to harm someone else
 - 11 had acted on the plan
- **75 of the cases were deemed severe enough to require immediate mental health intervention**
 - Of the 75 soldiers, 70 were treated in theater and returned to duty
 - **5 were evacuated**

Risk Factors for those with a History of TBI

Individuals with a history of TBI are
at increased risk of dying by suicide

Members of the military are
sustaining TBIs

Role of Pre-injury vs. Post-Injury Risk Factors

Post-injury psychosocial factors, in particular the presence of **post injury emotional/psychiatric disturbance** (E/PD) had far greater significance than pre-injury vulnerabilities or injury variables, in predicting elevated levels of suicidality post injury.

Higher levels of hopelessness were the strongest predictor of suicidal ideation, and high levels of SI, in association E/PD was the strongest predictor of post-injury attempts

Respondents with a co-morbid history of psychiatric/emotional disturbance **and** substance abuse were 21 times more likely to have made a post-TBI suicide attempt.

TBI – Symptoms, Functioning and Outcomes

Qualitative Analysis of Suicide Precipitating Events, Protective Factors and Prevention Strategies among Veterans with Traumatic Brain Injury

Brenner, L., Homaifar, B., Wolfman, J., Kemp, J., & Adler, L.,
Qualitative Analysis of Suicide Precipitating Events, Protective
Factors and Prevention Strategies among Veterans with
Traumatic Brain Injury, Rehabilitation Psychology.



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."

**Evidence-Based Measures:
Suicidality in Those
With TBI:**

1

**RESEARCH
NEEDED!!!**

PTSD and Suicide

Members of the military developing
PTSD



Those with PTSD at Increased Risk for Suicidal Behavior

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



Why?

- Veteran Population
 - Survivor guilt (Hendin and Haas, 1991)
 - Being an agent of killing (Fontana et al., 1992)
 - Intensity of sustaining a combat injury (Bullman and Kang, 1996)

Self-harm as a means of regulating overwhelming internal experiences

unwanted emotions
flashbacks
unpleasant
thoughts

Post-Traumatic Symptoms and Suicidality

- Avoidance/Numbing
- Hyperarousal
- Re-experiencing

Re-experiencing Symptom Cluster
Associated with Suicidal Ideation

A Qualitative Study of Potential Suicide Risk Factors in Returning Combat Veterans

Brenner LA, Gutierrez PM, Cornette MM, Betthausen LM, Bahraini N, Staves P. A qualitative study of potential suicide risk factors in returning combat veterans. *Journal of Mental Health Counseling*. 2008;30(3): 211-225.. 2009; 24(1):14-23.

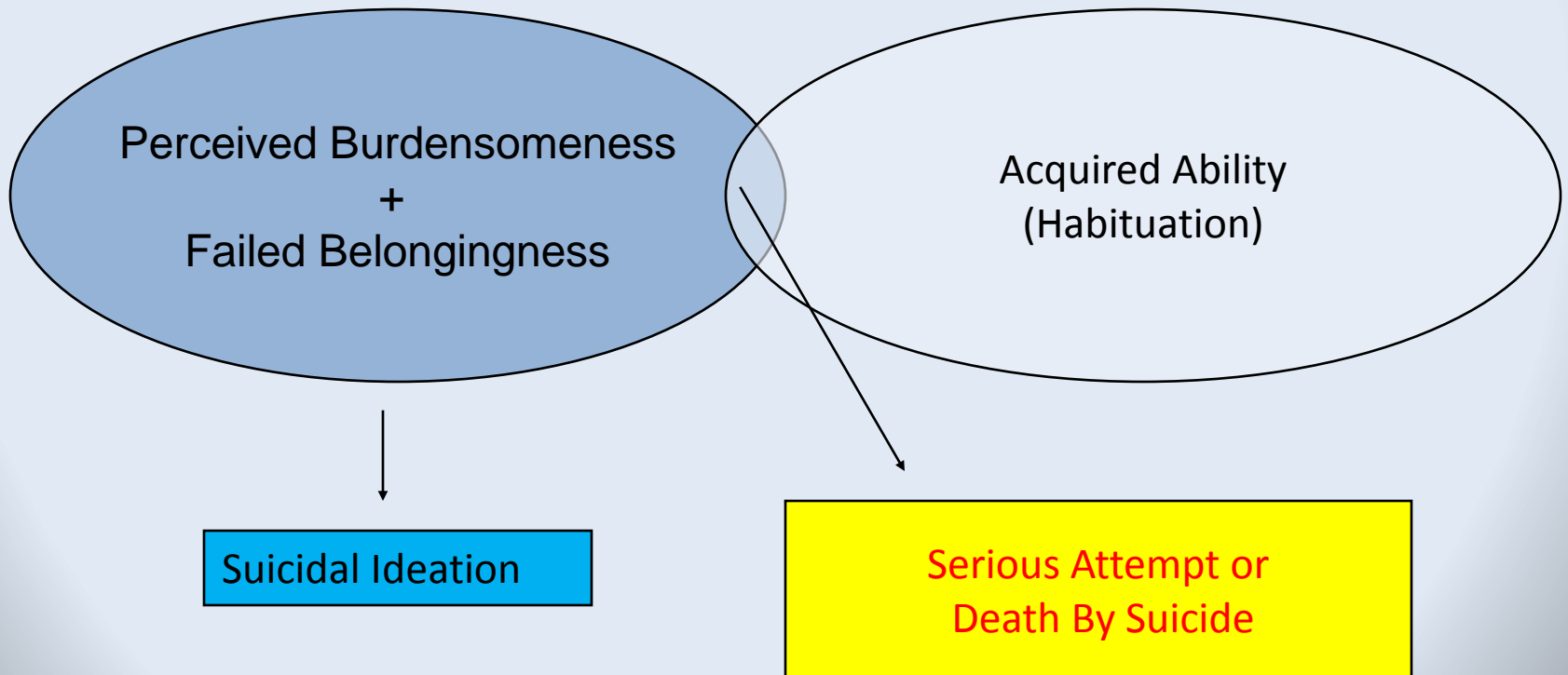


Interpersonal-Psychological Theory of Suicide Risk

Joiner 2005

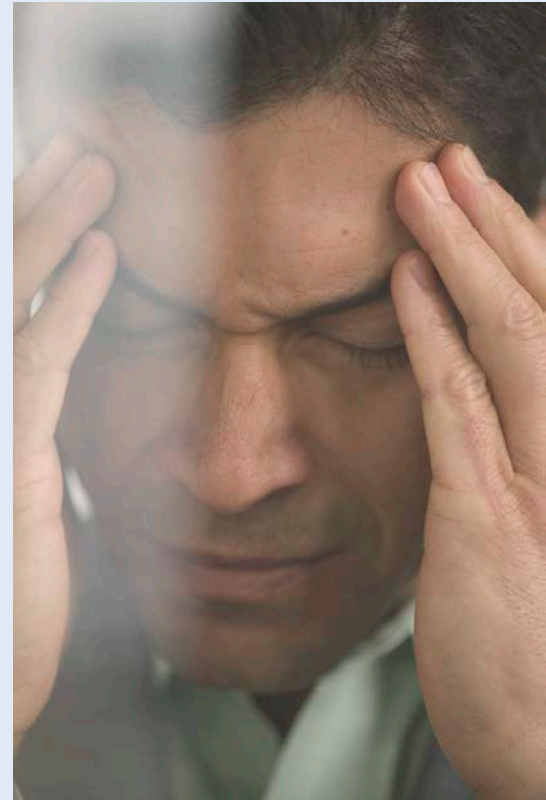
Those who desire
death

Those capable of
suicide



Themes

- Combat experiences were a setting for exposure to pain
- It takes more to be hurt now than in the past
- Increased tolerance for pain in conjunction with a variety of maladaptive coping strategies



Pain

- “I think that during the time that I was overseas I ah, kind of lost connection with reality and lost connection with my feelings...if you don't have any emotions, then you are not scared or afraid either, which really helps you to get through the days in such a dangerous environment.”



Belongingness

- Feeling disconnection from civilians and/or society in general
- “I separate myself from society, that part of society. I don’t know how to deal with those people....I just keep myself away.”



Findings – Belongingness

- “That connection [to other veterans] never weakens. That’s the strange thing about it. I mean I may not communicate as much with active duty soldiers, soldiers from my unit...but every where I go, I run into vets. It’s just the way of life, and we talk and we talk about things we’ve done...”



Belongingness

- Loss of sense of self post-discharge
 - This loss seemed to be exacerbated when separation from the military was not their choice
- “They made me retire when I got back from this one, and it wasn't a choice...I still haven't redefined who I am.”





Burdensomeness

- Despite ambivalence - veterans reported feeling a sense of importance regarding their mission overseas relative to their civilian avocational and occupational activities
- “I said I'm going to try and find something where I don't have to worry about hurting people. That would be nice for once in my life, but I don't know what that is. So I'm trying to redefine myself.”

Burdensomeness

- “I feel like I am burden, 100%, I don't feel like I belong anywhere ... like if I'm out with some friends, I don't feel like I belong. Family, I'm the outsider.”

The International Classification of Functioning (ICF)

- Disability – impairment in bodily function (e.g., cognitive dysfunction)
- Activity limitation – “...difficulties an individual may have in executing” a task or action (e.g., not being able to drive)
- Participation restriction – “...problems an individual may experience in involvement with life situations” (e.g., not being able to work)

The International Classification of Functioning (ICF)

Model developed by the World
Health Organization (WHO)

Means of understanding factors that
can impact how people live with TBI

REGARDLESS OF INJURY SEVERITY

Key Terms

- **Disability** – impairment in bodily function (e.g., cognitive dysfunction)
- **Activity limitation** – “...difficulties an individual may have in executing” a task or action (e.g., not being able to drive)
- **Participation restriction** – “...problems an individual may experience in involvement with life situations” (e.g., not being able to work)

It is necessary to consider individual functioning and disability post-TBI in the context of personal and environmental factors

History of combat experience

Limited public transportation

Pre-TBI history of depression

Limited social supports

TBI and Suicide Risk Assessment Strategy

- Assess for
 - Acquired Ability
 - Burdensomeness
 - Failed Belongingness
- In the context of
 - Disability
 - Activity limitation
 - Participation restriction

Interpersonal-Psychological Theory of Suicide Risk

Joiner 2005

Those who desire
death

Those capable of
suicide

Perceived Burdensomeness
+
Failed Belongingness

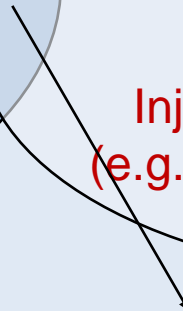
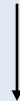
Cognitive Dysfunction, Inability
to Drive, Inability to Work,
Loss of Sense of Self

Acquired Ability
(Habituation)

Injury History, TBI Sequelae
(e.g., chronic pain), Depression

Suicidal Ideation

Serious Attempt or
Death By Suicide



“Never worry alone”

Gutheil 2002

Clinical Consultation Services for Providers with Patients at Suicide Risk

Consultation as a Means of Veteran Suicide Prevention

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The development and implementation of a suicide consultation service being run by an interdisciplinary team in a metropolitan Veterans' Administration (VA) medical center is described. This service is grounded in a collaborative theoretical framework. An overview of the consultation process and theoretical and empirical literature to support the framework used by the service are provided. Some of the interventions commonly recommended to referring clinicians to reduce client suicide risk are reviewed. Although there are many challenges to running a service such as this, the authors conclude that the model presented is flexible enough to be applied in a variety of settings.

Keywords: suicide, veterans, consultation, assessment, collaboration

What options exist for mental health providers to increase clinical competence in working with high-risk suicidal patients? To whom can clinicians turn for help with case conceptualization and treatment planning? By what means can clients become

increasingly engaged in their own treatment? In order to address these clinical issues within a Veteran Affairs (VA) Medical Center setting, a novel suicide prevention consultation service was developed. This service was organized by an interdisciplinary

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What is the consult service?

- Interdisciplinary group of clinicians with expertise in suicide, treatment, and assessment
 - (e.g., psychodiagnostic, neuropsychological)
- Provides assistance with diagnostic and treatment conceptualization
- Consultees – VA outpatient Mental Health Clinic and a psychiatric inpatient unit

Fundamental Components

- The larger system as context must be considered
- Consultation is an inherently complex process involving a triadic relationship - client, consultee, and consultant
- Ultimately, the consultant relationship is non-coercive
 - The consultee is free to accept or reject whatever the consultant says
- Didactic element - helps consultees and clients function with an increased sense autonomy when similar situations arise in the future

Components of a Consult

- Medical record review
- Clinical interview
- Standardized psychological and neuropsychological measures
 - Self report measures of suicide-related constructs
- Collateral data



The consultant first reviews the case with the consultee and makes sure that the idea of the consult has been discussed with the veteran

The consultant and client meet for an average of
8-10 hours

With outpatient consults this process may occur over
the course of 4-6 weeks

Facilitating Communication

- Preliminary findings discussed throughout the assessment
 - Progress note in the client's medical record at each appointment
- Veteran is aware that this sharing will occur
- Encourage consultees to remain active participants throughout the consultation process

Risk and Protective Factors

- Risk - historical events, psychopathology, personality structure, cognitive functioning, and current stressors
- Protective factors - responses to treatment, available supports, and religious, spiritual, and cultural beliefs

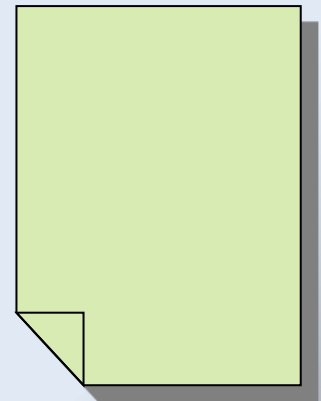
Early, 1992; Jobes & Mann, 1999; Malone et al., 2000; Quinnett, 2000; Simpson & Tate, 2007

Warning Signs and Safety Planning

- Warning signs - the "earliest detectable sign that indicated heightened risk for suicide in the near term (i.e., within minutes, hours, or days)" (Rudd et al 2006, p. 258)
- Identified veteran specific warning signs discussed with clients and consultants -- potentially imminent risk and facilitate safety planning (Stanley, Brown, Karlin, Kemp, & VonBergen, 2008)

Feedback

- Components
 - Psychodiagnostic information
 - Conceptualization of suicide risk
 - Treatment recommendations (therapy, meds)
 - Recommendations - systemic factors
- Feedback meetings
- Written report



Process Issues for Veterans

- Assessment can be activating to the client
 - Concept of self-discovery - the ability to organize and understand one's life experiences - quite powerful
 - Normalize clients' experience - talking openly, candidly, and non-judgmentally about suicidality

COLLABORATION

Termination

- Addressed early in the consultation process
- Revisited throughout
- Facilitated by the ongoing message that consultant is the primary provider



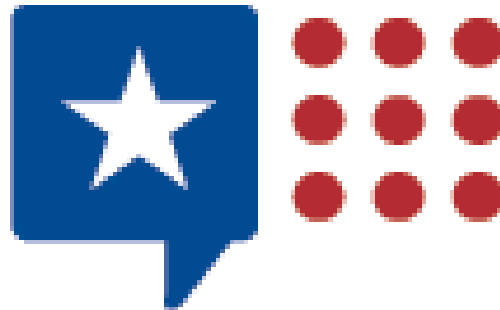
Lessons Learned

- Maintaining good collaborative relationships with the mental health staff
 - Active involvement with mental health team meetings, complex case reviews, and morbidity and mortality conferences
- Vital for the consultant provide recognition of the clinicians' skills and efforts

Lessons Learned

- The “consultant-consultee” dyad embodies its own dynamics – requires respect for the complexity of this relationship and attention
- Systemic challenges can also arise
- Consultant’s responsibility to convey and manage the boundaries in the triad

Veterans Crisis Line



1-800-273-8255

“...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



There is more work to be done!

Thank you

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