



A Brief Intervention to Reduce Suicide Risk Among Veterans

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Points of Intervention to Prevent Suicide

Population Prevention Public Health Measures



Background

- Majority of suicidal individuals who commit suicide do so on their first attempt
- Only a small percentage of suicide attempts are seen in the emergency department
- The most frequent professional contact prior to suicide is the primary care physician, not a mental health professional
- High risk period---3 months following an attempt

Background

- Suicidal patients are very difficult to engage in treatment
 - (Rudd et al., 1996)
- 11% to 50% of attempters refuse outpatient treatment or drop out of outpatient therapy quickly
 - (Kurz & Moller, 1984)
- Up to 60% of suicide attempters do not even attend more than one week of treatment post-discharge from the ED
 - (O'Brien et al., 1987; Granboulan, et al., 2001; King et al., 1997; Piacentini et al., 1995; Trautman et al., 1993; Spirito et al., 1989; Taylor & Stansfield, 1984; Kurz & Moller, 1984; Litt et al., 1983)

Background

- Of those who do attend treatment, 3 months after hospitalization for an attempt, 38% have stopped outpatient treatment

(Monti et al., 2003)

- After a year, 73% of attempters will no longer be in any treatment

(Krullee & Hales 1988)

Background

- Most suicidal individuals who go to the ED for help attend very few outpatient treatment sessions
- Many do not attend even one session
- Therefore, it's important to intervene whenever they are accessible

Typical Strategy for Crisis Intervention

Assess imminent danger then refer for treatment

But, given the limited success of referrals, alternative strategies that include immediate intervention ought to be considered

Crisis contact may be the ONLY contact the suicidal individual has with the mental health system

May be able to increase its “therapeutic” capacity

Safety Plan: The Basics

- What is it?
- What it's not
- Why do it?
- When is it done?
- Who develops it?
- How do I do it?

Safety Plan: What is it?

Prioritized list of coping strategies and resources for use during a suicidal crisis

It is a written document

Uses a brief, easy-to-read format that uses the patients' own words

Involves a commitment to treatment process (and staying alive)

Safety Plans are not “no-suicide contracts”

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

No suicide contracts may serve to “protect” the institution or therapist more than the patient

Virtually *no empirical evidence* to support effectiveness of no-suicide contracts

Safety Plan: Why do it?

- Development and implementation of a safety plan **is** treatment
- May be the first intervention with a suicidal patient
- Helps to immediately enhance patients' sense of control over a suicidal crisis and conveys a feeling that they can "survive" a suicidal crisis
- Patient may be more likely to engage further treatment if the safety plan is perceived as a helpful intervention

Safety Plan: Who develops it?

- Collaboratively developed by the VA clinician and the veteran
- Veterans who have made a suicide attempt, have suicide ideation, have psychiatric disorders that increase suicide risk, or who are otherwise determined to be at high risk for suicide
- VA clinicians who evaluate, treat, or have contact with patients at risk for suicide in any VA setting
- Relevant family members or friends of the veteran can be involved

Safety Plan: When is it done?

- During the first contact with a VA clinician
- Usually follows a suicide risk assessment
- First, obtain an accurate account of the events that transpired before, during, and after the most recent suicidal crisis

Helps to identify warning signs

May also identify strategies that may have been used to alleviate the crisis

What the Safety Plan Does and Doesn't Do

- It doesn't substitute for treatment
- It doesn't help if the individual is in **imminent** danger of committing suicide
- It does arm a person with strategies to fight suicidal urges
- It does increase the possibility of self-reliance

Safety Plan: How do I do it?

Resources:

- Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (draft)
- VA Safety Plan Form (draft)
- VA Safety Plan: Brief Instructions (draft)
- VA Safety Plan Template (*in development*)
- VA Safety Plan Satellite Broadcast (*in development*)

Safety Plan: Improving Collaboration

- VA clinician and patient should sit side-by-side, use a problem solving approach, and focus on developing the safety plan
- Safety plan should be completed using a paper form with the veteran
- Information from the safety plan may then be entered using the computerized template once the session has ended or scanned into the electronic medical record

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
- 4) Contacting family members or friends who may help to resolve a crisis
- 5) Contacting mental health professionals or agencies
- 6) Reducing the potential for use of lethal means (firearms)

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?”
- Ask, “What do you experience when you start to think about suicide or feel extremely distressed?”
- List 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”
- “I am a failure”
- “I don’t make a difference”
- “I am worthless”
- “I can’t cope with my problems”
- “Things aren’t going to get better”

Images

- “Flashbacks”

Thinking Processes

- “Having racing thoughts”
- “Thinking about a whole bunch of problems”

Mood

- “Feeling depressed”
- “Intense worry”
- “Intense anger”

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 prevent suicide ideation from escalating
- It is useful to have patients try to cope on their own with their suicidal feelings, even if it is just for a brief time
- Ask “What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?”

Step 2: Using Internal Coping Strategies

Examples:

- Going for a walk
- Listening to inspirational music
- Taking a hot shower
- Walking 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?”

If doubt about using coping strategies is expressed, 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 ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

Step 3: Socializing with Family Members or Others

- Instruct 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
- Ask “Who are those people in your life who you feel good when socializing with them?” or “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 patients to list several people, in case they cannot reach the first person on the list.

Step 4: Contacting Family Members or Friends for Help

- Instruct 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 that you feel you can talk with when you’re feeling under stress?”
- Ask patients to list several people, in case they cannot reach the first person on the list. Prioritize the list.

Step 4: Contacting Family Members or Friends for Help

- Ask “How likely would you be willing to contact these individuals?”
- If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them

Step 5: Contacting Professionals and Agencies

- Instruct patients to use Step 5 if Step 4 does not resolve the crisis or lower risk
- Ask “Who are the mental health professionals that we should identify to be on your safety plan?” and “Are there other health care providers?”
- List names, numbers and/or locations of clinicians, local urgent care services, VA Suicide Prevention Coordinator and VA Suicide Prevention Hotline
- If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them

Step 5: Contacting Professionals or Agencies

Example of Prioritized Professionals/Agencies:

1. Primary mental health clinician
2. Other mental health clinician, primary care physician, psychiatrist, etc.
3. 24-hour Urgent Care Services facility
4. VA Suicide Prevention Resource Coordinator
5. VA Suicide Prevention Hotline:
800-273-TALK (8255), press "1" if veteran

Step 6: Reducing the Potential for Use of Lethal Means

- The clinician should ask patients which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these 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, having them ask a trusted family member to store the medication in a secure place might be a useful strategy.

Step 6: Reducing the Potential for Use of Lethal Means

- The clinician should routinely ask whether the veteran has access to a firearm (such as a handgun, rifle or shotgun), whether or not it is considered a “method of choice” and make arrangements for securing the weapon
- Ask, “What means do you have access to and are likely to use to make a suicide attempt or to kill yourself?” and “How can we go about developing a plan to limit your access to these means?”
- When restricting the veterans’ access to a highly lethal method – firearm should be safely stored by a designated, responsible person—usually a family member or close friend, or even the police

Implementation: What is the Likelihood of Use?

1. Ask: "Where will you keep your safety plan?"
2. Ask: "How likely is it that you will use the safety plan when you notice the warning signs that we have discussed?"
3. Ask: "What might get in the way or serve as a barrier to your using the safety plan?"
4. For identified barriers, say: "Let's discuss some ways to deal with this problem(s) so that you will be able to use the safety plan when it would be the most helpful for you."

Implementation: Is format appropriate?

- The implementation of the safety plan should always be made using good clinical judgment: Is the safety plan appropriate for the specific circumstances or capacity of the veteran?
- If the veteran is unable to follow a plan on his or her own, the clinician should adapt the approach to the veteran's needs
- 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 is it used
- The plan is *not* a static document
- It should be revised as veterans' circumstances and needs change over time

BE SAFE

Signs of an impending crisis

Activities to do by oneself and with others

Family and friends who can provide support or assistance

Emergency information for providers, ED, hotline

Safety Plan: Participant Role Play

- Form small groups (3 per group)
 - Veteran
 - VA clinician
 - VA consultant
- Use the Safety Plan Form
- Refer to the Brief Instructions
- Switch roles, time permitting

Workshop Evaluation