Introduction

Introduction

Welcome to the Suicide Risk Management Training for Clinicians. The intent of this guide is to provide non–behavioral health clinicians with the necessary information to recognize and bring into treatment veterans who are struggling with suicidal thought.

Goals:

1. Understand the prevalence and scope of suicide in our society and among our veteran population
2. Understand assessment of potentially suicidal veterans
3. Recognize warning signs and make necessary referrals
4. Become familiar with risks related to suicide in patients presenting with other medical and psychiatric concerns
5. Learn about systemic and environmental risks related to treating suicidal veterans
6. Recognize the importance of what is termed “means restriction”
7. Understand the basic concepts of formulating a safety plan

As you move through this guide, please remember that the information provided is presented with the knowledge that current research is ongoing and that the clinician can benefit from additional self–study and from keeping abreast of the literature.

Background

Background

Suicide was the 11th leading cause of death for all ages in the United States during 2005, the 8th leading cause of death for males, and the 16th leading cause of death for women. In 2005, suicide was the 4th leading cause of death among adults 18–65. Individuals aged 65 and older account for 16% of all suicides. The suicide rate among men over age 75 is nearly six times the national average [(1)]. Importantly, the greatest social impact due to suicide falls between the ages of 40–54 years when measured in terms of total deaths, relative risk, years of potential life lost, and lost productivity in our society [(2)].

Of those who attempt suicide and live, 10–20% will make an additional attempt within one year, 1–2% will complete suicide within the year of an attempt, and an estimated 10–15% of suicide attempters may die by their own hand [(3)]. Those who attempt suicide and survive may also have serious injuries like broken bones, brain damage, organ failure that requires expensive medical treatment. Family and friends of people who attempt or die by suicide may feel shock, anger, guilt, and depression. The medical costs and lost wages associated with suicide and suicide–related behavior exact a toll on the community.

(1) (National Center for Health Statistics 2008)
(2) (Knox KL, Caine ED 2005)
(3) (Fremouw WJ, dePerczel M, Ellis TE 1990)

Background

Background Continued

Preventing suicide requires knowledge of variables or factors that increase risk. Over 60% of individuals who die by suicide suffer from depression [4]. In fact, more Americans suffer from depression than coronary heart disease (12 million), cancer (10 million) and HIV/AIDS (1 million) [5]. Fortunately, depression is treatable, especially if is it identified and treated early [6]. Between 80 percent and 90 percent of people with depression respond positively to treatment, and almost all patients gain some relief from their symptoms.

Beyond its well–known relationship to psychiatric disorders such as depression, suicide is also associated with bipolar disorder, schizophrenia, and alcohol or drug abuse and dependence [7] and their ravaging effects including domestic violence [8] problems with parenting, and lost effectiveness in the workplace [9]. **To prevent suicide, communities must develop prevention programs that address an array of psychiatric and social conditions.**

(4) (Broadhead et al 1991, Goldney RD et al 2000)
(5) (American Foundation for Suicide Prevention, 2008)
(6) (Goldberg RJ, Steury S 2001)
(7) (Conner K et al 2000, Conner K, Duberstein P, Conwell Y 2000, Conner K et al 2003)
(8) (Dube et al 2001)
(9) (Kessler et al 1999, Goldberg et al 2003)

Background

Background Continued

A recent community study found that male veterans were at approximately twice the risk for suicide, than male non–veterans [(10)]. Risk of suicide may increase with the severity of veterans' war–related injuries. Bullman and Kang (1995) provided compelling evidence of a dose–response effect between the degree of traumatic injury suffered during deployment and suicide risk. These data, however, do not include veterans from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). The mental health needs of our newest cohort is of growing public health concern as 17% of Army and Marine Corps combatants have self reported experiencing early psychiatric symptoms [(11)]. In response to the knowledge that veterans are at elevated risk, Congress (H.R. 327; S. 479) passed the Joshua Omvig Veterans Suicide Prevention Act, which directs the VA to create a comprehensive suicide prevention program to address suicide among the veteran population.

(10) (Kaplan et al 2006)
(11) (Authors 2008)

Background

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Assessment & Referral

Suicide Risk Assessment Pocket Card

The Suicide Risk Assessment Pocket Card was developed to assist clinicians in all areas, but especially in primary care and the emergency room/triage area. The Pocket Card can assist clinicians in making assessments and care decisions regarding patients who present with suicidal ideation or provide reason to believe that there is cause for concern.

Select this link for a text version of the Suicide Risk Assessment Card.
Suicide Risk Assessment Card (text)

Assessment & Referral

Suicide Risk Assessment Guide Introduction

The Suicide Risk Assessment Reference Guide provides more specific information and the rationale for the sections on the pocket card. The sections of the guide correspond with the sections of the card. The Reference Guide may also be used as a teaching aid for new providers, residents and students at all levels and disciplines as well as other caregivers. This introduction provides general information regarding the nature and prevalence of suicidal behaviors and factors associated with increased risk for suicide and suicide attempts. Suicidal thoughts and behaviors (including suicide attempts and death by suicide) are commonly found at increased rates among individuals with psychiatric disorders, especially major depressive disorder, bipolar disorders, schizophrenia, PTSD, anxiety, chemical dependency, and personality disorders (e.g., antisocial and borderline). A history of a suicide attempt is the strongest predictor of future suicide attempts, as well as death by suicide. Intentional self–harm (i.e., intentional self injury without the expressed intent to die) is also associated with long term risk for repeated attempts as well as death by suicide.

Suicide Risk Assessment Guide Introduction Continued

Psychiatric co–morbidity (the presence of more than one psychiatric disorder) increases risk for suicide, especially when substance abuse or depressive symptoms coexist with another psychiatric disorder or condition.

A number of psychosocial factors are also associated with risk for suicide and suicide attempts. These include recent life events such as losses (esp. employment, careers, finances, housing, marital relationships, physical health, and a sense of a future), and chronic or long–term problems such as relationship difficulties, unemployment, and problems with the legal authorities (legal charges). Psychological states of acute or extreme distress (especially humiliation, despair, guilt and shame) are often present in association with suicidal ideation, planning, and attempts. While not uniformly predictive of suicidal ideation and behavior, they are warning signs of psychological vulnerability and indicate a need for mental health evaluation to minimize immediate discomfort and to evaluate suicide risk.

Certain physical disorders are associated with an increased risk for suicide including diseases of the central nervous system (epilepsy, tumors, Huntington's Chorea, Alzheimer's Disease, Multiple Sclerosis, spinal cord injuries, and traumatic brain injury), cancers (esp. head and neck), autoimmune diseases, renal disease, and HIV/AIDS. Chronic pain syndromes can contribute substantially to increased suicide risk in affected individuals.

Suicide Risk Assessment Guide Introduction Continued

A recent national survey [(12)] found that 13.5 % of Americans report a history of suicide ideation at some point over the lifetime, 3.9% report having made a suicide plan, and 4.6% report having attempted suicide. Among attempters, about 50% report having made a “serious” attempt. The percentages are higher for high school students asked about suicidal ideation and behavior over the preceding year: 16% report having seriously considered attempting suicide, 13% report having made a suicide plan, and 8.4% report having made an attempt during the prior 12 months (CDC, YRBS 2005). These numbers are even higher when a psychiatric disorder is present.

Suicidal Ideation can lead to attempt. Approximately 34% of individuals who think about suicide report transitioning from seriously thinking about suicide to making a plan, and 72% of planners move from a plan to an attempt. Among those who make attempts, 60% of planned attempts occur within the first year of ideation onset and 90% of unplanned attempts (which probably represent impulsive self–injurious behaviors) occur within this time period [(13)]. These findings illustrate the importance of eliciting and exploring suicidal ideation and give credence to its role in initiating the suicidal process.

(12) (Kessler, et al., 1999)
(13) (Kessler, et al., 1999)

Assessment & Referral

Look For WARNING Signs

What are warning signs and why are they important?

There are a number of known suicide risk factors. Nevertheless, these risk factors are not necessarily closely related in time to the onset of suicidal behaviors – nor does the presence of any single risk factor necessarily indicate that the individual is at elevated risk. Population based research suggests that the risk for suicide increases with the number of risk factors, such that individuals with a greater number of risk factors are at a greater risk for suicide than individuals with fewer risk factors.

A recent review of the literature has identified a number of acute warning signs that precede the onset of suicidal behaviors (e.g., within hours to a few days). These signs should warn the clinician of ACUTE risk for the expression of suicidal behaviors, especially in those individuals with other risk factors [(14)]. Three of these warning signs (bolded on the **VA SUICIDE RISK ASSESSMENT** Pocket Card) carry the highest likelihood of short–term onset of suicidal behaviors and require immediate attention, evaluation, referral, or consideration of hospitalization.

(14) (Rudd, et al., 2006)

Assessment & Referral

The First Three Warning Signs Are:

THE FIRST THREE WARNING SIGNS ARE:

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

The remaining list of warning signs should alert the clinician that a mental health evaluation needs to be conducted in the **VERY** near future and that precautions need to be put into place **IMMEDIATELY** to ensure the safety, stability and security of the individual.

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, or 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
Gives away valued possessions

Other behaviors that may be associated with increased short–term risk for suicide are when the patient makes arrangements to divest responsibility for dependent others (children, pets, elders), or making other preparations such as updating wills, making financial arrangements for paying bills, saying goodbye to loved ones, etc.

Specific Factors That May Increase or Decrease Risk For Suicide

Risk and protective factors:

Factors that increase or decrease risk are those that have been found to be associated with the presence or absence of suicidal behaviors. They do not necessarily impart a causal relationship. Rather, they serve as guidelines for the clinician to weigh the relative risk of an individual engaging in suicidal behaviors taking into consideration the current clinical presentation and psychosocial setting. Individuals differ in the degree to which risk and protective factors affect their propensity for engaging in suicidal behaviors. Within an individual, the contribution of each risk and protective factor to their suicidality will vary over the course of their lives.

No single risk factor, or set of risk factors, can be used to predict who will die by suicide. Nor does one protective factor, or set of protective factors, insure safety. Furthermore, because of the different strengths of their associations with suicide–related behaviors, all factors are not equal and one cannot "balance" one set of factors against another in order to derive a sum total score of relative suicidal risk. Some risk factors are immutable (e.g., age, gender, race/ethnicity), while others are more situation–specific (e.g., loss of housing, exacerbation of pain in a chronic condition, and onset or exacerbation of psychiatric symptoms).

Ideally, with knowledge of an individual's risk and protective factors, the sensitive clinician will inquire about the individual's reasons for dying and reasons for living to better evaluate current risk for suicide.

Assessment & Referral

Specific Factors That May Increase or Decrease Risk For Suicide

Factors that may increase a person's risk for suicide include:

Current ideation, intent, plan, access to means
Previous suicide attempt or attempts
Alcohol / Substance abuse
Current or previous history of psychiatric diagnosis
Impulsivity and poor self control
Hopelessness – presence, duration, severity
Recent losses – physical, financial, personal
Recent discharge from an inpatient psychiatric 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

Assessment & Referral

Specific Factors That May Increase or Decrease Risk For Suicide

Factors that may decrease the risk for suicide are also called protective factors.

- 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
- Fear of death and/or suicide

The VA now has its own Crisis Hotline, staffed by VA professionals 24/7. Veterans in distress should be encouraged to call the Hotline at any time if they are unable to access their own support system for any reason. The veteran calls **1–800–273 TALK (8255)**, the number of the National Suicide Lifeline, and will be asked to “press 1” if they are a veteran. This automatically routes their call to the special Veterans Suicide Hotline Call Center in Canandaigua, New York. There, trained professional mental health clinicians will help the caller, even arranging for police or emergency medical technicians to be called to the scene. The Hotline staff are able to make immediate direct referrals to the Suicide Prevention Coordinators at any VA treatment center across the country, who will contact the veteran in a matter of hours. This comprehensive service should be made known to all veterans on your caseload whom you think may benefit.

Assessment & Referral

Ask The Questions: Introduction

Asking questions about suicidal ideation, intent, plan, and attempts is not easy. Sometimes the patient will provide the opening to ask about suicide, but there are times when the topic does not readily flow from the presenting complaint and gathering of history related to the present illness. This can be particularly true in medical as opposed to behavioral health type settings. Nevertheless, it is important to ask a set of screening questions whenever the clinical situation or presentation warrants it. The key is to set the stage for the questions and to signal to the patient that the assessment of the current problem is a collaborative task. A good place in the clinical interaction for beginning this discussion is immediately following the report and/or the elicitation of the patient/veteran's pain (physical or psychic) and distress. Introductory statements that lead into the questions pave the way to ensuring an informative and smooth dialogue and reassure the patient that you are prepared for and interested in the answers.

For example:

I appreciate how difficult this problem must be for you at this time. Some of my patients with similar problems/symptoms have told me that they have thought about ending their life. I wonder if you have had similar thoughts?

Ask The Questions: Introduction Continued

The questions on the pocket card are examples of the items that should be asked. They form a cascading questioning format where the answer would naturally lead to another question which will elicit additional important information. Please keep in mind that a veteran may answer “no” to the first question below and still have had thoughts about taking their own life.

Are you feeling hopeless about the present or 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?

It is worth keeping in mind that suicidality can be understood as an attempt by the individual to solve a problem that they find overwhelming. It can be much easier for the provider to be nonjudgmental when s/he keeps this perspective in mind. The provider then works with the suicidal individual to develop alternative solutions to the problems leading to suicidal feelings, intent and/or behaviors. The execution of this strategy can of course be more difficult than its conceptualization.

Assessment & Referral

Ask The Questions: Why is it Important to Ask About Feeling Hopeless?

Hopelessness – about the present and the future – has been found to be a very strong predictor of suicidal ideation and suicide–related behavior. Associated with hopelessness are feelings of helplessness, worthlessness, and despair. Although often found in depressed patients, these affective states can be present in many disorders – both psychiatric and physical. If present, it is important to explore these feelings with the individual to better assess for the development or expression of suicidal behaviors.

Assessment & Referral

Ask The Questions: Why is it Important to Ask About Ideation?

In most cases, suicidal ideation is believed to precede the onset of suicidal planning and action. Suicidal ideation can be associated with a desire or wish to die (intent) and a reason or rationale for wanting to die (motivation). Hence, it is essential to explore the presence or absence of ideation – currently, in the recent past, and concurrent with any change in physical health or other major psychosocial life stress.

Many individuals will initially deny the presence of suicidal ideation for a variety of reasons including: 1. the stigma that is associated with acknowledging symptoms of a mental disorder; 2. fear of being ridiculed, maligned and/or being judged negatively by the clinician; 3. loss of autonomy and control over the situation; and 4. fear that the clinician might overreact and hospitalize the individual involuntarily.

Even if denied, certain observable cues (affective and behavioral) should prompt the clinician to remain alert to the possible presence of suicidal ideation. Some signs and symptoms include: profound social withdrawal, irrational thinking, paranoia, global insomnia, depressed affect, agitation, anxiety, irritability, despair, shame, humiliation, disgrace, anger and rage. The clinician may point out the apparent disparity between the current observable clinical condition (what is seen and felt in the examining room) and a denial of suicidal thinking on the part of the patient. Identifying and labeling the clinical concern may pave the way for an open and frank discussion of what the patient is thinking and feeling – and help shape a treatment response.

Asking about suicidal ideation and intent does not increase the likelihood of someone thinking about suicide for the first time or engaging in such behaviors. In fact, most patients report a sense of relief and support when a caring, concerned clinician non–judgmentally expresses interest in exploring and understanding the patient's current psychological pain and distress that leads them to consider suicide or other self–injurious behaviors.

All suicidal ideations and suicidal threats need to be taken seriously.

Ask The Questions: Why is it Important to Ask About Timing of Ideation and Presence of a Plan?

Although a minority of individuals are chronically suicidal, most people become suicidal in response to negative life events or psychosocial stressors that overwhelm their capacity to cope and maintain control, especially in the presence of a psychiatric disorder. Hence it is important to understand what elicits suicidal thoughts and the context of these thoughts. Knowing how much time has been spent thinking about suicide alerts the clinician to its role and influence in the daily life of the patient. Knowing what makes things better and what makes things worse regarding the onset, intensity, duration and frequency of suicidal thoughts and feelings assists the clinician in developing a treatment plan. Also knowing what situations in the future might engender the return of suicidal thoughts helps the clinician and patient agree upon a safety plan and techniques to avoid or manage such situations.

The presence of a suicide plan indicates that the individual has some intent to die and has begun preparing to die. It is important to know the possibilities and potential for implementation of the plan, the likelihood of being rescued if the plan is undertaken, and the relative lethality of the plan.

Although some research suggests a relationship between the degree of suicidal intent and the lethality of the means, the clinician should not assume there was no intent if the method chosen does not appear to be necessarily lethal [(15)]. It is also important to know whether the individual has begun to enact the plan, by engaging in such behaviors as rehearsals, hoarding of medications, gaining access to firearms or other lethal means, writing a suicide note, etc.

(15) (Brown, et al., 2004)

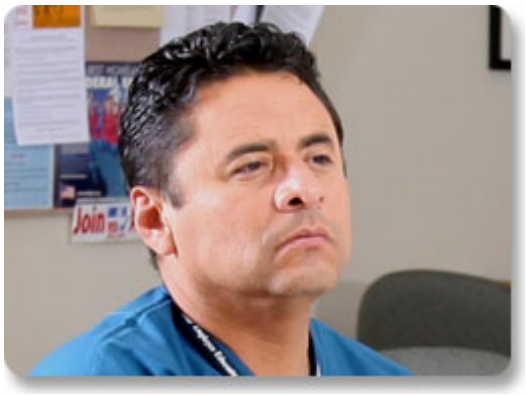
Ask The Questions: Why is it Important to Ask About a History of Attempts?

Although most people who attempt suicide only make one attempt, about 16% repeat within one year, 21% repeat within 1–4 [(16)]. The majority of repeat attempters will use more lethal means on subsequent attempts – increasing the likelihood of increased injury or death. Approximately 2% of attempters die by suicide within 1 year of their attempt, and 8–10% will die by suicide during their lifetime. The history of a prior suicide attempt is the best known predictor for future suicidal behaviors, including death by suicide.

(16) (Owens et al., 2002: Beautrais, 2003)

Assessment & Referral

Responding to Suicide Risk: What is a Crisis?



A crisis is when an individual's usual and customary coping skills are no longer adequate to address a perceived stressful situation. Often such situations are novel and unexpected. A crisis occurs when unusual stress, brought on by unexpected and disruptive events, render an individual physically and emotionally disabled – because their usual coping mechanisms and past behavioral repertoire prove ineffective. A crisis overrides an individual's normal psychological and biological coping mechanisms – moving the individual towards maladaptive behaviors. A crisis limits one's ability to utilize more cognitively sophisticated problem–solving skills and conflict resolution skills. Crises are, by definition, time–limited. However, every crisis is a high risk situation.

Responding to Suicide Risk: Crisis Intervention and Management

The goals of crisis intervention are to lessen the intensity, duration, and presence of a crisis that is perceived as overwhelming and that can lead to self–injurious behaviors. This is accomplished by shifting the focus from an emergency that is life–threatening to a plan of action that is understandable and perceived as doable. The goal is to protect the individual from self harm. When intervening, it is critical to identify and discuss the underlying disorder, dysfunction, and/or event that precipitated the crisis. Involving family, partners, friends, and social support networks is advisable.

The objectives are to assist the patient in regaining mastery, control, and predictability. This is accomplished by reinforcing healthy coping skills and substituting more effective skills and responses for less effective skills and dysfunctional responses. The goal of crisis management is to re–establish equilibrium and restore the individual to a state of feeling in control in a safe, secure, and stable environment. Under certain circumstances this might require hospitalization.

The techniques include removing or securing any lethal methods of self–harm, decreasing isolation, decreasing anxiety and agitation, and engaging the individual in a safety plan (crisis management or contingency planning). It also involves a simple set of reminders for the patient to utilize the crisis safety plan and skills agreed upon by both the provider and the patient.

Lessen the intensity, duration, and presence of a crisis
Shift the focus from an emergency that is life–threatening to a plan of action that is understandable and perceived as doable
Protect the individual from self–harm
Identify and discuss the underlying disorder, dysfunction, and/or event that precipitated the crisis
Involve family, partners, friends, and social support networks
Assist the patient in regaining mastery, control, and predictability
Reinforce healthy coping skills and substitute more effective skills and responses for less effective skills and dysfunctional responses
Re–establish equilibrium and restore the individual to a state of feeling in control in a safe, secure, and stable environment
Remove or secure any lethal methods of self–harm, decrease isolation, decrease anxiety and agitation, and engage the individual in a safety plan

Assessment & Referral

Responding to Suicide Risk: Referrals for Mental Health Assessment and Follow–up

Any reference to suicidal ideation, intent, or plans mandates a mental health assessment. If the patient is deemed not to be at immediate risk for engaging in self–destructive behaviors, then the clinician needs to collaboratively develop a follow–up and follow–through plan of action. This activity best involves the patient along with significant others such as family members, friends, spouse, partner, close friends, etc.).

Here are some ways to be helpful to someone who is threatening suicide or engaging in suicidal behaviors:

Be aware – learn the risk factors and warning signs for suicide and where to get help
Be direct – talk openly and matter–of–factly about suicide, what you have observed, and what your concerns are regarding his/her well–being
Be willing to listen – allow expression of feelings, accept the feelings, and be patient
Be non–judgmental – don't debate whether suicide is right or wrong or whether the person's feelings are good or bad; don't give a lecture on the value of life
Be available – show interest, understanding, and support
Don't dare him/her to engage in suicidal behaviors
Don't act shocked (If you are shocked, focus on the patient, rather than your alarm)
Don't ask "why" (Asking "why" may invalidate the patient's pain. Instead, ask "what is so bad that you are thinking about suicide?" or "what hurts so bad that suicide seems like an option?")
Don't be sworn to secrecy
Offer hope that alternatives are available – but don't offer reassurances that any one alternative will turn things around in the near future
Take action – remove lethal means of self–harm such as pills, ropes, firearms, and alcohol or other drugs
Get help from others with more experience and expertise
Be actively involved in encouraging the person to see a mental health professional as soon as possible and ensure that an appointment is made

Individuals contemplating suicide often don't believe that they can be helped, so you may have to be active and persistent in helping them to get the help they need. And, after helping a friend, family member, or patient during a mental health crisis, be aware of how you may have been affected emotionally and seek the necessary support for yourself.

Responding to Suicide Risk: Immediate Psychopharmacological Interventions

The most common psychiatric symptoms associated with acute risk for suicidal behaviors include: agitation, anxiety, insomnia, acute substance abuse, affective dysregulation, profound depression, and psychosis. The only two evidence–based medications that have been shown to lower suicidal behaviors are lithium (usually prescribed for bipolar disorder and recurrent unipolar depression) and clozapine (usually prescribed for schizophrenic disorders). However these medications do not reach therapeutic levels immediately.

As VHA clinical practice guidelines suggest, it is also indicated to prescribe anxiolytics, sedative/hypnotics, and short–acting antipsychotic medications up to or at the maximum indicated dosages to directly address agitation, irritability, psychic anxiety, insomnia, and acute psychosis, until such time as a behavioral health assessment can be made. The amount and type of medications to address these clinical presentations needs to be carefully chosen and titrated when the individual is deemed to be under the influence of alcohol, illicit substances, or medication in prescribed or overdose amounts.

Although depressive symptoms are often associated with risk for suicide, no antidepressant medication has been shown to reliably lower suicide risk in depressed patients. However, because of the relationship between low CSF serotonin levels and the emergence of aggression and impulsivity, the selective serotonin reuptake inhibitors (SSRIs) have been recommended for the treatment of depressive disorders when suicidal risk is present. However, treatment with SSRIs must be carefully monitored and managed during the initial treatment phase because of the potential for the possible emergence of suicidal ideation and behaviors during this time. The FDA has recently created a black box warning when prescribing SSRIs, and increased risk for suicide–related behavior has been documented for individuals under the age of 25.

Assessment & Referral

Myths About Suicide

There are many myths about suicide and suicidal behavior that have been passed down through generations of healthcare providers that some providers still believe today and may have actually been taught. Examples of these myths are:

• Myth: Asking about suicide would plant the idea in my patient's head.

Reality: Asking about suicide doesn't create suicidal thoughts, and may actually decrease them.

• Myth: There are talkers and there are doers.

Reality: Most people who die by suicide have communicated some intent. Someone who talks about suicide gives the physician an opportunity to intervene before suicidal behaviors occur.

• Myth: If somebody really wants to die by suicide, there is nothing you can do about it.

Reality: Most suicidal ideas are associated with the presence of underlying treatable disorders. Providing a safe environment for treatment of the underlying cause can save lives. The acute risk for suicide is often time–limited. If you can help the person survive the immediate crisis and the strong intent to die by suicide, then you will have gone a long way towards promoting a positive outcome.

• Myth: He/she really wouldn't kill themselves since _____.

he just made plans for a vacation
she has young children at home
he made a verbal or written promise
he knows how dearly his family loves him

Reality: The intent to die can override any rational thinking. In the presence of suicidal ideation or intent, the physician should not be dissuaded from thinking that the patient is capable of acting on these thoughts and feelings. No Harm or No Suicide contracts have been shown to be ineffective from a clinical and management perspective.

• Myth: Multiple and apparently manipulative self–injurious behaviors mean that the patient is just trying to get attention and are not really suicidal.

Reality: Suicide "gestures" require thoughtful assessment and treatment. Multiple prior suicide attempts increase the likelihood of eventually dying by suicide. It may help to empathically and non–judgmentally engage the patient in trying to understanding the function of the behavior and finding safer and healthier ways of asking for help or coping.

Assessment & Referral

Associated Medical & Psychiatric Concerns: OEF/OIF Veterans

Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans present a new challenge in determining the potential for suicidal behavior. Deployment to these theaters has led to a series of experiences that are unique to OEF/OIF veterans. These deployments have introduced a new set of modern combat techniques and realities that further complicate the impact of service there. Service persons deployed to these regions have had to adjust from traditional line–of battle warfare to counter–insurgency operations. These operations are fluid and not limited to defined locations on a map creating a shift hostile environment and the threat of brief intense combat happening almost anywhere.

Adding to the in–theater stressors is the need for frequent deployments and longer combat tours. The frequency and longevity of the tours have had a major impact on families. Another concern is the stress of anticipating future deployments and the conflict of a desire to remain with their families and the sense of loyalty and fidelity of deploying with their units.

Note: The OEF/OIF Counselor can be a valuable asset in assisting with family education, as can integrating family into treatment.

Associated Medical & Psychiatric Concerns: OEF/OIF Veterans Continued

OEF/OIF veterans are also affiliated with the Reserves and National Guard. The guard and reserve deployment picture presents challenges not seen with active duty deployment:

- First time Guard and Reserve dealing with multiple deployments.
- Unlike active duty units that may rotate together, reservists can be pulled individually or in small groups.
- Families of Reserve units are often spread across a wide geographic area, making regular support meetings difficult. Need for outreach.
- Job and employment concerns for Reserves and Guard.
    - Issues with skills for employment
- Reserves and Guard return to a culture in which people need to be reminded of recent deployment.
- Often a more difficult adjustment on return to CONUS–multiple adjustments: family, job changes (nothing stays static), switching from military to civilian culture.
- Financial pressures, put on hold, now become critical.
- More complicated if wounded, have psych/neuro symptoms, etc.
- Unresolved grief over losses in OIF can occur because there are not the opportunities to discuss it in an environment supportive of military life.

Associated Medical & Psychiatric Concerns: OEF/OIF Veterans Continued

The overall impact of all of these factors is not completely understood due to lack of formal studies. When evaluating these veterans it is important to understand their combat history, the presence of any pathological mourning or survivor guilt, the effects their service had on family or other relationships, as well as the impact on employment or financial stability. This type of evaluation should also focus on risk taking behaviors, substance abuse, signs or admission of violent or aggressive behavior and any other sign or symptom normally associated with suicidal thinking.

In summary, the evaluation of the returning OEF/OIF veteran is a complicated task and involves far more than the routine intake evaluation for new patients. They present with inherent risk factors for suicide and other self–destructive behaviors, family and job stresses and profound grief. Obtaining complete and in–depth histories of their military experience will assist the clinician in providing appropriate, proactive treatment and care.

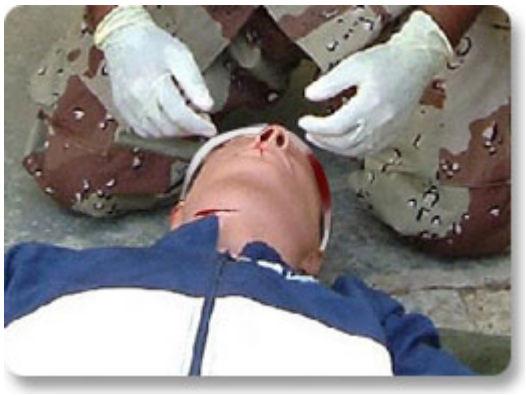
Associated Medical & Psychiatric Concerns: PTSD

Individuals with posttraumatic stress disorder (PTSD) have been found to be at greater risk for suicide than the general population [(17)]. Marshall et al (2001) found that the presence of sub threshold PTSD symptoms significantly raised the risk for suicide ideation even after they controlled for major depressive disorder. The incidence of PTSD in this group of veterans is currently being assessed but these statistics may not be known for several years as these soldiers return, are re–deployed, and attempt to reassimilate into community life after deployment. Unit demoralization has been linked to PTSD prevalence. Evaluating patients for early indications of PTSD symptoms is crucial.

(17) (Amir et al, 1999, Freeman et al, 2000 and others)

Assessment & Referral

Associated Medical & Psychiatric Concerns: Traumatic Brain Injury



In comparison to the general population TBI survivors are at increased risk for suicide ideation [(18)], suicide attempts [(19)] and suicide [(20)]. TBI–related sequelae can be enduring and may include motor disturbances, sensory deficits, and psychiatric symptoms (such as depression, anxiety, psychosis, and personality changes) as well as cognitive dysfunction. These cognitive impairments include impaired attention, concentration, processing speed, memory, language and communication, problem solving, concept formation, judgment, and initiation. Another important TBI sequelae that contributes to suicidal risk is the frequent increase in impulsivity. These impairments may lead to a life–long increased suicide risk which requires constant attention.

Some veterans are returning with diagnosed and yet to be diagnosed traumatic brain injuries. Assessment of negative outcomes after TBI must include a suicide risk assessment. The strongest predictors of suicide attempts among the TBI survivors are strong feelings of hostility and aggression.

(18) (Simpson and Tate, 2002)
(19) (Silver et al. 2001)
(20) (Teasdale and Engberg, 2001)

Assessment & Referral

Associated Medical & Psychiatric Concerns: Elder Suicide

Among depressed veterans, Zivin and colleagues (2007) reported that older (=65) and younger veterans (18–44) were more likely to complete suicide than middle aged veterans (45–64).
Kaplan and colleagues (2007) reported that veterans who completed suicide were more likely than non–veterans to:

Be older, Caucasian and educated (≥ 12)
Have more activity limitations at baseline
Have used a firearm at the time of death
And were less likely to be married or divorced

Older adults are less likely to report suicidal ideation and have well constructed suicide plans.
At a rate of 31 suicides per 100,000 annually, the greatest risk for suicide in the United States is seen in older (≥ 65 years) Caucasian men (CDC, 2004).

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Systemic and Environmental Issues

Inpatient

A good risk reduction process should be comprised of three basic components. First, clinical assessment and reassessment, second, environmental evaluation, and third, staff communication and participation. The following comments are directed toward in–patient psychiatric units, as that is where we are seeing the highest level of risk; however they are certainly applicable in other settings.

Potential environmental hazards

- Lack of protocols or procedures for protecting suicidal patients
- Lack of processes to assess the environmental hazards
- Lack of monitoring devices
- Architectural hazards such as points that could be used for hanging

Remediation

- Eliminate doors when not required by the Life Safety Code, or
- Remove doors on wardrobe cabinets and replace rods and hangers with shelves
- Eliminate belts, shoelaces, and safety razors – Shave high–risk patients or observe while shaving
- Ensure there is a protocol in place to eliminate access to drugs that could be used for an overdose
- Conduct environmental rounds using active observations skills and a comprehensive, checklist of potential environmental hazards
- Eliminate structures that are capable of supporting a hanging object
    - Plumbing, ductwork, fire sprinkler heads, curtain or clothing rods, hooks, shower heads and controls, doors, hinges, door handles, light fixtures
    - Include structures close to the floor
    - Towel bars, grab bars, toilet/sink plumbing & faucets, projections, and side–rails on beds
- Reduce strangulation devices such as drapery cords, belts, shoe laces, ties, kerchiefs, bathrobe sashes, drawstring pants, coat hangers, call cords, privacy curtains, and trash can liners

Note: Some of these recommendations should not be applied universally as they may have undesired effects on patients who are not suicidal.

Systemic and Environmental Issues

Outpatient

In FY01 VA's National Center for Patient Safety (NCPS) and Mental Health and Behavioral Sciences Service (MH&BSS) collaborated in the development of a brief report responsive to Congressional interest in mental illness and suicide among veterans. The primary findings in the 2001 report were: out of 678 total adverse event and close call root causes analyses in the NCPS Patient Safety Information Systems data base, 300 appeared to be related to veterans with some type of mental illness, and 100 (of the 300) were suicides, with 63 (of the 100) suicides occurring within or shortly after 30 days of inpatient or outpatient treatment. Of note, there is some belief that the Veteran population may be more at risk for suicide than the general population, due to both age and a greater frequency of psychiatric diagnoses commonly linked with suicide (e.g., substance abuse, major depression, schizophrenia, and personality and anxiety disorders).

This report suggests that careful and ongoing monitoring of patients needs to be conducted beyond discharge from the hospital or treatment on an out–patient basis. The Suicide Prevention Coordinator plays a significant role in this process.

Suicide Prevention Coordinator Responsibilities:

- To promote awareness at the facility about suicide and that suicide prevention is everyone's responsibility
- This includes providing "Guide Training" for non–clinical staff throughout the facility and clinics and coordinating other training programs to provide on–going education for all staff
- Assisting the facility in identifying those patients who may be at high risk for suicide and assuring that the care and monitoring for these patients is intensified
- Assisting in the national tracking and trending program so that we can learn more about these veterans and provide more targeted interventions
- Assisting the facility in identifying those veterans who have attempted suicide and working with the patient safety team to review the care we are providing to these patients in order to determine if we could do things better

Systemic and Environmental Issues

Means Restriction

Means restriction is a risk reduction strategy designed to prevent suicide by restricting access to common means of suicide completion or attempts.

A major premise of means restriction is that many patients act on suicidal thoughts impulsively. If there is a delay between the impulse and the obtaining of a preferred means, the patient would be afforded time to reconsider and seek help.

Means restriction is based on studies that address the following assumptions:

1. Suicidal persons have a preferred means that they have thought about very carefully
2. The preferred means is often based upon culture, age and likelihood of availability
3. Means restriction could serve to mitigate the fact that 73% of all suicides happen in the home
4. Healthcare professionals are not always trained in means restriction
5. The contemporary treatment models in ER settings are often not consistent with means restriction models [(21)]
6. Studies reflect that a period of impulsivity can precede suicidal attempts and delaying that impulse increases the chance the patient will not act [(22)]

(21) (Grossman, et. al., 2003)
(22) (Lambert, 1998)

Systemic and Environmental Issues

Means Restriction: Stats

Completed suicides by method numbers illustrate the significance of firearms.

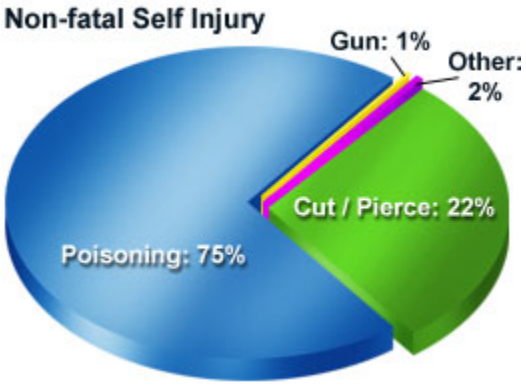
Guns & Veteran Suicide

(CDC 2004, 13 States)

Gun = 51% of suicides
Veterans = 21% of suicides
Veteran = 28% of gun suicides
Gun = 68% of veteran suicides

Non–fatal Self Injury

Gun: 1%
Other: 2%
Cut/ pierce: 22%
Poisoning: 75%



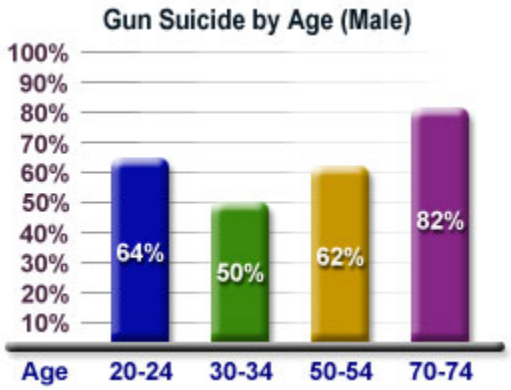
Systemic and Environmental Issues

Means Restriction: Stats Continued

The preferred means differs by age, gender, and ethnicity.

Gun Suicide by Age (Male)

20–24: 64%
30–34: 50%
50–54: 62%
70–74: 82%



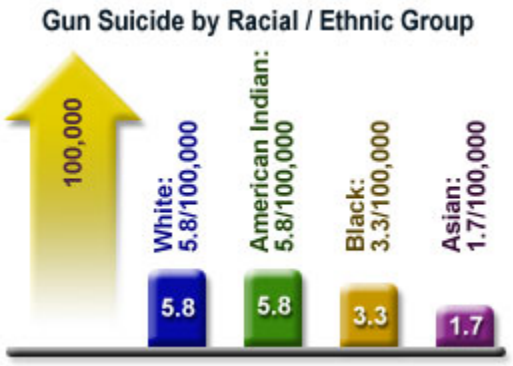
Gun Suicide by Gender

Male: 50–80% across age groups
Female: 20–40%

Gun Suicide by Racial / Ethnic Group

White: 5.8/100,000
American Indian: 5.8/100,000
Black: 3.3/100,000
Asian: 1.7/100,000

(Age adjusted rates / 100,000)



Means Restriction: Stats Continued

Guns, Suicide & Geography

Suicide rates are highest in Western (Rocky Mountain) states
Suicide rates higher in rural areas
Gun ownership is higher in Western states & rural areas
Gun in the home highly predictive of use in suicide: 31.1–107.9 times more likely
192 million guns/ 62 million handguns (1994)

Means Restriction: Stats Continued

Studies reflect that impulsivity increases risk for suicide, suggesting that preventing immediate behavior increases the chance the patient will not act (Lambert, 1998).

Guns & Impulsive Suicide

Impulsive/ aggressive personality factors associated with suicidal behavior
25% of 153 survivors of near lethal suicide attempt acted in 5 minutes of the impulse
71% acted in one hour

Systemic and Environmental Issues

Means Restriction: Stats Continued

Means restriction could serve to mitigate the fact that 73% of all suicides happen in the home.

Guns Hygiene and Suicide Risk: Odds Ratio

Handgun(s): Odds ratio 5.8
Long gun(s): 3.0
Loaded gun(s): 9.2
Unlocked gun(s): 5.6
Unloaded guns (s): 3.3
Locked gun(s): 2.4
No guns: 1 [23]

Other thoughts

Firearms has been a focus of this program due to the lethality associated with this method however, clinicians ought not avoid discussion about other means. It is imperative to address potential for overdose, storage of poison substances, ownership of sharp objects and tools, etc. It also behooves the clinician to ask about alternative means should the veteran's original plan be thwarted.

(23) (Grossman, 2005)

Means Restriction: Conclusion

Healthcare professionals are not always trained in means restriction.

Educating the healthcare provider is the first objective in implementing a comprehensive means restriction program. A study of nurses clearly showed that where the nurse was adequately trained in means restriction, there was a direct correlation between the use of means restriction and decreased likelihood of suicide completions [(24)]. Generally speaking, healthcare providers need to know how to formulate a means restriction plan as well as how to integrate that process into their overall treatment plan.

The contemporary treatment models in ER settings are often not consistent with means restriction models [(25)]. Therefore, clinicians are challenged with keeping abreast with information in this area. This task is difficult due to the limited studies conducted in the area of practical application of means restriction. A further complicating factor is that each patient's situation (as well as the clinical environments across the VA) is unique.

The best approach is using common sense and having a good safety plan. By remaining cognizant of this information, a clinician should be able to formulate an appropriate safety plan that reinforces means restriction.

(24) (Grossman, et. al., 2003)
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Safety Planning

The Case Against No Suicide/No Harm Contracts

The United States Department of Veterans Affairs in no way endorses the use of “no suicide” or “no harm contracts” as a means to prevent suicide. Further, we strongly discourage the use of such contracts with our nation’s veterans.

What is a “no suicide/no harm contract”?

There does not appear to be a uniform definition of a “no suicide/no harm” contract. However, one common element includes an agreement, on the part of the patient, not to kill him/her before seeking help in the midst of crisis. These agreements may be elicited by a clinician either verbally or in written form. Often times, “contracts” are not followed by the development of a crisis plan or a discussion about how the patient might cope during a psychiatric emergency [(26)].

(26) (see Rudd, Mandrusiak, & Joiner, 2006)

Safety Planning

The Case Against No Suicide/No Harm Contracts Continued

Why shouldn't we use no suicide/no harm contracts?

At present, there is no empirical evidence available that supports the use of "no suicide/no harm" contracts [(27)]. Despite this fact, researchers have reported their use by up to 57% of surveyed clinicians. To make matters worse, there is no true consensus on the standard of care where "no suicide/no harm" contracts are concerned [(28)]. Furthermore, qualitative researchers have revealed that patients who have agreed to "contract for safety" have felt coerced, intimidated and disempowered – the complete opposite of clinicians' reported perceptions [(29)].

Others have argued that, contracts early–on in therapy may imply that the clinician is only interested in the legal repercussions of suicide or foster the sense that the clinician is just there to "do a job". If this is true, one might suppose that "no suicide/no harm" contracts would undermine the establishment of a therapeutic alliance. Not to mention, they may strip patients of their last sense of control and autonomy without practical solutions to fall back on. Lastly, clinicians who rely too much on no–suicide contracts may circumvent a thorough assessment and end up limiting the number of safety measures they implement with a patient [(30)].

(27) (Drew, 2001; Farrow, Simpson, & Warren, 2002; Kelly & Knudson, 2000; Kroll, 2000; Rudd et al., 2006)
(28) (Drew, 2001; Kroll, 2000)
(29) (Farrow et al., 2002)
(30) (Britton, Williams & Conner, 2007; Kelly & Knudson, 2000; Rudd et al, 2006)

Safety Planning

So Where do We go From Here?

Several clinician–researchers support the notion of collaborative commitments with the patient [(31)].
Rudd and Colleagues (2006) recommend the therapist work with the patient to establish the following:

- Identifying clinician and patient roles and expectations in therapy
- Honest communication regarding all aspects of treatment
- How to access help during crises that may threaten the collaborative agreement

Jobes (2006) also advocates building in specific suggestions for coping including a plan of action for family and loved ones.
Najavits (2002) includes session–by–session commitments as an integral component of the Seeking Safety treatment.
Linehan (1993) supports exploring and teaching distress tolerance skills to patients as crisis survival strategies.

(31) (Jobes, 2006; Najavits, 2002; Rudd et al., 2006; Rudd, 2006)

Safety Planning

Piecing it all Together: VA Safety Plan Implementation to Reduce Suicide Risk

Safety planning is a brief clinical intervention that can serve as a valuable adjunct to suicide risk assessment. The intent of the safety plan is to help veterans lower their imminent risk of suicidal behavior. Consistent with the Recovery Model, the safety planning approach views veterans as collaborators in their own care and empowers them with more effective means to cope [(32)].

The clinician simply works with the patient to identify alternative coping strategies. Safety plans include five basic steps. When the first step fails to decrease the level of suicide risk, the veteran is instructed to move on to the next step, and so forth. The steps of a safety plan are as follows:

1. Recognizing warning signs
2. Using internal coping strategies
3. Socializing with family members or others who may offer support or distraction from the crisis
4. Contacting family members or friends who may offer help to resolve a crisis
5. Contacting professionals or agencies

After reviewing each step with the veteran, a copy of the agreed upon safety plan, clearly identifying the points discussed in each step, should be furnished for the patient and maintained in their record.

(32) (Stanley and Brown, Unpublished)

Safety Planning

VA Safety Plan Implementation to Reduce Suicide Risk: Step 1

Step 1: Recognizing Warning Signs

In order to avert a crisis, it is important that the veteran is able to recognize his/her warning signs. Clinicians may assist the veteran in identifying their warning signs by asking them about what they encounter when they start to think about suicide or experience extreme distress. Keep in mind the following points when working with the veteran on identifying warning signs:

1. What does the veteran experience emotionally? (e.g. irritability, anxiety, etc.)
2. What does the veteran experience physically? (e.g. muscle tension, fatigue, etc.)
3. What does the veteran think about? (e.g. “No one loves me”.)
4. How does the veteran’s behavior change? (e.g. isolating from support system, drinking more, etc.)

Safety Planning

VA Safety Plan Implementation to Reduce Suicide Risk: Step 2

Step 2: Using Internal Coping Strategies

After the veteran is able to recognize their personal warning signs, the clinician should work with the patient on identifying strategies that he/she can employ on his/her own, without the help of others, to thwart suicidal behavior. When the veteran has generated a list, keep in mind that some strategies may be more effective than others. It is important to determine what strategies the veteran is most likely to use and which strategies they would realistically engage first. Examples of internal coping strategies include the following:

1. Going for a walk
2. Prayer
3. Listening to uplifting music
4. Cleaning the house
5. Petting the dog

Safety Planning

VA Safety Plan Implementation to Reduce Suicide Risk: Step 3

Step 3: Socializing with Family Members or Others Who May Offer Support and Distraction from the Crisis

When internal coping strategies do not work, it may become necessary to enlist the support of others. Clinicians should work with the veteran to identify supportive people whom he/she will realistically contact during a crisis. During this step, it is not necessary for the veteran disclose their suicidal thoughts. The idea is to be around amiable people who will provide distraction from suicidal behavior. In some cases, the veteran may not have an adequate support system. When this is the case, it may be suggested the veteran go to a public venue such as a coffee shop or mall.

VA Safety Plan Implementation to Reduce Suicide Risk: Step 4

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

Should socialization and distraction fail, the veteran may identify family members or friends with whom they can disclose that they are experiencing a suicidal crisis. When reviewing this step with the veteran it is important to determine who they are most likely to contact in a crisis and establish a realistic hierarchy of names. It is also recommended that the veteran identify a supportive person with whom he/she might share their safety plan. If the veteran agrees, this person should also be clearly named on the safety plan.

Safety Planning

VA Safety Plan Implementation to Reduce Suicide Risk: Step 5

Step 5: Contacting Professional Agencies

When the aforementioned steps do not divert a suicidal crisis, the clinician must instruct the veteran to contact professionals or agencies equip to manage the crisis. Professional contacts should be prioritized and documented clearly with the following components:

1. Name of the contact person or hospital
2. Phone numbers (business and on–call page or other back–up phone number)
3. Addresses

The following are examples of professionals the veteran may contact:

1. Primary mental health clinician
2. 24–hour urgent care facility
3. Veteran's Suicide Prevention Hotline: 1–800–273 TALK (8255)

Safety Planning

Other Considerations

Clinicians should consider that a key component in a safety plan involves eliminating or limiting access to lethal means. This requires restricting access to medications, knives and household poisons; and implementing firearm safety procedures.

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Suicide Risk Assessment Pocket Card Text

ACCESS 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?

RESPONDING TO SUICIDE RISK

ASSURE THE PATIENT'S IMMEDIATE SAFETY AND DETERMINE MOST APPROPRIATE TREATMENT SETTING

- Refer for mental health treatments or assure the 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: 1-800-273-8255 (TALK)

References:

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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.
ACCESS 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.