Suicide Risk Assessment and Safety Planning in Homeless Veterans

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Disclosure Statement

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Synopsis of Presentation

• Suicide Risk Assessment
  • Facts about Veteran Suicide
    • Homeless Veterans and Suicide
  • Suicide Risk Assessment
  • Safety Planning
• Questions and Comments
Facts about Veteran Suicide
<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
<th>Number of suicides</th>
<th>Population</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alaska</td>
<td>149</td>
<td>681,111</td>
<td>21.8</td>
</tr>
<tr>
<td>2</td>
<td>Montana</td>
<td>196</td>
<td>956,624</td>
<td>20.5</td>
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<tr>
<td>3</td>
<td>New Mexico</td>
<td>401</td>
<td>1,964,402</td>
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</tr>
<tr>
<td>4</td>
<td>Wyoming</td>
<td>101</td>
<td>523,252</td>
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</tr>
<tr>
<td>5</td>
<td>Nevada</td>
<td>471</td>
<td>2,554,344</td>
<td>18.4</td>
</tr>
<tr>
<td>6</td>
<td>Colorado</td>
<td>811</td>
<td>4,842,770</td>
<td>16.7</td>
</tr>
</tbody>
</table>

Facts about Veteran Suicide

• ~34,000 US deaths from suicide/year
  (Centers for Disease Control and Prevention)

• ~20% are Veterans
  (National Violent Death Reporting System)

• ~18 deaths from suicide/day are Veterans
  (National Violent Death Reporting System)

• ~5 deaths from suicide/day among Veterans receiving care in VHA.
  (VA Serious Mental Illness Treatment, Research and Evaluation Center)
Homelessness and Suicide Risk

• Homeless individuals are **10 times** more likely than the general population to have suicidal ideation (Fitzpatrick, 2007)

• Rates of substance abuse are 6-7 times higher among the homeless (Fischer & Breakey, 1991)

• Consider the impact of substance abuse on suicide risk
Homeless Veterans and Suicide

• Approximately 1 in 7 homeless adults is a Veteran (Khuddari, 2010)

• Study of 10,111 Veterans entering GPD programs (Schinka et al., 2012)
  – Approximately 12% reported suicidal ideation before admission to the GPD program
  – Approximately 3% reported a suicide attempt in the 30 days prior to admission
VA Suicide Prevention Efforts

• Annual depression and PTSD screens
• For each Veteran determined to be at high risk:
  – A VA Safety Plan is created
  – A suicide risk flag is placed in their medical record
• Every VAMC is staffed with a suicide prevention coordinator
• VA Crisis Line (1-800-273-TALK)
• Online chat (www.veteranscrisisline.net/chat)
• Text option (838255)
Suicide Risk Assessment
We assess risk to...

• Take good care of our patients and to guide our interventions

• The purpose of systematic suicide risk assessment is to identify modifiable and treatable risk factors that inform the patient’s overall treatment and management requirements (Simon 2001)

• Fortunately, the best way to care for our potential suicidal patients and ourselves are one in the same (Simon 2006)
Shock, Disbelief, Denial, Grief, Shame, Anger, and FEAR

Clinically Based Risk Management

• Clinically based risk management is patient centered
• Supports treatment process and therapeutic alliance
• Good clinical care = best risk management
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.
Good Clinical Practice is the Best Medicine

• Evaluation
  – Accurate diagnosis
  – Systematic suicide risk assessment
  – Get/review prior treatment records

• Treatment
  – Formulate, document, and implement a cogent treatment plan
  – Continually assess risk

• Management
  – Safety management (hospitalize, safety plans, precautions, etc)
  – Communicate and enlist support of others for patient’s suicide crisis

“Never worry alone.” (Gutheil 2002)
Suicide Risk Assessment

• No standard of care for the prediction of suicide
• Suicide is a rare event
• Efforts at prediction yield lots of false-positives as well as some false-negatives
• Structured scales may augment, but do not replace systematic risk assessment
• Actuarial analysis does not reveal specific treatable risk factors or modifiable protective factors for individual patients
Suicide Risk Assessment

• Standard of care does require suicide risk assessment whenever indicated
• Best assessments will attend to both risk and protective factors
• Risk assessment is not an event, it is a process
• Inductive process to generate specific patient data to guide clinical judgment, treatment, and management
• Research identifying risk and protective factors enables evidence-based treatment and safety management decision making
APA Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors


- Quick Reference Guide
- Indications
- Risk/protective factors
- Helpful questions to uncover suicidality
- And more
Important Domains of a Suicide-Focused Psychiatric Interview

- Psychiatric Illness
- History
- Psychosocial situation
- Individual strengths and vulnerabilities
- Current presentation of suicidality
  - Specifically inquire about suicidal thoughts, plans and behaviors
Thorough Psychiatric Evaluation

• Identify psychiatric signs and symptoms
  – In particular, sx’s that might influence risk: aggression, violence, impulsivity, insomnia, hopelessness, etc.

• Assess past suicidal and self-injurious behavior
  – For each attempt document details: precipitant, timing, intent, consequences, and medical severity
  – Substances involved?
  – Investigate pt’s thoughts about attempt: perception of lethality, ambivalence about living, degree of premeditation, rehearsal

• Review past treatment history and relationships
  – Gauge strength of therapeutic alliance
Thorough Psychiatric Evaluation

• Identify family history of suicide, mental illness, and dysfunction

• Investigate current psychosocial situation and nature of any current crisis
  – Acute crisis or chronic stressors may augment risk: financial, legal, interpersonal conflict or loss, housing, employment, etc.

• Investigate strengths!
  – Coping skills, personality traits, thinking style, supportive relationships, etc.
Specific Inquiry of Thoughts, Plans, and Behaviors

• Elicit any suicidal ideation
  – Focus on nature, frequency, extent, timing
  – Assess feelings about living

• Presence or Absence of Plan
  – What are plans, what steps have been taken
  – Investigate patient’s belief regarding lethality
  – Ask what circumstances might lead them to enact plan
  – Ask about GUNS and address the issue
Specific Inquiry of Thoughts, Plans, and Behaviors

• Assess patient’s degree of suicidality, including intent and lethality of the plan
  – Consider motivations, seriousness and extent of desire to die, associated behaviors and plans, lethality of method, feasibility
  – Realize that suicide assessment scales have low predictive values

• Strive to know your patient and their specific or idiosyncratic warning signs
Identify Suicide Risk Factors

• Specific factors that may generally increase risk for suicide or other self-directed violent behaviors

• A major focus of research for past 30 years

• Categories of risk factors
  – Demographic
  – Psychiatric
  – Psychosocial stressors
  – Past history
Warning Signs

• Warning signs – person-specific emotions, thoughts, or behaviors precipitating suicidal behavior

• Proximal to the suicidal behavior and imply imminent risk

• The presence of suicide warning signs, especially when combined with suicide risk factors generates the need to conduct further suicide risk assessment
# 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-based</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>
<tr>
<td>Risk Factors</td>
<td>Warning Signs</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>• Suicidal ideas/behaviors</td>
<td>• Threatening to hurt or kill self or talking of wanting to hurt or kill him/herself</td>
<td></td>
</tr>
<tr>
<td>• Psychiatric diagnoses</td>
<td>• Seeking access to lethal means</td>
<td></td>
</tr>
<tr>
<td>• Physical illness</td>
<td>• Talking or writing about death, dying or suicide</td>
<td></td>
</tr>
<tr>
<td>• Childhood trauma</td>
<td>• Increased substance (alcohol or drug) use</td>
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<tr>
<td>• Genetic/family effects</td>
<td>• No reason for living; no sense of purpose in life</td>
<td></td>
</tr>
<tr>
<td>• Psychological features (i.e. hopelessness)</td>
<td>• Feeling trapped - like there’s no way out</td>
<td></td>
</tr>
<tr>
<td>• Cognitive features</td>
<td>• Anxiety, agitation, unable to sleep</td>
<td></td>
</tr>
<tr>
<td>• Demographic features</td>
<td>• Hopelessness</td>
<td></td>
</tr>
<tr>
<td>• Access to means</td>
<td>• Withdrawal, isolation</td>
<td></td>
</tr>
<tr>
<td>• Substance intoxication</td>
<td></td>
<td></td>
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<tr>
<td>• Poor therapeutic relationship</td>
<td></td>
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</table>
Determine if factors are modifiable

<table>
<thead>
<tr>
<th>Non-modifiable Risk Factors</th>
<th>Modifiable Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Family History</td>
<td>• Treat psychiatric symptoms</td>
</tr>
<tr>
<td>• Past history</td>
<td>• Increase social support</td>
</tr>
<tr>
<td>• Demographics</td>
<td>• Remove access to lethal means</td>
</tr>
</tbody>
</table>
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
Establish Diagnosis and Risk

• Axis I, II, III, and IV all extremely pertinent to informed determination of risk

• In estimating risk, combine all elements:
  – Psychiatric illness
  – Medical illness
  – Acute stressors
  – Risk factors and patient-specific warning signs
  – Protective factors
  – Nature, intensity, frequency of suicidal thoughts, plans, and behaviors
Acute v. Chronic Risk

• These are very different, and each carry their own specific treatment/safety

A 29 y/o female with hx of 18 suicide attempts and chronic suicidal ideation, numerous psychiatric admissions, family hx of suicide, gun ownership, TBI, intermittent homelessness, alcohol dependence, and BPD presents to ER with c/o SOB; asked to conduct psychiatric evaluation given her well-known history. What is her risk?

• Formulation and plan for such individuals necessitates separate consideration of chronic and acute risk
Acute v. Chronic Risk

• Acute and chronic risk are dissociable
• Document estimation for each

“Although patient carries many static risk factors placing her at high chronic risk for engaging in suicidal behaviors, her present mood, stable housing, sustained sobriety, and SI below baseline suggest little acute/imminent risk for suicidal behavior.”
Psychiatric Management

• Establish/Maintain therapeutic alliance
  – Taking responsibility for patient’s care is not the same as taking responsibility for the patient’s life

• Attend to safety and determine treatment setting
  – Level of observation, frequency of sessions
  – Restricting access to means
  – Consider safety needs, optimal treatment setting, and patient's ability to benefit from such
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
Safety Planning: A Stand Alone Intervention
Major Challenges

1. How can a patient manage a suicidal crisis in the moment that it happens?
2. How can a clinician help the patient do this?
What is Safety Planning?

• A brief clinical intervention
• Follows risk assessment
• A hierarchical and prioritized list of coping strategies and sources of support
• To be used during or preceding a suicidal crisis
• Involves collaboration between the patient and clinician

“No-Suicide Contracts”

• No-suicide contracts ask patients to promise to stay alive without telling them how to stay alive.

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

• DON’T USE THEM!
### SAFETY PLAN: VA VERSION

<table>
<thead>
<tr>
<th>Step 1: Warning signs:</th>
</tr>
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<tbody>
<tr>
<td>1. __________________________</td>
</tr>
<tr>
<td>2. __________________________</td>
</tr>
<tr>
<td>3. __________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. __________________________</td>
</tr>
<tr>
<td>2. __________________________</td>
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<tr>
<td>3. __________________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 3: People and social settings that provide distraction:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name_________________ Phone_________________________</td>
</tr>
<tr>
<td>2. Name_________________ Phone_________________________</td>
</tr>
<tr>
<td>3. Place_________________ 4. Place ______________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 4: People whom I can ask for help:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name_________________ Phone_________________________</td>
</tr>
<tr>
<td>2. Name_________________ Phone_________________________</td>
</tr>
<tr>
<td>3. Name_________________ Phone_________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 5: Professionals or agencies I can contact during a crisis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clinician Name_________________ Phone____________________</td>
</tr>
<tr>
<td>Clinician Pager or Emergency Contact #________________________</td>
</tr>
<tr>
<td>2. Clinician Name_________________ Phone____________________</td>
</tr>
<tr>
<td>Clinician Pager or Emergency Contact #________________________</td>
</tr>
<tr>
<td>3. Local Urgent Care Services_______________________________</td>
</tr>
<tr>
<td>Urgent Care Services Phone_________________________________</td>
</tr>
<tr>
<td>4. VA Suicide Prevention Resource Coordinator Name____________</td>
</tr>
<tr>
<td>VA Suicide Prevention Resource Coordinator Phone______________</td>
</tr>
<tr>
<td>5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a</td>
</tr>
<tr>
<td>VA mental health clinician</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Step 6: Making the environment safe:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. __________________________</td>
</tr>
<tr>
<td>2. __________________________</td>
</tr>
</tbody>
</table>

Tips for Developing a Safety Plan

• Ways to increase collaboration
  – Sit side-by-side
  – Use a paper form
  – Allow the patient to write
• Brief instructions using the patient’s own words
• Easy to read
• Address barriers and use a problem-solving approach

6 Steps of Safety Planning

- Step 1: Recognizing Warning Signs
- Step 2: Using Internal Coping Strategies
- Step 3: Utilizing Social Contacts that Can Serve as a Distraction from Suicidal Thoughts and Who May Offer Support
- Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve the Crisis
- Step 5: Contacting Professionals and Agencies
- Step 6: Reducing the Potential for Use of Lethal Means
Step 1: Recognize Warning Signs

• Purpose: To help the patient identify and pay attention to his or her warning signs
• Recognize the signs that immediately precede a suicidal crisis
• Personal situations, thoughts, images, thinking styles, mood or behavior
• “How will you know when the safety plan should be used?”
• Specific and personalized examples
Step 2: Using Internal Coping Strategies

- **Purpose:** To take the patient’s mind off of problems to prevent escalation of suicidal thoughts
  - **NOT** to solve the patient’s problems
- **List activities the patient can do without contacting another person**
- **This step helps patients see that they can cope with their suicidal thoughts on their own, even if only for a brief period of time**
- **Examples:** Go for a walk, listen to inspirational music, take a hot shower, play with a pet
Step 3: People and Social Settings that Provide Distraction

- **Purpose:** To engage with people and social settings that will provide *distraction*
- Also increases social connection
- The client is not telling someone they are in distress during this step
- Importance of including phone numbers and multiple options
- Avoid listing any controversial relationships
Step 4: Contacting Family Members or Friends Who May Offer Help

• Purpose: To explicitly tell a family member or friend that he or she is in crisis and needs support

• Can be the same people as Step 3, but different purpose

• If possible, include a family member or friend in the process by sharing the safety plan with them
Step 5: Contacting Professionals and Agencies

- **Purpose:** The client should **contact a professional** if the previous steps do not work to resolve the crisis.

- Include name, phone number and location:
  - Primary mental health provider
  - Other providers
  - Urgent care or emergency psychiatric services
  - National Crisis Hotline 800-273-TALK (8255)
  - 911
Step 6: Reducing the Potential for Use of Lethal Means

- Complete this step even if the client has not identified a suicide plan
- Eliminate or limit access to any potential lethal means
- Always ask about access to firearms
- Discuss medications and how they are stored and managed
- Consider alcohol and drugs as a conduit to lethal means
Considerations for Homeless Veterans

• Might need to get creative with coping strategies
  – Where to go to de-stress
  – Information about free days
  – Safe places to get a break

• Can be used to help with substance abuse relapse and homicidal ideation as well
Resources

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

• VA Safety Planning Manual
  www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.doc
It takes the courage and strength of a warrior to ask for help.....

If you’re in an emotional crisis, call 1-800-273-TALK “Press 1 for Veterans”

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

Research
Education
Clinical Care
Assessment Tools
Fellowship Info
Personnel
Presentations
Study Participation
Contact Us
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
Thank you!

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