Suicide Risk Assessment and Prevention in Military Personnel

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Acknowledgments

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• Dr. Gregory Brown
• Dr. Barbara Stanley
Overview

• Suicide Risk Assessment
  – Language of Self-Directed Violence
  – Suicide-Specific Assessment Tools
  – Suicide- Focused Psychiatric Interview
  – Risk Factors and Warning Signs
  – Additional Considerations for Military Personnel

• Safety Planning
  – Overview of 6 steps
  – Creating a Safety Plan
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.
Is a common language necessary to facilitate suicide risk assessment?

Do we have a common language?
The Language of Self-Directed Violence

Identification of the Problem

- Suicidal ideation
- Death wish
- Suicidal threat
- Cry for help
- Self-mutilation
- Parasuicidal gesture
- Suicidal gesture
- Risk-taking behavior

- Self-harm
- Self-injury
- Suicide attempt
- Aborted suicide attempt
- Accidental death
- Unintentional suicide
- Successful attempt
- Completed suicide
- Life-threatening behavior
- Suicide-related behavior
- Suicide
The Language of Self-Directed Violence
Implications of the Problem

Example from Research

**Abstract**

**Background.** Psychiatric emergency room (ER) patients are thought to be at increased risk of suicide. The prevalence and characteristics of suicidal behavior in a recent sample of patients who came to the ER for psychiatric evaluation were examined.

**Methods.** Charts of 311 consecutive psychiatric ER patients were reviewed. Suicidal behavior was considered present if current suicidal ideation or attempts within 24 hours of or during the emergency evaluation were noted in the chart.

**Results.** Suicidal behavior was present in 38% of the psychiatric ER patients. Younger age, white race, affective disorders in female patients, and substance abuse disorders in male patients were features of the suicidal group. Sex of the patient was not associated with suicidal behavior.

**Conclusions.** Suicidal behavior is prevalent in the psychiatric ER. Effective suicide prevention in this setting will hinge on finding more specific risk factors.
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
Self-Directed Violence Classification System

Lisa A. Brenner, Ph.D.
Morton M. Silverman, M.D.
Lisa M. Betthauser, M.B.A.
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>
</tbody>
</table>
| Suicidal Ideation    |                                               | 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.                                                                                      |                                | •Suicidal Ideation, Without Suicidal Intent  
•Suicidal Ideation, With Undetermined Suicidal Intent  
•Suicidal Ideation, With Suicidal Intent    |
| Preparatory          |                                               | 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. | • Suicidal Intent  
-Without  
-Undetermined  
-With                           | •Non-Suicidal Self-Directed Violence, Preparatory  
•Undetermined Self-Directed Violence, Preparatory  
•Suicidal Self-Directed Violence, Preparatory |
| Behaviors            | Non-Suicidal Self-Directed Violence           | 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). | • Injury  
-Without  
-With  
-Fatal  
-Interrupted by Self or Other | •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           | 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. | • Injury  
-Without  
-With  
-Fatal  
-Interrupted by Self or Other | •Undetermined Self-Directed Violence, Without Injury  
•Undetermined Self-Directed Violence, With Injury, Interrupted by Self or Other  
•Undetermined Self-Directed Violence, With Injury, Interrupted by Self or Other  
•Undetermined Self-Directed Violence, Fatal |
|                      | Suicidal Self-Directed Violence               | 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. | • Injury  
-Without  
-With  
-Fatal  
-Interrupted by Self or Other | •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 |
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

Gutierrez and Osman, 2008
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.”

Important Domains of a Suicide-Focused Psychiatric Interview

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

Specific Inquiry of Thoughts, Plans, and Behaviors

- Elicit any suicidal ideation

- Presence or Absence of Plan

- Assess patient’s degree of suicidality, including intent and lethality of the plan
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

### Risk Factors
- Suicidal ideas/behaviors
- Psychiatric diagnoses
- Physical illness
- Childhood trauma
- Genetic/family effects
- Psychological features (i.e. 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
## 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
## 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
**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:**

**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.

**Employee Education System**

**MIRECC**

VISN 19 Rocky Mountain Network
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 Risk Assessment Manual

• Provides more specific information and the rationale for the sections on the pocket card
• Sections of the guide correspond with the sections of the card
  – Look for the warning signs
  – Factors that may increase or decrease suicide risk
  – Ask the questions
  – Respond to suicide risk

[Website Link]

www.mentalhealth.va.gov/docs/Suicide_Risk_Assessment_Guide.doc
Additional Considerations for Risk Assessment in Military Personnel

At risk for post traumatic stress disorder, traumatic brain injury (TBI), and suicide
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
### Substance Abuse and Suicide in Veteran Population

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Male Hazard Ratio</th>
<th>Male 95% Confidence Interval</th>
<th>Female Hazard Ratio</th>
<th>Female 95% Confidence Interval</th>
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</thead>
<tbody>
<tr>
<td>Any Psychiatric Diagnosis</td>
<td>2.50</td>
<td>(2.38, 2.64)</td>
<td>5.18</td>
<td>(4.08, 6.58)</td>
</tr>
<tr>
<td>Any Substance Abuse or Dependence</td>
<td>2.27</td>
<td>(2.11, 2.45)</td>
<td>6.62</td>
<td>(4.72, 9.29)</td>
</tr>
<tr>
<td>Alcohol Abuse or Dependence</td>
<td>2.28</td>
<td>(2.12, 2.45)</td>
<td>6.04</td>
<td>(4.14, 8.82)</td>
</tr>
<tr>
<td>Other Drug Abuse or Dependence</td>
<td>2.09</td>
<td>(1.90, 2.31)</td>
<td>5.33</td>
<td>(3.58, 7.94)</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>2.98</td>
<td>(2.73, 3.25)</td>
<td>6.33</td>
<td>(4.69, 8.54)</td>
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<tr>
<td>Depression</td>
<td>2.61</td>
<td>(2.47, 2.75)</td>
<td>5.20</td>
<td>(4.01, 6.75)</td>
</tr>
<tr>
<td>Other Anxiety</td>
<td>2.10</td>
<td>(1.94, 2.28)</td>
<td>3.48</td>
<td>(2.52, 4.81)</td>
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<tr>
<td>PTSD</td>
<td>1.84</td>
<td>(1.70, 1.98)</td>
<td>3.50</td>
<td>(2.51, 4.86)</td>
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<tr>
<td>Schizophrenia</td>
<td>2.10</td>
<td>(1.93, 2.28)</td>
<td>6.08</td>
<td>(4.35, 8.48)</td>
</tr>
</tbody>
</table>

Ilgen et al. (2010)
Chronic Risk

• Increase psychosocial stressors

• Exacerbate co-occurring psychopathology

• Increase potential for injuries associated with suicide
Intoxication & Acute Risk

- Psychopharmacological effects on the brain
  - Impair problem solving
  - Impulsivity
  - Disinhibition

- Intoxication from alcohol and other substances may increase the likelihood of an individual acting on suicidal thoughts

Steele & Joseph, 1990
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.
TBI and Psychiatric Co-morbidity

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.

Simpson and Tate 2005
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.”

Brenner et al., 2009
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."
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
A Qualitative Study of Potential Suicide Risk Factors in Returning Combat Veterans

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.”
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.”
Other considerations

• Document
  – The risk level
  – The basis for the risk level

• Seek consultation / supervision as needed

• Suicide risk will need to be reassessed at various points throughout treatment, as a patient’s risk level will wax and wane.

Jacobs 2003
Safety Planning
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?
Overview

• Description of the Safety Plan
• The 6 steps of creating the Safety Plan
• Demonstrate implementation of the Safety Plan
No-suicide contracts ask patients to promise to stay alive without telling them how to stay alive.

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

DON’T USE THEM!
Safety Plan: What is it?

- Hierarchically-arranged list of coping strategies for use during a suicidal crisis or when suicidal urges emerge
- Written document
- Brief, easy-to-read format
Who Develops the Plan?

• Collaboratively developed by the clinician and the Veteran in any clinical setting.

• Veterans who have...
  – made a suicide attempt.
  – suicide ideation.
  – psychiatric disorders that increase suicide risk.
  – otherwise been determined to be at high risk for suicide.
When Is It Appropriate?

• A safety plan may be done at any point during the assessment or treatment process.
• Usually follows a suicide risk assessment.
• Safety Plan may not be appropriate when patients are at imminent suicide risk or have profound cognitive impairment.
• The clinician should adapt the approach to the Veteran’s needs -- such as involving family members in using the safety plan.
Overview of Safety Planning: 6 Steps

1. Recognizing warning signs.

2. Employing internal coping strategies without needing to contact another person.

3. Socializing with family members or others who may offer support as well as distraction from the crisis.
Overview of Safety Planning: 6 Steps

4. Contacting family members or friends who may help to resolve a crisis.

5. Contacting mental health professionals or agencies.

6. Reducing the potential use of lethal means.
Step 1: Recognizing Warning Signs

• Safety plan is only useful if the patient can recognize the warning signs.
• The clinician should obtain an accurate account of the events that transpired before, during, and after the most recent suicidal crisis.
• Ask “How will you know when the safety plan should be used?”
Step 1: Recognizing Warning Signs

- **Ask** “What do you experience when you start to think about suicide or feel extremely distressed?”
- **Write down** the warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patients’ own words.
Step 1: Recognizing Warning Signs
Examples

- Automatic Thoughts
  - “I am a nobody”
- Images
  - “Flashbacks”
- Mood
  - “Feeling depressed”
- Behavior
  - “Crying”
  - “Isolating myself”
  - “Using drugs”
Step 2: Using Internal Coping Strategies

• List activities that patients can do without contacting another person.
• Activities function as a way to help patients take their minds off their problems and promote meaning in the patient’s life.
• Coping strategies prevent suicide ideation from escalating.
Step 2: Using Internal Coping Strategies

• Ask “What can you do on your own if you become suicidal again, to help yourself not to act on your thoughts or urges?”

• “What activities could you do to help take your mind off your problems even if it is for a brief period of time?”
Step 2: Using Internal Coping Strategies

• Examples
  – Go for a walk
  – Listen to inspirational music
  – Take a hot shower
  – Walk the dog
Step 2: Using Internal Coping Strategies

• Ask “How likely do you think you would be able to do this step during a time of crisis?”
• Ask “What might stand in the way of you thinking of these activities or doing them if you think of them?”
• Use a collaborative, problem solving approach to address potential roadblocks.
Step 3: Using External Strategies: Socializing with Family Members or Others

• Coach patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.

• Family, friends, or acquaintances who may offer support and distraction from the crisis.
Step 3: Socializing with Family Members or Others

• *Ask* “Who 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: Seeking Support: Contacting Family Members or Friends for Help

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

• Ask “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: Seeking Support: Contacting Family Members or Friends for Help

- Ask “How likely would you be willing to contact these individuals?”
- Identify potential obstacles and problem solve ways to overcome them.
Step 5: Contacting Professionals and Agencies

- Coach patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask “Which clinicians should be on your safety plan?”
- Identify potential obstacles and develop ways to overcome them.
Step 5: Contacting Professionals and Agencies

• List names, numbers and/or locations of:
  – Clinicians
  – Local urgent care services
  – VA Suicide Prevention Coordinator
  – VA Crisis Line 800-273-TALK (8255), press “1” if Veteran
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?”
- Regardless, the clinician should always ask whether the Veteran has access to a firearm.
Step 6: Reducing the Potential for Use of Lethal Means

• For methods with low lethality, clinicians may ask Veterans to remove or restrict their access to these methods themselves.
  – For example, if patients are considering overdosing, discuss throwing out any unnecessary medication.
Step 6: Reducing the Potential for Use of Lethal Means

- For methods with high lethality, collaboratively identify ways for a responsible person to secure or limit access.
  - For example, if patients are considering shooting themselves, suggest that they ask a trusted family member to store the gun in a secure place.
Implementation: What is the Likelihood of Use?

- *Ask* “Where will you keep your safety plan?”

- *Ask* “How likely is it that you will use the Safety Plan when you notice the warning signs that we have discussed?”
Implementation: What is the Likelihood of Use?

- *Ask* “What might get in the way or serve as a barrier to your using the safety plan?”
- Help the Veteran find ways to overcome these barriers.
- May be adapted for brief crisis cards, cell phones or other portable electronic devices – must be readily accessible and easy-to-use.
Implementation: Review the Safety Plan Periodically

- Periodically review, discuss, and possibly revise the safety plan after each time it is used.
- The plan is **not** a static document.
- It should be revised as Veterans’ circumstances and needs change over time.
Safety Plan Use

- 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
Let’s Create a Safety Plan

Mr. X is a 62-year old Vietnam Veteran who sustained a severe TBI during a motor vehicle accident while in the service. Since his discharge from the Army, Mr. X has had a hard time keeping jobs. He has difficulty getting started on tasks and following multi-step directions. He has not engaged with mental health consistently, preferring only to come in during periods of crisis. He often forgets appointments. Additionally, he is easily frustrated, sensitive to perceived criticism, perseverative, tangential, concrete, and has problems with cognitive flexibility. Mr. X has reported thoughts about suicide since his brain injury and has made three prior suicide attempts by overdose on prescription psychotropic medication, most recently last week.

Special thanks: Lisa Brenner, Gregory K. Brown, Heath Hodges, Beeta Homaifar, Walter Matweychuk, Jarrod Reisweber, and Barbara Stanley
Identifying Warning Signs

T: Before we begin let me briefly tell you what a safety plan is and how it can be useful. A safety plan is a list of steps you can take when you're feeling suicidal. We will develop this safety plan together now so you will have it ready for when you need it. The first thing we will be doing is identifying signs – thoughts or feelings you might be having or have had in the past that can help us to know that you may be at greater risk of hurting yourself. Sometimes these signs are also actions, like participating in an activity that often leads to you feeling suicidal. Something we have talked about in the past is you looking around the house for old medication and counting pills. I think it is helpful to call these thoughts, feelings or actions “warning signs” – because they can help “warn” us that it is time for you to use this safety plan that we are working on here together. So can you tell me about this last time you attempted suicide? What triggered you to feel that way?
Identifying Warning Signs

P: Coping with my TBI. The worst part with traumatic brain injury is that people can’t see it. And they see on the outside that I move around. I do this. I do that. But they don’t see the struggle that’s inside, the memory loss, the struggles to remember, the struggles to forget. So there’s times where it all just gets really overwhelming if you have to write everything down because you can’t remember one day from the next. You read a book and it’s one of your favorite books and you’re reading it and you can’t even remember the last 10 pages that you’ve read. And you’re reading words but not comprehending them. That’s the thing that I’m fighting with all the time is that I get to the point where I fight with my memory and the other things. And it’s just not worth it.

T: Okay. So it sounds like your problems with memory feel pretty overwhelming. And maybe that was partly what triggered this past attempt?
Identifying Warning Signs

T: Let’s see if we can work on this safety plan together, so that you can have some alternatives to suicide during times of crisis. Does that sound okay?

P: Alright. A plan I can use to help me out when I feel like I am gonna kill myself.

T: It is important that we identify what you think, feel and do when you start to feel suicidal. So when you think of times in the past when you tried to hurt yourself....do you remember what you did, felt, or thought.

P: I told you I don’t know. It’s so frustrating for people to keep asking me this because I don’t know. Sometimes I know what I want to say although I get into a thought and about half way through it just dissolves into my brain. It’s like I wouldn’t know where it was, what it was, and five minutes later I couldn’t even remember that I had a thought. So I just don’t know. It adds to a lot of frustration going on. And, ya know, because of my TBI a couple days later I can’t even remember that I was frustrated to begin with.
Identifying Warning Signs

T: That sounds really hard.

P: Yeah. It’s a big slap in the face because of the fact that you’ve gone from this manly man and now you have to be taken care of. So you’re still trying to live up to this standard of being a tough military man and then having to turn into somebody that needs help.

T: Yeah. Asking for help can be hard, but us being here together working on this safety plan is a great step in the right direction.

P: I guess the worst is feeling like there’s nowhere else to go or nothing else to try. That really depresses me, and that’s when I start drinking.

T: Okay. Those sound like things we should put on your safety plan.

P: Yes, and I feel like I have lost my mind.

T: That sounds like another thing we should write down.
Step 1: Warning Signs

1. Nowhere else to go
2. Nothing else to try
3. Lost your mind
4. Feeling depressed
5. Being alone
6. Drinking
T: Sounds like that link between feeling depressed, being alone, and drinking, is an important one. OK, now that we identified some of your “warning signs,” the idea would be that in the future whenever you pull out your safety plan it will cue you to start using the coping strategies. So what are some things that you can do to distract yourself when you are ... [refer back to the list and read a few items from Step 1].

P: Hell if I know.

T: Well are there things you like to do for fun or things that are distracting?

P: I don’t know. I mean the closest thing that I can say I do for fun would be playing videogames on the computer.

T: Great. Shall we write that down? How likely do you think you would be to be able to do this during a time of crisis?

P: I don’t know.
T: Okay, so the one thing that works as a distracter for you is playing videogames but you’re worried that in a time of crisis you may not even remember that playing videogames distracts you. Is that accurate?
P: Yeah.

T: Okay. Well one of the good things about having a safety plan is that you don’t have to remember all the details that we are coming up with now. It is all on the plan. We just have to help you remember that the plan exists and to refer to it. Now I know that memory is a problem for you and you need some prompts and cues. What sorts of prompts work for you? What sorts of things help you in general to remember things that are important? For example, how do you remember to come to your appointments at the hospital when you have them? What have you found that works?
Internal Coping Strategies

T: We were coming up with distracting activities we can add to your list to use if videogames don’t work. Do you have anything else you can think of to add here?
P: No ideas.
T: What about animals? Do you have any pets?
P: Yeah
T: Okay. So what kind of pet do you have?
P: I have a cat.
T: You have a cat. What’s your cat’s name?
P: Spot.
Internal Coping Strategies

• T: Okay. So would it make sense for Spot to be a second activity to turn to if playing videogames wasn’t a good enough distraction?

• P: Yeah. I mean, she’s always there. She’s never going to leave me.

• T: Okay. Alright, so let’s put that down as step two: play with Spot. Okay?
Step 2: Things I can do to take my mind off my problems without contacting another person

1. Playing videogames
2. Playing with Spot
Step 3: People who can help to support and distract me

T: Alright. So if that doesn’t work and you are not feeling better the next step would be to identify some people that can help you take your mind off things or distract you when you start to feel suicidal. Is there anyone you can think of who helps you take your mind off your problems at least for a little while?

P: Not really. I mean when I get that way I usually don’t feel like talking to anyone so...

T: Okay. Alright, are there any places near your apartment that you ever go to where people are around?

P: No.

T: No. Okay. Are there people who, when you’re feeling okay, who you do socialize with? When you’re not thinking about suicide are there people who you like to spend time with?

P: Honestly, I don’t really like people.
Step 3: People who can help to support and distract me

T: Okay. So there isn’t anyone you like. I’ve noticed though that sometimes just being around people, not necessarily having to talk with them, but just being around people can have a positive impact on our mood. Are there places you like to hang out where there are people who you can be with but with whom you do not have to socialize with but may if the mood strikes you?

P: Well there is the 24-hour diner down the street. I guess I could go there and talk to the waitresses they’re pretty OK.

T: Okay, good let me write that on your safety plan.
Step 3: People who can help to support and distract me

1. Name    24 Hour Diner    Phone
People Who Can Help

T: Alright. So if that doesn’t work and you are not feeling better the next step would be to turn to people you can ask for help and talk about your crisis. Now you said that you really don’t like people and the fourth step of safety planning is to identify people who you really feel like you could turn to for help in a crisis; people who you could actually say to them, “I’m thinking about killing myself and I need some help.” So who are those people in your life? Think about your family and friends first.

P: I mean I’ve really not wanted to bother anybody with my problems because it’s embarrassing. It’s embarrassing to tell people that I have a problem so it’s just easier to ignore it or not worry about it.
T: Okay. Is there anyone in your family or any of your friends who you would be able to say “I’m thinking about killing myself” to?

P: No.

T: What about non-family members, non-friends? Are there people at the VA, are there other providers besides me, anyone that you could say to “I’m thinking about killing myself”? 

P: Other than you? No, I can’t think of anyone.

T: Okay, let's leave that blank for now. We can come back to this in the future and we can hopefully add to it then.
Step 4: People who I can ask for help

1. Name    Phone
2. Name    Phone
3. Name    Phone
T: Okay. Well I certainly will continue to be a source of support for you. So, let's write my name and number down on the first line under Step 5. Nazanin Bahraini, 303-399-8020 x5642. But the thing is I’m not here all the time. So, fortunately, we do have Psychiatric Emergency Services here. If you couldn’t get a hold of me, you know it was really a crisis, you’ve reached that step on your safety plan, do you feel like you could call PES?

P: Maybe.

T: Maybe?
Professional Contacts

P: I mean, I don’t want to lie to you. I’ve had three attempts so far where, you know, I didn’t make those calls and so I don’t want to lie to you.

T: And I appreciate that. And there’s probably no good way to predict whether or not you’d make that call or not.

P: Yeah.

T: Yeah, but we can predict that if you don’t have the number in front of you, you’re less likely to make the call.

P: Okay. You make a good point.
Professional Contacts

T: And then another thing that the VA has started doing is we now have a staff person who’s called our Suicide Prevention Coordinator and it’s this person’s job to kind of check in with folks who have been, you know, really suicidal lately and to just kind of offer one more set of eyes, one more contact person. Do you remember Michelle Steinwand our Suicide Prevention Coordinator?

P: I think I met her on the unit.

T: Yes, she’s very supportive and I’d like to put her name on the list as well, again, just so you have an option. You may never get to the point of calling her but just kind of another contact person. Does that seem okay?

P: Okay.

T: Good, her name is M-i-c-h-e-l-l-e   S-t-e-i-n-w-a-n-d, and her number is 303-399-8020 x3093.

P: Okay.
Professional Contacts

T: In addition I wonder about the VA Crisis Line. The VA has a national crisis line. It’s a toll-free telephone number that you can call 24 hours a day, 7 days a week. And you will always get a real live human being on the other end of the phone; that’s one of the really great things about the Crisis Line. And you can be totally anonymous. You don’t have to tell them your name. You don’t have to tell them where you live. But their job is to listen to guys like you who are thinking about suicide and to give them that kind of connection that we’ve been talking about. Would it feel less embarrassing to tell a stranger on the other end of the phone that you’re thinking about suicide?

P: I mean in some ways yeah. It would feel less embarrassing.
Step 5: Professionals or agencies I can contact during a crisis

1. Clinician Name Nazanin Bahraini Phone 303-399-8020 x5642
2. Local Urgent Care Services Denver VA Medical Center
   Urgent Care Services Address 1055 Clermont St.
   Urgent Care Services Phone 303-393-2835
Step 5

3. VA Suicide Prevention Coordinator Name
   Michelle Steinwand

VA SPC Phone 303-399-8020 x3093

4. VA National Crisis Line Phone: 1-800-273-TALK (8255), push 1 to reach VA mental health clinician
Identify Barriers to Use

- Unique to each patient
- Problem solve ways to overcome
T: Alright, well we’re almost done. The last step of the plan is to think about ways that we can make it harder for you to get access to means for killing yourself. And all three times when you’ve made a suicide attempt you’ve overdosed on your prescription medication. Is that the only way you’ve ever thought about killing yourself, I mean, is that the way that you’d be most likely to do it in the future?

P: Yeah, cause I don’t want it to be painful and I don’t want it to be messy.

T: And you don't own a gun, right?

P: Right.
T: Alright, what would you think about making a slight change in the way you get your meds and instead of getting them by mail and having a month or more at a time on hand? What if you only got a week supply at a time?

P: That would stink.

T: What would stink about it?

P: Well because it just makes it harder for me to do that?

T: Harder how?

P: You know...to want to kill myself.

T: Oh, it would stink because it would be harder to kill yourself?

P: Well yeah.
Step 6: Making the environment safe

1. Getting medication a week at a time
Will the Patient Use their Plan?

T: Okay. So we’ve got our plan and, you know, we’ll make multiple copies of this. And I’ll hang on to the original so just in case you lose a copy or you need more it’ll be no problem to make more. We have a plan to help you hang them up when you get home and if I don’t hear from you I will be calling you later today. Next time we meet we’ll revisit the plan to see if it’s working for you, if it’s really helping, if you’ve had a crisis and the plan has helped you get through it then fantastic. But if it hasn’t then we want to be able to make changes to the pieces that aren’t working. Does that make sense?

P: Yeah.

T: Okay. So how do you feel about, you know, having put together this safety plan? What are your thoughts about what we’ve just done?

P: I don’t know. I mean, I don’t know if it makes me feel better because it’s not like my life is going to improve because of this plan. It’s not like I’m never going to be suicidal again. I mean, I get it, but I just don’t know. I don’t feel right making promises to you about whether or not I’m going to kill myself.
T: Well I’m not asking you to promise me you’ll never kill yourself. I’m asking you to try and use this plan to deal with the crises that you have. That’s all I’m asking you if you think you can do.

P: Yeah, I’ll give it a shot.

T: So, what was the most helpful thing that we discussed today?

P: I think it was identifying the warning signs and figuring out how I’m going to remember the coping strategies when I’m in a crisis.

T: Great! I'm going to go make copies for you. I'll be right back.

P: Okay.
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

Nazanin.Bahraini@va.gov

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