Suicide Risk Assessment: Risk factors, warning signs and protective factors **– Page 1**

Demographic risk factors: Predisposing and historical risk factors

- ☐ **Psychiatric disorder**
  - ☐ Major depression
  - ☐ Bipolar disorder
  - ☐ Schizophrenia
  - ☐ Anorexia nervosa
  - ☐ PTSD
  - ☐ Substance use disorder: _____
  - ☐ Personality disorder: _____
  - ☐ Other: _____
- ☐ Male
- ☐ Male with age >65yo
- ☐ History of physical or sexual abuse
- ☐ **Medical illness**
  - ☐ Cancer (esp. head and neck)
  - ☐ Chronic pain
  - ☐ HIV/AIDS
  - ☐ Nervous system disease
  - ☐ Seizure disorder
  - ☐ Traumatic brain injury
  - ☐ Other: _____
- ☐ Death of family member by suicide
- ☐ Sexual minority (LGBT)
- ☐ Native American/Alaska Native (esp. youth)
- ☐ Veteran

Situational Risk Factors: Life circumstances, precipitants, stressors

- ☐ **Family or marital conflict**
- ☐ **Unemployment**
- ☐ **Social withdrawal/isolation**
- ☐ Medical problems
- ☐ Legal problem
- ☐ Loss (financial, interpersonal, professional)
- ☐ Recent discharge from inpatient unit
- ☐ Other: _____

Symptomatic and Psychological Risk Factors: Response to life circumstances

- ☐ Depressed mood
- ☐ Anhedonia
- ☐ Impaired concentration
- ☐ Sleep disturbance (esp. severe insomnia)
- ☐ Guilt
- ☐ Loneliness
- ☐ Desperation
- ☐ Psychotic symptoms (esp. command auditory hallucinations)

Warning signs: IS PATH WARM? (AAS, 2003)

- ☐ **SUICIDAL IDEATION**
- ☐ **SUBSTANCE USE**
- ☐ **PURPOSELESSNESS (FEELING LIKE A BURDEN)**
- ☐ **ANXIETY: PANIC, INSOMNIA, AGITATION**
- ☐ **FEELING TRAPPED**
- ☐ **HOPELESSNESS**
- ☐ **SOCIAL WITHDRAWAL**
- ☐ **ANGER, SEEKING REVENGE**
- ☐ **RECKLESSNESS/IMPULSIVITY**
- ☐ **MOOD CHANGES**

Suicide-Specific Risk Factors: Suicidal ideation and behavior – refer to C-SSRS as needed

Yes	No	
☐	☐	**SUICIDAL IDEATION**: Note passive or active, frequency, intensity, duration.
☐	☐	**SUICIDE METHOD:** _____
☐	☐	**SUICIDAL INTENT:** Note subjective or objective.
☐	☐	**SUICIDE PLAN**
☐	☐	**SUICIDE PREPARATION**
		☐ Researching or assembling means
		☐ Giving away possessions
		☐ Writing suicide note
☐	☐	**Access to lethal means**: Note any **firearms**

Yes	No	
☐	☐	**Previous suicide attempt**
☐	☐	…within past 3 months
☐	☐	**Previous interrupted attempt**
☐	☐	…within past 3 months
☐	☐	**Previous self-interrupted attempt**
☐	☐	…within past 3 months
☐	☐	**Multiple attempts (2 or more)**
☐	☐	**Previous self-injury** without intent to die (NSSI)

Protective Factors: Buffers against suicide (connectedness)

- ☐ **Positive and available social support**
- ☐ **Positive therapeutic relationship**
- ☐ Responsibility to others (family, children)
- ☐ Fear of suicide
- ☐ Positive problem-solving or coping skills
- ☐ Hope for the future
- ☐ Intact reality testing
- ☐ Fear of social disapproval
- ☐ Religious beliefs against suicide
- ☐ Life satisfaction

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Suicide Risk Stratification and Management: Clinical judgment on level of risk and interventions – **Page 2**

High Suicide Risk ☐ Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) …**OR…** ☐ Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	• Behavioral health consultation. • Initiate local psychiatric admission process. • Stay with patient until transfer to higher level of care is complete. • Follow-up and document outcome of emergency psychiatric evaluation.
Moderate Suicide Risk ☐ Suicidal ideation with method, **WITHOUT plan, intent or behavior in past month** (C-SSRS Suicidal Ideation #3) …**OR…** ☐ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) …**OR…** ☐ Multiple risk factors and few protective factors	• Behavioral health consultation. • Directly address suicide risk, implementing strategies to reduce risk: ▪ Foster **connectedness**. ▪ Address **mental health** (MH) and **substance use** disorders (SUD). ▪ Reduce access **to lethal means**. ▪ Develop a **safety plan**.
Low Suicide Risk ☐ Wish to die or Suicidal Ideation **WITHOUT method, intent, plan or behavior** (C-SSRS Suicidal Ideation #1 or #2) …**OR…** ☐ Modifiable risk factors and strong protective factors …**OR…** ☐ No reported history of Suicidal Ideation or Behavior	• Discretionary outpatient referral. • Provide NSPL and Crisis Text information. Adapted from SAFE-T with CSSR-S embedded. Risk stratification and interventions are **suggestions** to guide **clinical judgment**.

Interventions for Suicide: Suicide-specific management strategies

Connectedness	MH & SUD Treatment	Lethal Means Safety	Safety Planning
• Convey belonging, value and hope. • Coordinate with family, friends or other clinicians to build supports; address interpersonal stressors. • Make follow-up calls or caring contacts after appt. • Provide NSPL number. • Provide referrals or arrange for mental health care: findtreatment.samhsa.gov	• Initiate or refer for treatment for **mental health** conditions: depression, anxiety, bipolar d/o, PTSD, psychotic d/o, personality d/o, etc. • Prioritize **anxiety, agitation and insomnia**. • Address **alcohol** and **substance use** disorders. • Suicide-specific treatment.	• Assess for **firearms**, medications or other lethal means. • Counsel on access to lethal means. • Coordinate with friends, family or law enforcement to secure lethal means. • Limit dispensed amounts of rx medication.	• Warning signs • Internal coping strategies • Distracting places and social contacts • Helpful friends or relatives • Professionals: **NSPL: 800-273-8255, Crisis Text: 'hello' to 741-741** • Securing the environment – secure **firearms** and other lethal means • Review Virtual Hope Box

Conceptualization of Suicide: Psychological theories of suicidality for treatment planning

• **Interpersonal theory** (Joiner, 2005): Thwarted belongingness, perceived burdensomeness, hopelessness, acquired capability. • **Cognitive theory** (Wenzel & Beck, 2008): Hopelessness, selective attention, attentional fixation on suicide.	• **Emotion dysregulation** (Linehan, 1993): Suicidal behavior functioning as **emotion regulation** (reducing emotional pain); **problem-solving** (addressing overwhelming circumstances); **communication** (message to self or others).

Justification for Level of Intervention: Why did you not choose a higher level of care?

☐ Current acute risk of suicide is judged to be low.
☐ Higher intensity treatment appears likely to be *ineffective or detrimental to patient's clinical status*. Risks of higher intensity care are likely to outweigh benefits.
☐ Higher intensity treatment appears likely to be *detrimental to patient's current treatment*. Higher intensity care may disrupt treatment plan or harm therapeutic relationship without providing more benefit.
☐ Current risk appears *likely to decrease substantially based on imminent future events* (e.g. resolving intoxication, impending visit from relative, seeing therapist).
☐ Threat of suicide best is viewed as escape behavior and clinical history suggests *targeting life problems is likely to be more effective in reducing risk*.
☐ Threat of suicide best viewed as operant behavior; *higher intensity intervention is likely to reinforce suicidal risk*.
☐ Other: _____

Consultants:

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Total Score	**Depression Severity**
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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SAFE-T Protocol with C-SSRS - Recent

Step 1: Identify Risk Factors

C-SSRS Suicidal Ideation Severity	Month
1) Wish to be dead *Have you wished you were dead or wished you could go to sleep and not wake up?*	Low
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*	Low
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might do this?*	Moderate
4) Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?*	High
5) Intent with Plan *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*	High
C-SSRS Suicidal Behavior: *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If "YES" Was it within the past 3 months?	**Lifetime** Moderate **Past 3 Months** High

Current and Past Psychiatric Dx:
□ Mood Disorder
□ Psychotic disorder
□ Alcohol/substance abuse disorders
□ PTSD
□ ADHD
□ TBI
□ Cluster B Personality disorders or traits (i.e., Borderline, Antisocial, Histrionic & Narcissistic)
□ Conduct problems (antisocial behavior, aggression, impulsivity)
□ Recent onset

Presenting Symptoms:
□ Anhedonia
□ Impulsivity
□ Hopelessness or despair
□ Anxiety and/or panic
□ Insomnia
□ Command hallucinations
□ Psychosis

Family History:
□ Suicide
□ Suicidal behavior
□ Axis I psychiatric diagnoses requiring hospitalization

Precipitants/Stressors:
□ Triggering events leading to humiliation, shame, and/or despair (e.g. Loss of relationship, financial or health status) (real or anticipated)
□ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
□ Sexual/physical abuse
□ Substance intoxication or withdrawal
□ Pending incarceration or homelessness
□ Legal problems
□ Inadequate social supports
□ Social isolation
□ Perceived burden on others

Change in treatment:
□ Recent inpatient discharge
□ Change in provider or treatment (i.e., medications, psychotherapy, milieu)
□ Hopeless or dissatisfied with provider or treatment
□ Non-compliant or not receiving treatment

□ **Access to lethal methods:** Ask <u>specifically</u> about presence or absence of a firearm in the home or ease of accessing

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)	
Internal: □ Ability to cope with stress □ Frustration tolerance □ Religious beliefs □ Fear of death or the actual act of killing self □ Identifies reasons for living	**External:** □ Cultural, spiritual and/or moral attitudes against suicide □ Responsibility to children □ Beloved pets □ Supportive social network of family or friends □ Positive therapeutic relationships □ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior)

If semi-structured interview is preferred to complete this section, clinicians may opt to complete C-SSRS Lifetime/Recent for comprehensive behavior/lethality assessment.

C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)	**Month**
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	
Total Score	

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE
High Suicide Risk □ Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) **Or** □ Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	□ **Initiate local psychiatric admission process** □ **Stay with patient until transfer to higher level of care is complete** □ **Follow-up and document outcome of emergency psychiatric evaluation**
Moderate Suicide Risk □ Suicidal ideation with method, **WITHOUT plan, intent or behavior in past month** (C-SSRS Suicidal Ideation #3) **Or** □ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) **Or** □ Multiple risk factors and few protective factors	□ **Directly address suicide risk, implementing suicide prevention strategies** □ **Develop Safety Plan**
Low Suicide Risk □ Wish to die or Suicidal Ideation **WITHOUT method, intent, plan or behavior** (C-SSRS Suicidal Ideation #1 or #2) **Or** □ Modifiable risk factors and strong protective factors **Or** □ No reported history of Suicidal Ideation or Behavior	□ **Discretionary Outpatient Referral**

Step 5: Documentation

Risk Level :

[ ] High Suicide Risk
[ ] Moderate Suicide Risk
[ ] Low Suicide Risk

Clinical Note:

- □ Your Clinical Observation
- □ Relevant Mental Status Information
- □ Methods of Suicide Risk Evaluation

- □ Brief Evaluation Summary
  - □ Warning Signs
  - □ Risk Indicators
  - □ Protective Factors
  - □ Access to Lethal Means
  - □ Collateral Sources Used and Relevant Information Obtained
  - □ Specific Assessment Data to Support Risk Determination
  - □ Rationale for Actions Taken and Not Taken

- □ Provision of Crisis Line 1-800-273-TALK(8255)
- □ Implementation of Safety Plan (If Applicable)

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

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The one thing that is most important to me and worth living for is:

_____

Example: Screening and suicide-specific assessment

Shaunne is a Veteran with multiple medical problems. In response to physical pain and disability, she has developed symptoms of depression with anhedonia and hopeless thoughts. She presents for follow-up medical care for back pain.

Category	Risk factors
Demographic	Veteran, medical problems (asthma, back pain, multiple joint problems)
Situational	Medical problems (back pain, multiple joint problems) Disability Separation from military
Symptomatic	Depression Anhedonia Hopelessness Sleep disturbance

Role play: Find a partner and decide who will be the **Clinician** and who will be the **Patient**.

Clinician: Screen for suicide risk by creating context and asking directly

Review the risk factors for suicide. Use the risk factors to create context and ask directly. Create context by referencing the risk factors. Practice asking directly using both normalization and shame attenuation as well as using direct language about suicide.

Patient: Answer yes to each question and provide additional information to describe the circumstances, suicidal thoughts or behavior.

Clinician: Create context and ask directly	**Patient**
Create context: Reference the risk factors you have heard *I can hear that you've been in a lot of pain and that it's affected your ability to do things, including take care of your son. It also sounds like you've been feeling pretty depressed.*	*Yes…*
Normalization: Others may have had these thoughts *Sometimes when people feel depressed and hopeless, they might start to wish they were dead or think of suicide. Can I ask if you've had those thoughts?*	*Yes…*
Shame attenuation: Suicidal thoughts are understandable *It sounds like you've been in a lot of pain and sometimes wonder if things will ever get better. When you feel trapped and hopeless, have you ever thought that suicide would be a way to escape?*	*Yes…*

Clinician: Express appreciation for your patient's participation, orient to the need for more assessment and continue your assessment of suicidal ideation and behavior using the Columbia Suicide Severity Rating Scale questions (C-SSRS).

Patient: Answer yes to each question and provide some information to describe the circumstances, suicidal ideation or behavior.

Clinician: Transition to a suicide-specific assessment *I appreciate you talking about this. If it's alright, I would like to ask you some more questions to help me understand how you've been feeling and what we could do to help.*	
Clinician: Ask about suicidal ideation	**Patient**: Answer yes to each question and provide more information
Passive: *Have you ever wished you were dead or wished you could go to sleep and not wake up?*	*Yes. Some days I think it would be better if I weren't around.*
Active: *Have you actually had any thoughts of killing yourself?*	*Yes. I can't believe I'm saying it, but, yes, I've thought about killing myself.*
Method: *Have you been thinking about how you might do this?*	*Yes. I have a lot of pills that I've gotten for pain. I've thought I could just take them all and be done with it.*
Intent without specific plan: *Have you had these thoughts and had some intention of acting on them?*	*Yes. I promised myself I would never become a burden to my family. If it ever gets to the point I can't get out of bed, I need to do it.*
Intent with plan: *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*	*Yes. My sister watches my son on Saturdays. I've thought I would get the pills together and do it one weekend. Like I said, if it ever got to the point I couldn't walk, I would do it.*

Clinician: Continue your assessment by asking about suicidal behavior.

Patient: Answer yes to the question and provide more information.

Clinician: Ask about suicidal behavior	**Patient**: Answer yes to each question and provide more information
Suicidal behavior: *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*	*Yes. One time, I don't really know what came over me. I was standing in the bathroom in front of the mirror and just started crying. I opened the medicine cabinet and poured all of my pain pills into my hand. I stared at them and then, I don't know, I just put them back and went to sleep.*
Time: *Was this within the past 3 months?*	*Yes. I don't remember exactly when, but it was sometime maybe a month ago.*

Breakout Group: Suicide Risk Stratification

Example 1

A 14 year-old girl reports being bullied at school and excluded from friends. She lives with her mother and does not know her father. Her mother uses alcohol daily, and the patient has found her mother passed out when arriving home from school. She endorses having wishes that she could be dead – "*Sometimes I wish I could be dead*." She denies active suicidal ideation or behavior – "*It's not like I would ever do anything to kill myself*."

Assign a level of risk based on the findings about suicidal ideation and behavior:

High Moderate Low

Example 2

A 58 year-old woman with systemic lupus erythematosus presents for an initial mental health assessment. Treatment with steroids for lupus has resulted in signifiant weight gain that has worsened her arthritis. Because of increasing disability, she has moved in with her daughter and three grandchildren. The patient reports that she has felt depressed and like a burden to her family. On assessment of suicidal thoughts and behavior, she reports that she has thought about ending her life by overdose. She reports one instance about a month ago of having combined her opioid pain medications with over-the-counter pills to look at the number of pills and decide whether she could swallow all of them. She denies any other suicidal behavior. She denies subjective suicidal intent – "*I know it's crazy – I know I can't do that to my daughter and grandkids*." She denies having made a plan for suicide.

Assign a level of risk based on the findings about suicidal ideation and behavior:

High Moderate Low

Example 3

A 22 year-old man presents to his chemical dependency group with ankle swelling. The patient had been living with his mother and sprained his ankle two weeks ago after jumping out of a window while intoxicated on meth-amphetamine. While intoxicated, he and his mother, who was intoxicated on alcohol, had been in a physical altercation during which she screamed at him that he could no longer stay with her. He reports, "*My mother keeps saying that I said I was going to kill myself by jumping out of the window, but I'm not suicidal. I just did something stupid*." He is sleeping on the floor of friend's apartment and must leave by the end of the month. He denies suicidal ideation on PHQ-9, and denies suicidal ideation on C-SSRS. He denies any history of suicidal behavior and reiterates that jumping from the window was "just something stupid I did."

Assign a level of risk based on the findings about suicidal ideation and behavior:

High Moderate Low

VETERAN SUICIDE PREVENTION HANDOUT - WA DOH

Operation S.A.V.E.

Signs of suicidal thinking should be recognized
Ask the most important question of all
Validate the Veteran's experience
Encourage treatment and **E**xpedite getting help

Warning Signs and Risks

- Loss of sense of belonging or identity
- Loss or change of job
- Unresolved Posttraumatic Stress Disorder (PTSD)
- Traumatic Brain Injury (TBI)
- Recent deployment
- Difficulty reintegrating into family after deployment
- Withdrawing from family and friends
- Lack of access to old support network, such as military team
- Increasing alcohol or drug use
- Rage or anger
- Hopelessness, feeling like there's no way out
- Anxiety, agitation, sleeplessness, or mood swings
- Engaging in risky activities without thinking
- Feeling like there's no reason to live
- Access to guns

Military Cultural Considerations

- The Warrior ideal: No matter what branch of service, Veterans are taught service comes before self and the mission comes first.
- Feeling like they cannot live up to the Warrior ideal can lead to Veterans feeling like failures.
- Being in the military provides a sense of purpose and identity that veterans might not have in their civilian lives.
- Missing one's battle buddies/team, not having a mission, and failure to live up to the values and ideals of the military can cause one to feel isolated and inadequate.
- Being out of the military often takes away the support system that helps to justify actions in combat.

Get Help

Talk
Veterans Crisis Line
1-800-273-8255, Press 1

Text a VA Responder
838255

Online Chat
www.VeteransCrisisLine.net/chat

Statistics

- In WA, 79% of Veterans receive care from community providers; only 21% receive healthcare from a VA Medical Center
- 22% of U.S. deaths from suicide are Veterans
- Almost 70% of male VHA suicide deaths are by firearms; 35% for females
- 950 suicide attempts per month among Veterans receiving VA healthcare services
- 33% of recent suicides have a history of previous attempts

Ask

- Have you ever served in the armed forces, guard, or reserves?
- Are you thinking of suicide?
- Do you own or have access to a firearm?

Breakout Group: Firearms, Culture and Clinical Care

Mr. A is a 29 year-old man presents for mental health evaluation after being prompted by his wife. He reports depressed mood and irritability in the setting of conflict with his wife over finances. He endorses suicidal ideation, stating that, "*When I'm driving, I sometime think about going into the other lane*," and follows this with, "*but I think suicide is a coward's way out – I don't think I'd ever do it*." When asked about firearms, he reports having a rifle for hunting that he purchased to go hunting with his brother-in-law and no other firearms. He states that his rifle is unlocked and unloaded in a bag on a shelf in his basement and that he has no ammunition in the home.

The therapist suggests, "*You've had thoughts about suicide, and we know that firearms are the most lethal suicide method. While we're working things out and getting you feeling better, what do you think about having someone else hold onto your rifle or locking it up more securely in your home?*" Mr. A replies, "*I don't know what you mean. There's no ammunition in the house, so it's not like I could shoot myself anyway. Besides, there's a lot of other ways people kill themselves.*"

What would you say to align with values?

I understand that safety is the first priority with gun owners and a source of pride for hunters. I recently learned that in Washington about 75% of gun deaths are suicides so I've been trying to make it a point to talk more about safety from suicide when people own guns.

What would you say to provide information on beliefs?

It's true that there are different ways that people can kill themselves. Often, the choice of a method comes down to what's immediately available. One study showed that when people intending to jump from the Golden Gate Bridge were stopped from jumping, about 90% of them did not choose another method for suicide and went on to live. When a lethal method for suicide is not immediately available, almost everyone finds a way survive the crisis and live.

How would you collaborate on storage practices?

*Do you have some ideas about how you might **temporarily** find a more secure way to store your rifle while you're going through this? Some of the recommendations are to lock the rifle up and give the key to someone – maybe your wife or your brother-in-law. Or maybe your brother-in-law would be willing to **hold** your rifle until things get better?*

Documentation: Justification for Outpatient Care

- **Example 1**: Overall long-term risk of suicide is judged to be high. Current acute risk is judged to be moderate to high. Hospitalization was considered and rejected, as referral for emergency evaluation or psychiatric hospitalization appears likely to be detrimental to the client's treatment and clinical status. This client is non-impulsive and has demonstrated some ability to control suicidal urges. Furthermore, this client has demonstrated an ability to deny suicidality convincingly, and it is unlikely that a hospitalization would result from an emergency evaluation. Continued outpatient work focused on resolving hopeless thoughts and suicidal coping is judged to be more likely to reduce risk over time.
- **Example 2**: Overall long-term risk of suicide is judged to be high. Current acute risk is judged to be moderate to high. Hospitalization was considered and rejected, as referral for emergency evaluation or psychiatric hospitalization appears likely to be ineffective in addressing suicide risk. This client has been psychiatrically hospitalized in the past, and hospitalization has not resolved risk over time. Furthermore, hospitalization has been associated with feelings of demoralization and stigma appear to have increased suicide risk. Continued outpatient work focused on resolving feelings of social isolation and self-hate is judged to be more likely to reduce risk over time.
- **Example 3**: Overall long-term risk of suicide is judged to be high. Current acute risk is judged to be moderate to high. Hospitalization was considered and rejected, as referral for emergency evaluation or psychiatric hospitalization appears likely to be detrimental to the client's current treatment. Hospitalization appears likely to reinforce a pattern of passive coping that has been associated with long-term maintenance of suicide risk. Continued outpatient work using a safety plan and regular appointments to manage risk while using psychotherapy to improve problem-solving, emotion regulation and communication skills appears more likely to resolve risk over time.

Breakout Group: Management of Suicide Risk

Karinna is veteran who experienced high level stressors after separation from the military. She developed depression, alcohol use and insomnia which progressed to suicidal ideation.

What interventions from the categories of connectedness, depression treatment, lethal means safety and safety planning would you use to develop an outpatient plan to manage suicide risk? (Suggestions are on the next page).

Suggestions:

Connectedness: Convey belonging, value and hope; arrange for outpatient mental health and substance use treatment; coordinate care with parents or friends; provide crisis contacts; schedule follow-up appointments; between-session phone call to provide support and encourage follow-up with mental health treatment.

Depression treatment: Medication treatment for depression and insomnia; brief interventions and referral for alcohol use.

Lethal means safety: Counseling on access to lethal means; coordinating care with parents or friends; limiting access to hypnotic medications; counseling on hazardous alcohol use and removal of alcohol.

Safety planning: Education on warning signs of suicide crisis, review of alternative coping strategies, providing crisis contacts.

Breakout Group: Indirect and Direct Drivers of Suicide

1. **What are the indirect drivers** – i.e. mental health conditions and life stressors?
2. **What are the direct drivers** – i.e. the suicidal storyline? What did you hear to indicate thwarted belongingness, perceived burdensomeness and hopelessness?
3. **How were the direct drivers targeted in a way that resolved suicide risk?**
4. **What other interventions would you consider or recommend?**

Working with Suicidal Clients: Hope and Recovery in Suicide Care	
8:30am	Registration
9:00–10:30am	Overview and Rationale Assessment of Suicide Risk
10:30–10:45am	Morning Break: 15min
10:45am–12:00noon	Management of Suicide Risk
12 noon–1:00pm	Lunch
1:00-1:45pm	Management of Suicide Risk
1:45–2:30pm	Treatment of Suicide Risk
2:30–2:45pm	Afternoon Break: 15min
2:45–4:30pm	Treatment of Suicide Risk Chronic Suicidality: Respondent vs. Operant Suicidality Summary

Breakout Group: Respondent and Operant Suicidality

Travis Bryant has generously allowed us to use his story to learn more about factors that drive the suicidal process. Please watch the video of him describing his suicide attempt while reviewing the worksheet below. For each video segment, review the direct driver(s) of suicide, the suggested intervention on how to treat the direct driver in psychotherapy and what the desired resolution would be.

Video segment	Direct driver(s)	Treatment intervention	Resolution
1:36: *I felt really alone.*	Thwarted belongingness.	Therapeutic alliance: Build connection with the therapist, given absence of other supports. Assessment of current relationships. Is the perception of having no one accurate or inaccurate? If some supports exist, are there any friends or relatives to bring in and involve in treatment? Can friends or relatives be made aware of the problems? Mindfulness to become aware of ruminations on "I'm all alone." If no supports exist, try problem-solving to find opportunities for connection: study groups, activities, support groups. If his caring for his mother has excluded all other relationships, find ways of managing his mother's needs while beginning to build his own life.	Belonging. Connection. Skillful problem solving. Finding a safe place to live. Personal agency.
1:45: *I just felt like I was dealing with all these problems by myself.*	Suicide to solve problems. Thwarted belongingness.		
1:53: *I didn't feel like I had anywhere I could turn to.*	Thwarted belongingness.		
2:00: *I didn't think there was ever a potential for happiness because unhappiness was all I'd ever known.*	Hopelessness. Suicide to reduce emotional pain.	Therapeutic alliance: Therapist models confidence and hope by framing problems as solvable and offering immediate suggestions. Crisis planning to ensure strategies for surviving suicidal crises: means safety, safety planning. Build problem-solving skills.	Hope. Increased pain tolerance. Finding meaning in life.
2:13: *I started losing hope.*	Hopelessness.	Offer use of a hope kit or Virtual Hope Box; review SAMHSA Stories of Hope and Recovery. Reinforce that "hope is a skill" rather than something you have or do not have. Find meaning in the struggle.	
2:41: *But once that thought, you know, went inside my head, it stuck there. And I couldn't get rid of it. And it kept coming over and over and over.*	Selective attention. Attentional fixation. Operant suicidality.	Mindfulness to become aware of ruminations. Stimulus control: Schedule ruminations only during specific activities. Distress tolerance skills: TIP skills to change physiology and get un-stuck (temperature, intense exercise, progressive relaxation); STOP (stop, take a step back, observe, proceed mindfully). Virtual Hope Box or hope kit to expand perspective.	Mindfulness. Increased pain tolerance.
3:05: *Finally, when I was 15 years old, I was done. And I decided I was going to try to end my own life.*	Attentional fixation. Suicide to solve problems.	Problem-solving: Find alternatives to suicide for solving life problems; find solutions to problems that are causing emotional pain. Mindfulness to become aware of cognitions that block problem-solving. STOP (stop, take a step back, observe, proceed mindfully).	Mindfulness. Cognitive flexibility. Goals and future plans.
4:10: *I still felt, and I didn't want to feel anymore.*	Suicide to reduce emotional pain.	Emotion regulation skills: Observe and describe emotion, reducing vulnerability, mindfulness to current emotion, opposite action.	Emotion regulation. Increased pain tolerance.
5:09: *I just didn't want to feel the pain anymore. I didn't want to feel the sadness.*	Suicide to reduce emotional pain.	Emotion regulation skills: Observe and describe emotion, reducing vulnerability, mindfulness to current emotion, opposite action. Exposure Distress tolerance	