Therapeutic Risk Management

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Disclaimer

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Overview

• **Background**

• **Risk Assessment Components**
  • Assessment + Formulation
  • Assessment Tools
  • Documentation

• **Conceptual Models**

• **Safety Planning**
  • Apps

• **Experiential Exercises**
We assess risk to...

- Take good care of our patients and to guide our interventions
- The purpose of systematic suicide risk assessment is to identify warning signs and modifiable and treatable risk and protective factors that inform treatment and management

Simon, 2001
We should also assess to...

- **Take good care of ourselves**
  - Risk management is a reality of mental health practice
  - 15-68% of psychiatrists have experienced a patient suicide
  - 33% report these patients’ deaths led to irritability at home, decreased ability to deal with routine family problems, poor sleep, low mood, anhedonia, preoccupation with suicide, and decreased self-confidence

Alexander 2000; Chemtob 1988
Provider Self-Care

www.twistedsifter.com
Supper and card games, walk with wife or daughter

Consultations & more analytic patients

Walk around Vienna’s Ringstrasse at terrific speed

Reading, writing for journals

Sleep

Breakfast, trim beard

Lunch

Gap time

Analytic patients, smoked as many as 20 cigars per day
A Self-Care Tool for Clinicians

• Provides tools to guard against burnout and compassion fatigue.

• Videos by service members describing the positive impact health care providers had in their lives are there when you need a reminder of the value of what you do.

http://t2health.org/apps/provider-resilience#.UjqbNhaCIIi
Shock, Disbelief, Denial, Grief, Shame, Anger, and FEAR

![Pie chart showing the most common malpractice claims against psychiatrists in the United States, 1999-2003.]


Fear and Clinical Decision Making

Not a good time to problem solve!

Will be better at making decisions
Curbing fear should help with decision making

Armed with a better way to assess, conceptualize, and mitigate risk, a clinician’s fear will not peak as high.
Mitigating Fear

• The best way to care of potentially suicidal Veterans and ourselves are one in the same
• Medico-legally informed practice, that exceeds the standard of care
• Clinically based risk management
  • Patient centered
  • Supports treatment process and therapeutic alliance
• Good clinical care = best management = good clinical care
Therapeutic Risk Management

• Affirms the **clinician’s role** in the collaborative treatment of the patient who is suicidal
  • **There is a reason that patients are coming to see you – a mental health provider**

• Requires **working knowledge of the legal regulation of practice to inform appropriate clinical management of legal concerns that frequently arise regarding suicidal patients in crisis**
Therapeutic Risk Management

- Supports the **therapeutic alliance** and **treatment plan**
- Avoids defensive practices of dubious benefit that, paradoxically, can invite a malpractice suit
  - Unduly defensive mindset can distract the clinician from providing good patient care
- **Seeks to balance the sometimes competing ethical principles of autonomy, non-maleficence, and beneficence**

Simon & Shuman 2009
Therapeutic Risk Management

• **Autonomy**
  • “personal rule of the self that is free from both controlling interferences by others and from personal limitations that prevent meaningful choice.”

• **Non-maleficence**
  • “do no harm”

• **Beneficence**
  • action that is done for the benefit of others
  • beneficent actions can be taken to help prevent or remove harms or simply improve the situation of others
Consequences?

• **Defensive practices may compromise:**
  • Adherence to ethical principals
    • Autonomy (e.g., privacy)
    • Non-maleficence (e.g., 90 day prescription)
    • Beneficence (e.g., means restriction)
  • Clinical/therapeutic relationships
  • Protective factors (e.g., maintaining employment vs. hospitalization)
  • Long-term progress
Bad Outcomes

Oncology

- Resistance to treatment
- Patient drop-out
- Hospitalization
- Involvement of leadership
- Grievance
- Legal involvement
- Death
National Suicide Risk Management Consultation Program

http://www.mirecc.va.gov/visn19/consult/index.asp
A Model for Therapeutic Risk Management

• **Suicide risk assessment**
  • Augment with structured instruments

• **Stratify risk in terms of both severity and temporality**

• **Documented clinical risk assessment**

• **Develop and document a Safety Plan**
Suicide Risk Assessment Components

Assessment + Formulation
Concepts to be on the same page about

- Suicide is a rare event
- No standard of care for the prediction of suicide
- 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
Guiding Principles

• **Standard of care does require suicide risk assessment whenever indicated**

• **Best assessments will attend to warning signs, and 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
VA/DoD Clinical Practice Guideline for the Assessment and Management of Suicide Risk
Intent of the guidelines

- Reduce current unwarranted practice variation and provide facilities with a structured framework to help prevent suicide and other forms of suicidal self-directed violent behavior

- Provide evidence-based recommendations to assist providers and their patients in the decision making process
Annotations are presented in four modules addressing the following components of care

**Module A: Assessment and Determination of the Risk for Suicide**

**Module B: Initial Management of Patient at Risk for Suicide**

**Module C: Treatment of the Patient at Risk for Suicide**

**Module D: Follow-up & Monitoring of Patient at Risk for Suicide**
Decision point:

• For whom should suicide risk assessment processes be completed?

• Any person who is identified as being at possible suicide risk should be formally assessed for suicide risk

A. Person Suspected to Have Suicidal Thoughts, a recent Suicide Attempt, or Self-directed Violence Behavior

A1. Any patient with the following conditions should be assessed for suicide risk:

- Person reports suicidal thoughts on depression screening tool
- Person scores very high on depression screening tool and is identified as having concerns of suicide
- Person is seeking help (self-referral) and reporting suicidal thoughts
- Person for whom the provider has concerns about suicide- based on the provider’s clinical judgment
- Person with history of suicide attempt or recent history of self directed violence.
What About Screening?

- University Screening: routine depression screening as part of regular health maintenance.
- Instruments like the PHQ-9 (which includes a question regarding presence of suicidal ideation) are widely accepted and administered to patients in primary care settings.
Suicide Risk Assessment

A **process** in which the healthcare provider gathers clinical information in order to determine the patient’s risk for suicide.
Assessment and Determination of Risk

• **Gather** information related to the patient’s intent to engage in suicide-related behavior.

• **Evaluate** factors that elevate or reduce the risk of acting on that intent.

• **Integrate** all available information to determine the level of risk and appropriate care.

C. Assessment of Suicidal Ideation, Intent, and Behavior

D. Assessment of Factors that Contribute to the Risk for Suicide

E. Determine the Level of Risk
Suicide Risk

Not just suicidal ideation

Current & Past

Risk Factors
Warning Signs
Protective Factors
Indicators of Risk

Ideation ➔ Intent ➔ Plan ➔ Access to Means
• **Specific & Direct**
  • “Tell me about what you think/what goes through your head”

• **Assess**
  • Onset, frequency, duration, severity

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C1. Ask the patient if he/she has thoughts about wishing to die by suicide, or thoughts of engaging in suicide-related behavior.

C2. Should be directly asked if they have thoughts of suicide and to describe them. The evaluation of suicidal thoughts should include the following: a. Onset, b. Duration, Intensity, and c. Frequency.
• **Intent**
  • Willingness to act/Reasons for dying
  • How do these size up to barriers to act/reasons for living?

C2. Assess for past or present evidence (implicit or explicit) that the individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions.
Suicide Intent

Subjective Suicide Intent

Objective Suicide Intent
• Plan
  • Preparatory Behaviors?
    • Access to means, letters, rehearsal, research

C3. Assess if the patient has begun to show actual behavior of preparation for engaging in Self-Directed Violence (e.g., assembling a method, preparing for one’s death).
Recognize Warning Signs

Precipitating emotions, thoughts, or behaviors that are most proximally associated with a suicidal act and reflect high risk

Direct Warning Signs

1. Suicidal communication
2. Preparation for suicide
3. Seeking access or recent use of lethal means
Other Potential Warning Signs

Substance abuse – increasing or excessive substance use
Hopelessness – feels that nothing can be done to improve the situation
Purposelessness – no sense of purpose, no reason for living
Anger – rage, seeking revenge
Recklessness – engaging impulsively in risky behavior
Feeling Trapped – feelings of being trapped with no way out
Social Withdrawal – withdrawing from family, friends, society
Anxiety – agitation, irritability, feeling like wants to “jump out of my skin”
Mood changes – dramatic changes in mood, lack of interest in usual activities
Sleep Disturbances – insomnia, unable to sleep or sleeping all the time
Guilt or Shame – Expressing overwhelming self-blame or remorse
• **Decision point:** How do additional factors contribute to risk?

• **Evaluate** factors that elevate or reduce the risk of acting on that intent.

D1. Assess factors that are known to be associated with suicide (i.e., risk factors, precipitants) and those that may decrease the risk (i.e., protective factors).

D2. Risk factors distinguish a higher risk group from a lower risk group. Risk factors may be modifiable or non-modifiable and both inform the formulation of risk for suicide. Modifiable risk factors may also be targets of intervention.

D3. Protective factors are capacities, qualities, environmental and personal resources that drive individuals towards growth, stability, and health and may reduce the risk for suicide.

D5. Assess the availability or intent to acquire lethal means including firearms and ammunition, drugs, poisons and other means in the patient’s home.
Risk vs Protective Factors

• **Risk Factors**
  • Increase the likelihood of suicidal behavior and include modifiable and non-modifiable indicators

• **Protective Factors**
  • Capacities, qualities, environmental and personal resources that increase resilience
  • Drive individuals towards growth, stability, and health
  • Increase coping with different life events
  • Decrease the likelihood of suicidal behavior
Structured Assessments
The addition of reliable/valid self-report measures can...

- Enhance clinical care
- Serve an important medicolegal function
- Help to realize therapeutic risk management of the suicidal patient
<table>
<thead>
<tr>
<th>Beck Scale for Suicidal Ideation (BSS)</th>
<th>Beck Hopelessness Scale (BHS)</th>
<th>Reasons for Living Inventory (RFL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-item scale used to assess the severity of suicidal ideation within the past week</td>
<td>20-true/false items that assesses hopelessness within the past week</td>
<td>48-item scale to assess the reasons for living that may serve a protective function for those at risk</td>
</tr>
<tr>
<td><strong>5 minutes</strong></td>
<td><strong>5 minutes</strong></td>
<td><strong>10 minutes</strong></td>
</tr>
</tbody>
</table>

Beck, Steer & Ranieri, 1988; Beck and Steer, 1988; Linehan et al, 1983
Inclusion of instruments such as the BSS in the patient’s medical record helps to establish a baseline regarding suicidal ideation

• Facilitates subsequent risk assessments
• May reduce unnecessary hospitalizations
• May facilitate life-saving interventions

Wortzel, Homaifar, & Matarazzo, 2013
Go to MH Assistant in CPRS
Click on Instrument Administrator
Scroll down until you see the BSI

Instrument Administrator

Instruments Ordered By:
BAHRANI, NAZANIN H

Interviewer:
BAHRANI, NAZANIN H

Date of Administration:
10/ 1/2014

Visit Location:

Link With Consult (Optional):

Instructions:
If you select someone else as the instrument orderer, that person will be notified by e-mail.

Instruments that are available depends on the instrument orderer.

Available Instruments and Batteries:

Show: All

Instrument Chosen:

Display:
One Question at a Time
All Questions at Once

Patient Entry
Staff Entry

My Battery
AAQ-2
AIMS
ASSIST
ATQ
AUDC
AUDIT
AUIR
BAI
BAM
BAM-C
BAM-HOP
BAM-R
BARTHEL INDEX
BASIS-24
BDI2
BHS
ROMC
Select BSI

Select one question at a time and patient entry.
Answer each question by selecting a response

1. Select the one statement in each group that BEST describes how you have been feeling for the PAST WEEK, INCLUDING TODAY.
   - 0. I have a moderate to strong wish to live.
   - 1. I have a weak wish to live.
   - 2. I have no wish to live.
BSI
This administration has been saved in Vista. Do you wish to:

- Save standard Progress note
- Edit then save Progress note
- Do not save Progress note
Entered in a separate note with selected responses and total score
Note total score, but do not rely on self-report measures alone to determine level of risk

BSI Score: 16 indicates low suicidal risk. The overall range is 0 to 42 with low suicidal risk between 0 - 21.

Identify concerning items and follow up with the patient to further assess.
Case Example

Image from DoD: www.defense.gov
What’s the Risk?

• 29 y/o female
• 18 suicide attempts and chronic SI
  • Currently reports below baseline SI & stable mood
• Numerous psychiatric admissions
• Family history of suicide
• Owns a gun
• Intermittent homelessness
  • Currently reports having stable housing
• Alcohol dependence
  • Has sustained sobriety for 6 months
• Borderline Personality Disorder
What’s the Risk?

• Risk factors?
• Warning signs?
• Protective factors?
• Assessment instruments?
Suicide Risk Assessment Components

Assessment + Formulation
Severity

- Low
- Intermediate
- High
Severity

Low

Intermediate

High
Stratify Risk – Severity & Temporality

- Low
- Intermediate
- High

- Acute
- Chronic
Integrate different sources of information to determine level of risk

<table>
<thead>
<tr>
<th>Risk of Suicide Attempt</th>
<th>Indicators of Suicide Risk</th>
<th>Contributing Factors †</th>
<th>Initial Action Based on Level of Risk</th>
</tr>
</thead>
</table>
| **High Acute Risk**     | • Persistent suicidal ideation or thoughts  
                          • Strong intention to act or plan  
                          • Not able to control impulse OR  
                          • Recent suicide attempt or preparatory behavior †† | • Acute state of mental disorder or acute psychiatric symptoms  
                          • Acute precipitating event(s)  
                          • Inadequate protective factors | • Maintain direct observational control of the patient.  
                          • Limit access to lethal means  
                          • Immediate transfer with escort to Urgent/ Emergency Care setting for Hospitalization |
| **Intermediate Acute Risk** | • Current suicidal ideation or thoughts  
                            • No intention to act  
                            • Able to control the impulse  
                            • No recent attempt or preparatory behavior or rehearsal of act | • Existence of warning signs or risk factors †† AND  
                            • Limited protective factor | • Refer to Behavioral Health provider for complete evaluation and interventions  
                            • Contact Behavioral Health provider to determine acuity of referral  
                            • Limit access to lethal means |
| **Low Acute Risk**       | • Recent suicidal ideation or thoughts  
                          • No intention to act or plan  
                          • Able to control the impulse  
                          • No planning or rehearsing a suicide act  
                          • No previous attempt | • Existence of protective factors AND  
                          • Limited risk factors | • Consider consultation with Behavioral Health to determine:  
                          - Need for referral  
                          - Treatment  
                          • Treat presenting problems  
                          • Address safety issues  
                          • Document care and rational for action |
High Acute Risk

• **Essential features:**
  - SI with intent to die by suicide **AND**
  - *Inability* to maintain safety independent of external support/help

• **Likely to be present:**
  - Plan
  - Access to means
  - Recent/ongoing preparatory behaviors and/or SA
  - Acute Axis I illness (e.g., MDD episode, acute mania, acute psychosis, drug relapse)
  - Exacerbation of Axis II condition
  - Acute psychosocial stressor (e.g., job loss, relationship change)

• **Action:**
  - Psychiatric hospitalization
Intermediate Acute Risk

• **Essential features:**
  • Ability to maintain safety independent of external support/help

• **Likely to be present:**
  • May present similarly to those at high acute risk except for:
    • Lack of intent or preparatory behaviors
    • Reasons for living
    • Ability/desire to abide by Safety Plan

• **Action:**
  • Consider psychiatric hospitalization
  • Intensive outpatient management
Low Acute Risk

- **Essential features:**
  - No current intent AND
  - No suicidal plan AND
  - No preparatory behaviors AND
  - Collective high confidence (e.g., patient, care providers, family members) in the ability of the patient to independently maintain safety

- **Likely to be present:**
  - May have SI but **without** intent/plan
  - If plan is present, it is likely **vague** with **no preparatory behaviors**
  - Capable of using appropriate coping strategies
    - Willing/able to use Safety Plan

- **Action:**
  - Can be managed in primary care
  - Mental health treatment may be indicated
Chronic Risk

• **High**
  - Prior SA, chronic conditions (diagnoses, pain, substance use), limited coping skills, unstable/erratic psychosocial status (housing, rltp), limited reasons for living
  - **Can become acutely suicidal**, often in the context of unpredictable situational contingencies
  - Routine mental health f/up, safety plan, routine screening, means restriction, intervention work on coping skills/augmenting protective factors

• **Intermediate**
  - **BALANCE** of protective factors, coping skills, reasons for living, and stability suggests **ENHANCED** ability to endure crises without resorting to SDV
  - Routine mental health care to monitor conditions and maintain/enhance coping skills/protective factors, safety plan

• **Low**
  - History of **managing stressors without resorting to SI**
  - Typically **absent**: history of SDV, chronic SI, tendency toward impulsive/risky behaviors, severe/persistent mental illness, marginal psychosocial functioning
What’s the Risk?

• 29 y/o female
• 18 suicide attempts and chronic SI
  • Currently reports below baseline SI & stable mood
• Numerous psychiatric admissions
• Family history of suicide
• Owns a gun
• Intermittent homelessness
  • Currently reports having stable housing
• Alcohol dependence
  • Has sustained sobriety for 6 months
• Borderline Personality Disorder
Stratify Risk – Severity & Temporality

- Low
- Intermediate
- High

- Acute
- Chronic
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 and no current intent suggest *low acute/imminent risk* for suicidal behavior.

Documentation

**Ideation → Intent → Plan → Access to Means**
Conceptual Models
Fluid Vulnerability Theory

Rudd, 2006
Core Concepts

• Suicidal episodes are time limited
• Factors that trigger an episode and determine the duration are fluid
• Baseline risk varies from person to person
...what does this look like?

Suicidal Mode

Person A
- Baseline Risk
- Acute Risk

Person B
- Baseline Risk
- Acute Risk
...what does this look like?

Suicidal Mode

Baseline Risk

Acute Risk
Interpersonal Theory of Suicide

Joiner, 2005; Van Orden et al., 2008; Van Orden et al., 2010
Perceived Burdensomeness & Thwarted Belongingness

Acquired Capability

Self Hate & Liability

Fearlessness about Death and Dying

Loneliness & Reciprocal Care

Heightened Pain Tolerance

Greatest Risk for Death by Suicide
Desire for Suicide

Lowered Fear of Death

Suicidal Intent

Increased Pain Tolerance

Suicide Attempt

Acquired Capability

Perceived Burdensomeness & Thwarted Belongingness
Safety Planning: A Stand Alone Intervention
Learning Objectives

1. Summarize the rationale behind safety planning
2. Discuss safety planning as a collaborative experience
3. Review available apps that can be used in conjunction with safety planning
How can this presentation be helpful?

• Determine the rationale for safety planning
• Familiarize yourself with the safety planning process
• Feel empowered to help your patients overcome barriers to safety plan creation or use
• Mirror our method of teaching the safety planning process when instructing your own staff about safety planning
Safety Planning Rationale
Safety Plan vs. Suicide Contract

- **No-Suicide Contracts**
  - Typically entails a patient agreeing to not harm themselves
  - Sometimes includes what to do if they can no longer abide by the contract

- **Up to 79% of mental health professionals report using them despite there being no empirical support regarding their effectiveness** (Drew, 1999; Rudd et al., 2006)
No-Suicide Contracts - Reasons to **Not** Use Them

- **Medicolegal**
  - Not legally binding; no protection against malpractice (Stanford et al., 1994; Simon, 1999)
  - Erroneous to believe it can prevent suicide (Simon, 1999)

- **Provider-specific**
  - False sense of security (Simon, 1999)
  - Absence of therapeutic relationship (Simon, 1999)

- **Patient-centered**
  - Concern that provider only worried about legal protection (Range et al., 2002)
  - Could discourage open disclosure of thoughts, plan, etc. (Range et al., 2002)
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 (ideally) preceding a suicidal crisis
• Involves collaboration between the client and clinician

Safety Planning

• **Components grounded in...**
  • Cognitive Therapy
  • Collaborative Assessment and Management of Suicidality
  • Recovery-Oriented Approach

Matarazzo et al., 2014; Stanley & Brown, 2012
Collaboration

• **Key factor in working with individuals who are suicidal**
  • Suicide risk assessment can strain the therapeutic alliance

• **“Ownership” of the therapeutic relationship**
  • Shared responsibility
  • Teaching problem-solving vs suggested solutions
    • Cultivation of self-efficacy
  • Meeting needs for connection & acceptance

Ellis, 2004; Meichenbaum, 2005
Tips for Developing a Safety Plan Collaboratively

• **Ways to increase collaboration**
  • Sit side-by-side
  • Use a paper form
  • Have the client to write

• **Brief instructions using the client’s own words**

• **Easy to read**

• **Conversational approach**

• **Jointly address barriers and use a problem-solving approach**
  • Share responsibility
It’s Always About the Relationship

- Be familiar with the Safety Planning steps so 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
The Safety Planning Process
Provide Rationale

• **What’s your thinking like in a crisis?**
  • Fight or flight response

• **Stop, drop, and roll**

• **Military SOP**

• **Catch it early!**
If Safety Plans are used BEFORE a crisis, they have the best chance of working.

Not an ideal time to use a Safety Plan.
6 Steps of Safety Planning

• Step 1: Recognizing Warning Signs
• Step 2: Using Internal Coping Strategies
• Step 3: People and Social Settings that Provide Distraction
• 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 client identify and pay attention to his or her warning signs for suicidal ideation/behavior
• What to ask: “How will you know when the safety plan should be used?”
• What to include in the safety plan: Specific and personalized examples
  • Physical sensations
  • Thoughts
  • Emotions
  • Behaviors
Step 1: Recognizing Warning Signs
Example of Barriers

• Patient: “I don’t know what I think or feel when I’m not doing well.”

• Clinician: “Okay, let’s focus on your behaviors. What do you do when you are not doing well?”

• Patient: “Oh, I stop showering and don’t talk to anyone.”
Step 2: Using Internal Coping Strategies

- **Purpose:** To take the client’s mind off of problems to prevent escalation of suicidal thoughts
  - NOT to solve the client’s problems

- **What to include in the safety plan:** List activities the client can do **without contacting another person**
  - Examples?
Step 2: Using Internal Coping Strategies

- Ask “How likely do you think it is that 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 2: Using Internal Coping Strategies

Example of Barriers

- **Patient:** “I don’t have any coping skills- that’s why I am here.”

- **Draw from past successes**
  - “Has there been any time in your life when you were having a hard time and coped with it?”

- **Build on recent experiences**
  - “Tell me what happened before this most recent crisis.”
Building “coping memory”

- The importance of rehearsing and practicing internal coping skills
  - The more you practice the internal coping strategies, the more these become automatic and likely to be used when needed the most
Step 3: People and Social Settings that Provide Distraction

- Purpose: To engage with people and social settings that will provide distraction
- What to include on the safety plan: Importance of including phone numbers and multiple options
- What not to include: Avoid listing any controversial relationships
Step 3: People and Social Settings that Provide Distraction

• 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 3: People and Social Settings that Provide Distraction

Example of Barriers

- **Patient:** “When I am having a hard time, the last thing I should do is be out around people.”
  - (Patient has PTSD)

- **Clinician:** “That can certainly be hard when your PTSD symptoms are triggered. How about...”
  - Library (quiet, yet still around people)
  - Park/mountains (outside and likely not many people)
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 4: Contacting Family Members or Friends Who May Offer Help

Example of Barriers

- **Patient:** “I don’t have anyone to call. That is part of the problem.”

- **Clinician**
  - Explore the validity of this, keeping in mind that the Veteran may have inaccurate beliefs regarding being a burden to others.
  - Other patients truly may have no one to call. Assure them that a safety plan can still work for them.
    - Reassure them that this is something they can work on in treatment (building relationships and support systems).
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 Suicide Prevention Line
  - 1-800-273-TALK (8255), press 1
  - 911
Step 5: Contacting Professionals and Agencies

Example of Barriers

- **Patient:** “I’m not going to call that Crisis Line. I heard they’ll just bring you right to the hospital or jail or something.”

- **Clinician**
  - Explain that only 5% of all calls made to the Crisis Line result in a “rescue”
  - Explain the circumstances in which they may initiate an emergency response
  - Add in that they can call the Crisis Line when in any distress- not just suicidal (remind them of the graph depicting preventing a crisis)
Step 6: Reducing the Potential for Use of Lethal Means

• Complete this step even if the client has not identified a suicide plan
• 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?”
Step 6: Reducing the Potential for Use of Lethal Means

• Always ask whether the client has access to a firearm
• Discuss medications and how they are stored and managed
• Consider alcohol and drugs as a conduit to lethal means
  ➢ Also include ways to increase safety of environment
    • Reasons for living
Step 6: Reducing the Potential for Use of Lethal Means

Example of Barriers

- **Patient:** “I’m not giving up my guns.”

- **Clinician**
  - As appropriate, recommend that guns are given to a person they trust (perhaps another Veteran) only while they are not doing well.
  - Recommend other options, such as gun locks (free from VA!), gun safes, separating ammunition from the gun, storing the gun (even if not locked up) in a difficult to access spot, pasting a picture of their reasons for living on gun case.
Implementation
Implementation

• Decide with whom and how to share the safety plan
• Discuss the location of the safety plan
• Discuss how it should be used **prior to a crisis**
Implementation

• Assess how likely it is that the client will use the safety plan
• Discuss where the client will keep the safety plan
  • Multiple copies; wallet-size versions; mobile phone or other device
• Review and update the safety plan frequently
Barriers to Implementation

- Problem-solve around any additional barriers, for example:
  - Difficult to reach out to others
  - Don’t like the name (Safety Plan)
  - Don’t remember to use it
  - Change in home setting
Mobile Apps
Mobile Safety Planning

• Includes: A safety plan page where users can customize a step-by-step plan that they can refer to when they are experiencing thoughts of suicide.
• The My3 plan is modeled after a plan originally developed by Drs. Barbara Stanley and Gregory Brown.
Mobile Safety Planning

Virtual Hope Box

• VHB contains simple tools to help patients with coping, relaxation, distraction and positive thinking
Mobile Safety Planning
Virtual Hope Box
Mobile Applications

Breathe2Relax

• Breathe2Relax is a portable stress management tool--hands-on diaphragmatic breathing exercise.
• Users can record their stress level on a 'visual analogue scale' by simply swiping a small bar to the left or to the right.

http://t2health.org/apps/breathe2relax#.UjqUbxaCIIl
Mobile Applications

LifeArmor

• Brief self-assessments help the user measure and track their symptoms, and tools are available to assist with managing specific problems, including sleep, depression, relationship issues, and post-traumatic stress.
Mobile Applications

Positive Activity Jackpot

• Uses augmented reality technology to combine a phone’s GPS and camera to find nearby enjoyable activities or pleasant diversions.

Clinician’s guide available for download
Resources

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

VA Safety Planning Manual
www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.doc
Experiential Exercises
Vignette A

- 24, male, OIF Vet, admitted to in-patient psychiatric unit
- Told GF he was going to kill himself during argument
- Refused to participate in evaluation ("I don’t need to be here")
- Observed to be calm, engaging with other Vets, eating/sleeping well, no signs of acute major mental illness
- Denies SI but denies being suicidal leading to admission
- 2 suicide attempts (also in context of rltp discord)
- Superficially invested in developing safety plan and plans for aftercare
Vignette B

- 30, female, OEF Vet, presents to outpatient appt
- Depression worsened over the last few weeks with impending anniversary of trauma
  - Not eating or sleeping much
- Thinking about killing self with pistol (kept in safe in closet)
- Support (best friend) will be out of town
- Internal coping strategies not working recently
  - Only talking to friend and looking at pictures of children have been helpful
- You are considering hospitalization but are concerned because she has 3 young children
  - No other support available to take care of children
Vignette C

- **63, male, widowed, Vietnam Vet, presents to outpatient visit**
- **Endorses SI**
  - “Yeah, I have thought about suicide in the past week...I still wonder if things would be better if I was dead”
- **1 suicide attempt**
  - Overdose which required hospitalization 10 years ago
- **Regularly attending outpatient visits**
  - Only miss in past 3 months was due to flu
- **Has recently reengaged contact w/daughter**
  - Desires to improve physical and psychological health because of this
- **Denies current plan for suicide; denies intent**
  - Cannot guarantee that he will never act on his thoughts again in the future if “things get worse”
Questions?
Thank you!

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If you’d like to keep the discussion going and/or leave comments and questions, please feel free to do so within GoSoapBox.