Suicide Risk Assessment & Safety Planning as a Stand Alone Intervention

VISN 19 Mental Illness, Research, Education and Clinical Center (MIRECC)

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Disclosure

This presentation is based on work supported, in part, by the Department of Veterans Affairs, but does not necessarily represent the views of the Department of Veterans Affairs or the United States Government.
“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
Agenda

• Introduction
• Facts about Veteran Suicide
• Developing a Common Language – Self Directed Violence Classification System (SDVCS)
• Suicide Risk Assessment
• Safety Planning
• Role-play
Acknowledgments

- Lisa Brenner, PhD, ABPP (Rp)
- Peter M. Gutierrez, PhD
- Patricia Alexander, PhD
- Hal Wortzel, MD
- Nazanin Bahraini, PhD
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)
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

Silverman et al 2006
Nomenclature: Essential Features

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

Essential Features

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

Silverman et al 2006
Self-Directed Violence Classification System

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

BEGIN WITH THESE 3 QUESTIONS:
1. Is there any indication the person engaged in self-directed violent behavior that was lethal, 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 TERM 
   IF YES, proceed to Decision Tree A
3. Did the behavior involve any injury or did it result in death?
   IF NO, proceed to Decision Tree B 
   IF YES, proceed to Decision Tree C

DECISION TREE A: THOUGHTS

Was/were the thoughts suicidal?

Yes

If the thoughts were/suicidal, is there evidence of Suicidal Intent?

No

Non-Suicidal SDV

Suicidal Ideation, With Undetermined Suicidal Intent

Suicidal Ideation, Without Suicidal Intent

Suicidal Ideation, With Suicidal Intent

Unknown

DECISION TREE B: BEHAVIORS, WITHOUT INJURY

Was the behavior preparatory only?

No

Was the behavior interrupted by Self/Other?

Yes

Is there evidence of Suicidal Intent?

No

Undetermined SDV, Preparatory

Suicide Attempt, Without Injury

Undetermined SDV, Preparatory

Unknown

Non-Suicidal SDV, Preparatory

Suicide Attempt, Without Injury

Suicide Attempt, With Injury, Interrupted by Self/Other

Suicide Attempt, With Injury

Suicide Attempt, With Injury, Interrupted by Self/Other

Suicide Attempt, With Injury

Suicide

Suicide

DECISION TREE C: BEHAVIORS, WITH INJURY

Was the injury fatal?

No

Was the behavior interrupted by Self/Other?

Yes

Is there evidence of Suicidal Intent?

No

Undetermined SDV, Fatal

Non-Suicidal SDV, Fatal

Non-Suicidal SDV, Fatal

Non-Suicidal SDV, Fatal

Suicide Attempt, With Injury

Suicide Attempt, With Injury

Suicide Attempt, With Injury

Suicide

Suicide

Reminder: Behaviors Trump Thoughts
Now that we are using a common language

How should we be assessing risk?
Suicide Risk Assessment

• Refers to the establishment of a
  – clinical judgment of risk in the near future,
  – based on the weighing of a very large amount of available clinical detail.

Jacobs 2003
We assess risk to...

Identify modifiable and treatable risk factors that inform treatment

Simon 2001

Take care of our patients

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

- Risk management is a reality of 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

Hal Wortzel, MD
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 not an event, it is a process
• Inductive process to generate specific patient data to guide clinical judgment, treatment, and management
• Research identifying risk and protective factors enables evidence-based treatment and safety management decision making
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 GUNS 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, lethality of method, feasibility
  – Realize that suicide assessment scales have low predictive values

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

Rudd et al. 2006
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<thead>
<tr>
<th><strong>Risk Factors</strong></th>
<th><strong>Warning Signs</strong></th>
</tr>
</thead>
<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>
</tr>
<tr>
<td>• Physical illness</td>
<td>• Talking or writing about death, dying or suicide</td>
</tr>
<tr>
<td>• Childhood trauma</td>
<td>• Increased substance (alcohol or drug) use</td>
</tr>
<tr>
<td>• Genetic/family effects</td>
<td>• No reason for living; no sense of purpose in life</td>
</tr>
<tr>
<td>• Psychological features (i.e. hopelessness)</td>
<td>• Feeling trapped - like there’s no way out</td>
</tr>
<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>
</tr>
<tr>
<td>• Substance intoxication</td>
<td></td>
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</table>
Determine if factors are modifiable

<table>
<thead>
<tr>
<th>Non-modifiable Risk Factors</th>
<th>Modifiable Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Family History</td>
<td>• 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>
</tr>
</tbody>
</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 18 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; 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
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 suggest little acute/imminent risk for suicidal behavior.”
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)
Sample SHBQ Question

Times you hurt yourself badly on purpose or tried to kill yourself.

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

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

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

Nye et al., 2007
A Qualitative Study of Potential Suicide Risk Factors in Returning Combat Veterans

Interpersonal-Psychological Theory of Suicide Risk

Joiner 2005

Those who desire death

Perceived Burdensomeness + Failed Belongingness

Suicidal Ideation

Those capable of suicide

Acquired Ability (Habituation)

Serious Attempt or Death By 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

Perceived Burdensomeness + Failed Belongingness
Cognitive Dysfunction, Inability to Drive, Inability to Work, Loss of Sense of Self

Those capable of suicide

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

Suicidal Ideation

Serious Attempt or Death By Suicide
Consultation as a Means of Veteran Suicide Prevention

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The development and implementation of a suicide consultation service brought on by an interdisciplinary team in a comprehensive program at a VA medical center is described. The service is grounded in a collaborative theoretical framework. An overview of the consultation process and developed and applied clinical practice are presented. Several of the interventions commonly recommended in returning to practice suicide risk are reviewed. Although there are many challenges to scaling a service such as this, the authors conclude that the model presented is flexible enough to be applied to a variety of settings.

Keywords: clinical, veteran, consultation, collaboration

What options exist for mental health providers to increase clinical competencies in working with high-risk suicidal patients? How can clinicians turn the hope with core conceptualizations and treatment planning? By what means can suicide 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 supported by an interdisciplinary team.

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Pamela Stavas received her MS in psychology and is a Licensed Psychologist. She is a psychologist at the Veterans Affairs Canada and the University of British Columbia. She is involved in research and treatment for suicide risk, trauma, and mental health.
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
Termination

• Addressed early in the consultation process

• Revisited throughout

• Facilitated by the ongoing message that consultant is the primary provider

Brown et al., 2001
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
“...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
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!
<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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<tr>
<th>Step 3: People and social settings that provide distraction:</th>
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<tr>
<td>1. Name_________________ Phone________________________</td>
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<tr>
<td>2. Name_________________ Phone________________________</td>
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<tr>
<td>3. Place_________________ 4. Place ____________________</td>
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<tr>
<th>Step 4: People whom I can ask for help:</th>
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<tr>
<td>1. Name_________________ Phone________________________</td>
</tr>
<tr>
<td>2. Name_________________ Phone________________________</td>
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<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>
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<tr>
<td>Clinician Pager or Emergency Contact #_______________________</td>
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<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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</tbody>
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<th>Step 6: Making the environment safe:</th>
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<tr>
<td>1. ________________________________</td>
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<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
- 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 limited 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.
“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)
Resources

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

• VA Safety Planning Manual
  www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.doc
**RESPONDING TO SUICIDE RISK**

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

**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.

**National Suicide Hotline Resource:**

1-800-273-TALK (8255)

References:
Raud et al., Warning signs for suicide: theory, research and clinical applications. Suicide and Life Threatening Behavior, 2006 June36 (3)255-62.
**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.
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
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