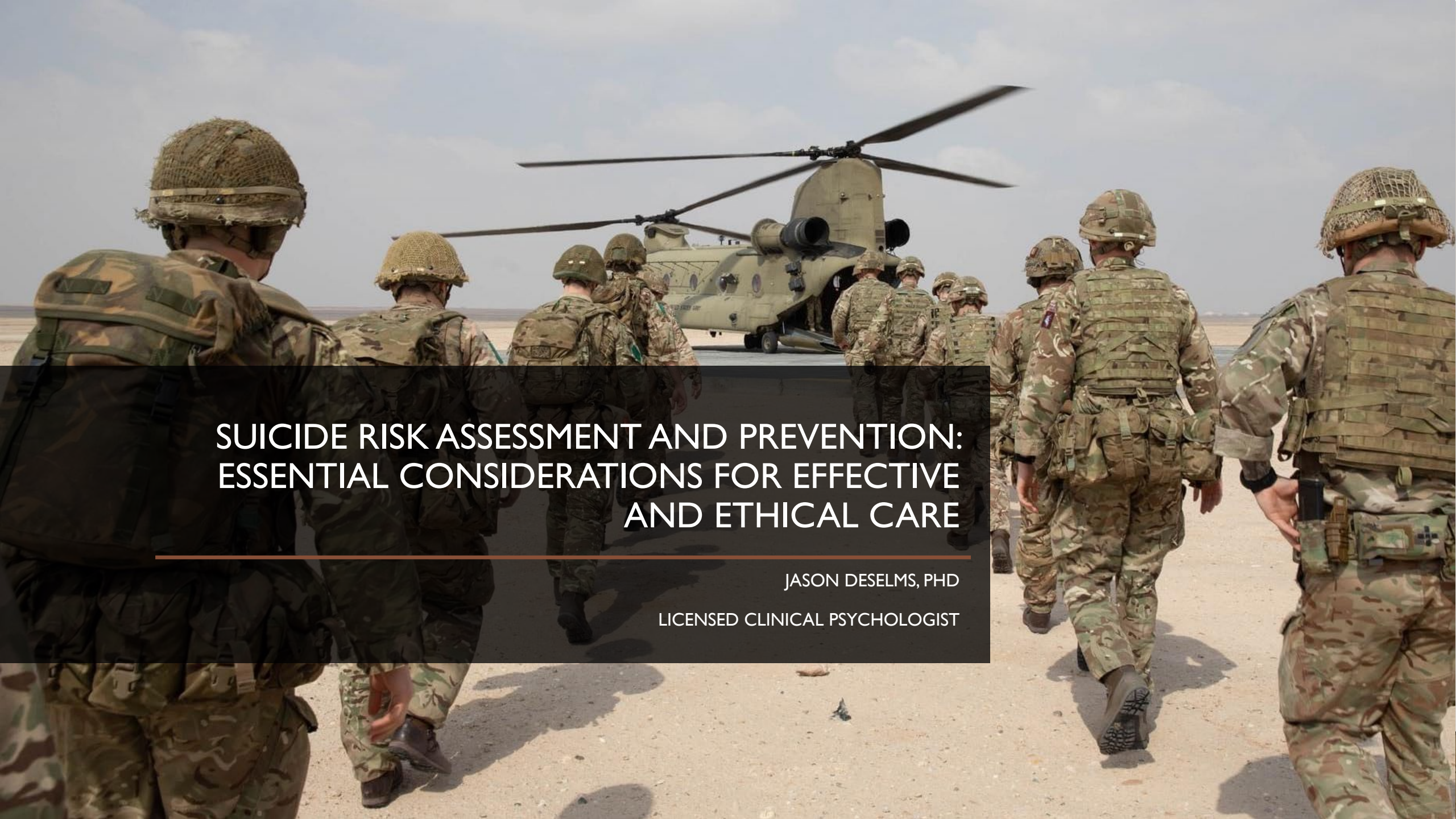




SUICIDE RISK ASSESSMENT AND PREVENTION: ESSENTIAL CONSIDERATIONS FOR EFFECTIVE AND ETHICAL CARE

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LICENSED CLINICAL PSYCHOLOGIST

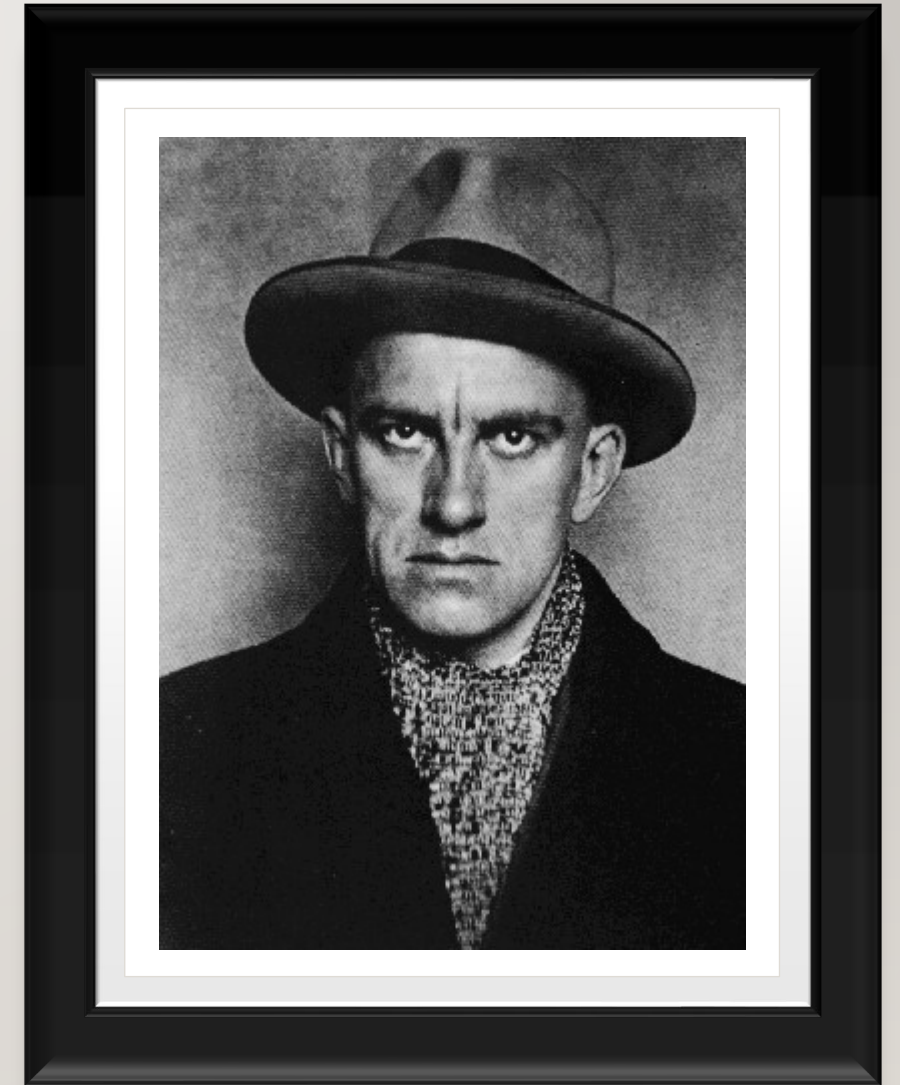
DISCLAIMER

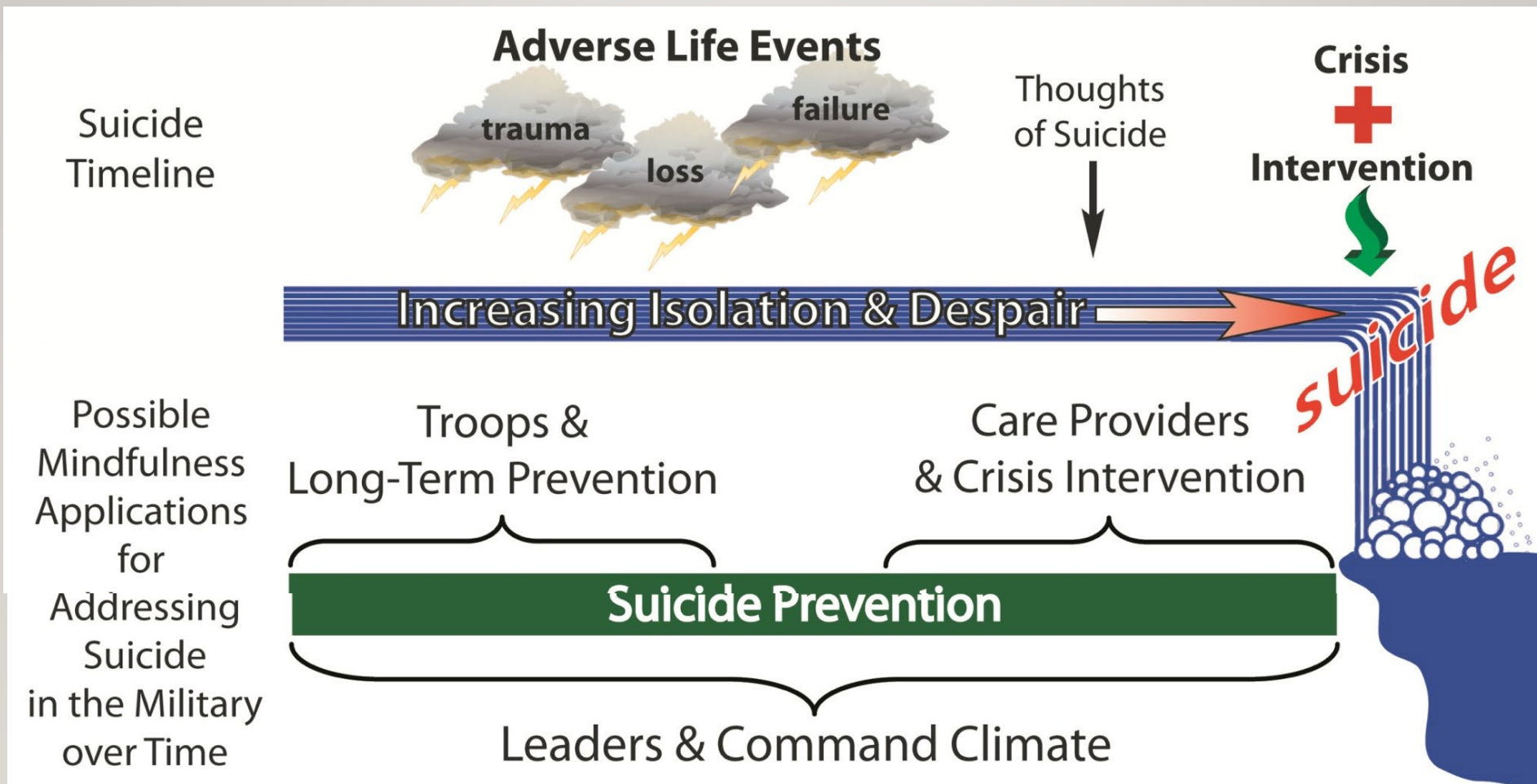
The opinions expressed in this presentation and on the following slides are solely those of the presenter and not necessarily those of United States Army, the Veterans Health Administration, or any other organizations I am affiliated with. The presenter is here as a private psychologist and subject matter expert.



IN THIS LIFE IT IS NOT
DIFFICULT TO DIE.
IT IS MORE DIFFICULT
TO LIVE.

Vladimir Mayakovsky
Russian Revolutionary





DATA: SUICIDE IN THE U.S.

- **National public health problem (as defined by CDC)**
 - 45,979 Americans died by suicide in 2020, including 6,146 Veterans.
 - For every suicide death, approximately 135 individuals are impacted.
- **Service member and Veteran issue**
 - The suicide rate among Veterans has increased faster than for non-Veterans since 2005.
 - The suicide rate for Veterans was 52.3% greater than for non-Veterans in 2019.
 - In 2020 the suicide rate was highest among Veterans between the ages of 18-34.
- **Suicide Rates in Kansas**
 - Kansas ranks 17th in the nation due to its suicide rate
 - Overall, suicide is the 10th leading cause of death in Kansas

After accounting for age differences,^b the Veteran suicide rate in Kansas:

- **Was not significantly different** from the national Veteran suicide rate
- **Was significantly higher** than the national general population suicide rate

Kansas Veteran Suicide Deaths, 2020

Sex	Veteran Suicides
Male	50–60
Female	<10
All	58

To protect confidentiality, suicide death counts are presented in ranges when the number of deaths in any one category was lower than 10.

Kansas, Midwestern Region, and National Veteran Suicide Deaths by Age Group, 2020^c

Age Group	Kansas Veteran Suicides	Midwestern Region Veteran Suicides	National Veteran Suicides	Kansas Veteran Suicide Rate	Midwestern Region Veteran Suicide Rate	National Veteran Suicide Rate
18–34	<10	179	843	--	50.1	46.1
35–54	16	339	1,575	29.6*	34.7	31.8
55–74	16	497	2,222	20.5*	28.4	27.4
75+	10–20	297	1,451	--	30.1	32.0
All	58	1,327	6,146	29.1	32.6	31.7

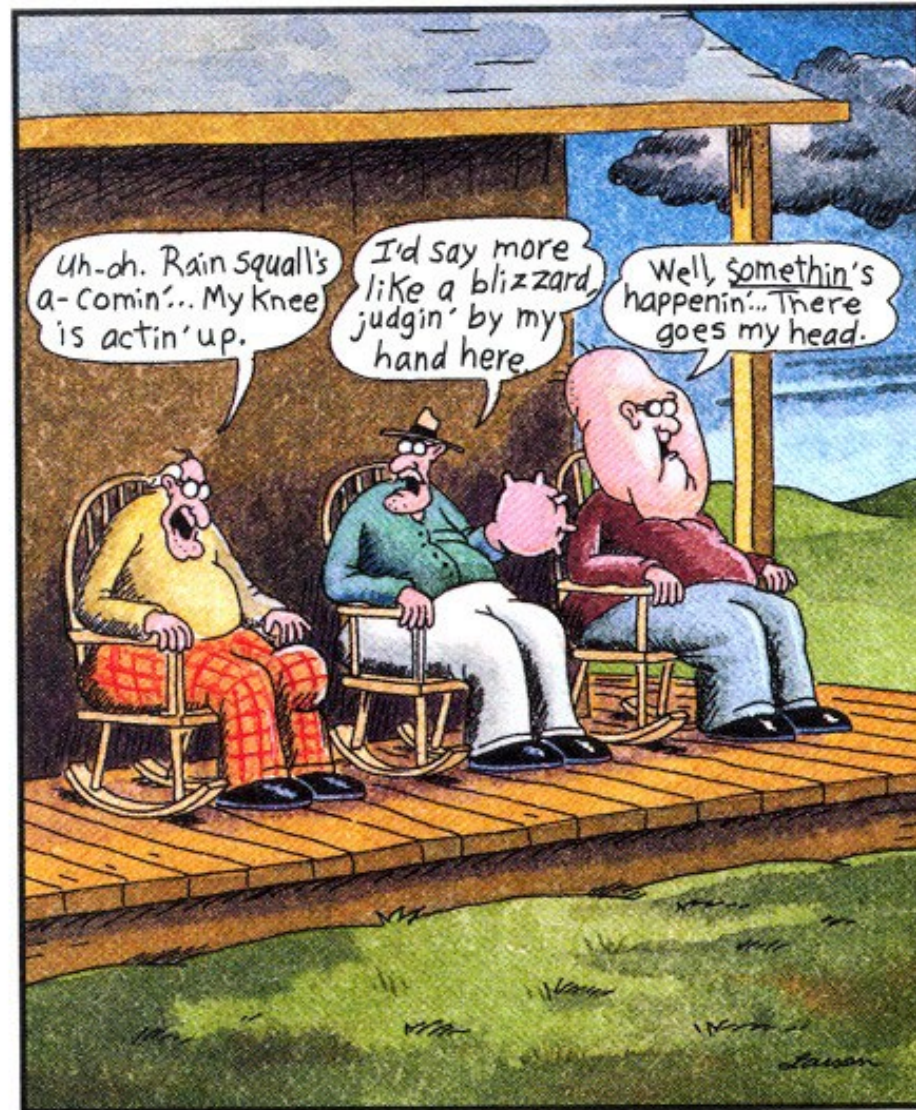
Kansas Veteran and Total Kansas, Midwestern Region, and National Suicide Deaths by Age Group, 2020^c

Age Group	Kansas Veteran Suicides	Kansas Total Suicides	Midwestern Region Total Suicides	National Total Suicides	Kansas Veteran Suicide Rate	Kansas Suicide Rate	Midwestern Region Suicide Rate	National Suicide Rate
18–34	<10	192	2,989	13,438	--	28.5	19.4	17.7
35–54	16	167	3,244	14,563	29.6*	24.2	19.5	17.7
55–74	16	113	2,398	11,876	20.5*	17.4	14.9	15.8
75+	10–20	34	903	4,421	--	16.5	18.4	19.1
All	58	506	9,534	44,298	29.1	22.8	18.0	17.3



PREVENTING SUICIDE: WHAT THE LAW DEMANDS

- Legal requirements
 - Once a provider enters into a relationship with a patient, there is a **duty of care** to prevent the patient from dying by suicide.
 - Duty of care is violated when the provider fails to act in a manner that is consistent with the **standard of care** for suicide.
 - The standard of care is ultimately judged by expert reviewers who determine whether the provider's care was **reasonable and prudent**.



Front porch forecasters

PROVIDER LIABILITY IN SUICIDAL DEATH

- What determines clinician liability?
- **Forseeability:** Providers are legally required to evaluate a patient's potential for suicide based on a competent risk assessment.
- **Reasonable Care:** The provider must illustrate that s/he took a logical and systematic approach to treatment that corresponds to what other professionals, with comparable training, would do with a similar patient.
 - Demands treatment planning and follow-up/follow through.

OVERLAP BETWEEN LAW & ETHICS

LEGAL TERMS

- Duty of care
- Standard of care
- Reasonable & Prudent (reasonable care)
- Foreseeability

ETHICAL CONSIDERATIONS

- Beneficence & Nonmaleficence
- Competence
- Record keeping, informed consent & confidentiality

SUICIDE RISK ASSESSMENT & COMPETENCE



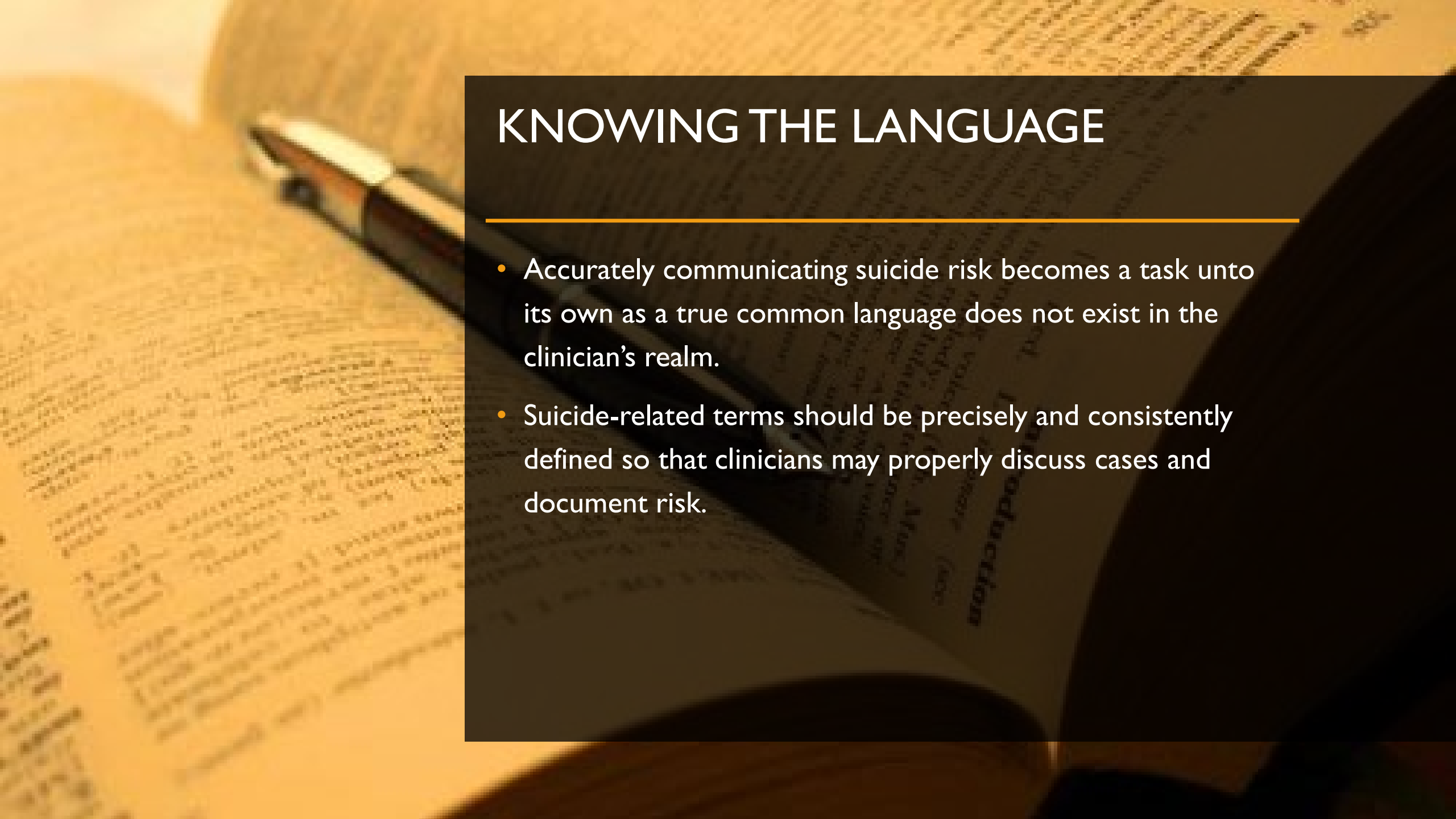
- Ethical standards pertaining to competence are outlined in the codes of conduct for mental health professionals (e.g. APA, 2017).
 - The boundaries of competence are generally based on one's:
- 
- Education
 - Training
 - Supervised experience
 - Consultation
 - Study
 - Professional practice
 - License or other legal recognition
- Mental health professionals are also required to stay abreast of developments in their respective fields.



HOW DO I COMPETENTLY ASSESS SUICIDE RISK

- Know the language
- Establish a good therapeutic alliance
- Understand the difference between acute and chronic risk
- Know to ask about specific suicidal thoughts and behavior
- Know to ask about other risk factors for suicide
- Assess protective factors and mental status
- Categorize the level of acute suicide risk
- Take action and make sure your treatment plan corresponds to the level of risk
- Ask for help- refer for treatment

Document

A close-up photograph of a fountain pen with a silver nib and a dark barrel, resting on the pages of an open book. The pages are filled with printed text, which is slightly blurred. A dark, semi-transparent rectangular overlay covers the right side of the image, providing a background for the title and list. The overall color palette is warm, with golden-brown tones from the book and a dark, muted brown for the overlay.

KNOWING THE LANGUAGE

- Accurately communicating suicide risk becomes a task unto its own as a true common language does not exist in the clinician's realm.
- Suicide-related terms should be precisely and consistently defined so that clinicians may properly discuss cases and document risk.

HISTORIC EFFORTS- KNOWING THE LANGUAGE

- A workgroup was established in the 1990's which set out to establish a standard nomenclature for suicidology.
 - This group produced a progression of papers known as the “Tower of Babel” series.
 - A revised nomenclature by Silverman et al. in 2007 was published to improve clinician surveillance and risk assessment.

KNOWING THE LANGUAGE

- The nomenclature is based on the following features of suicide-related thoughts & behaviors.
 - Intent
 - No intent
 - Undetermined intent
 - Some intent
 - Outcome
 - No injury
 - Injury
 - Death
 - Evidence of self-infliction
- In 2010 the nomenclature was further revised to more closely align with the CDC classification, hence the Self- Directed Violence Classification System was adopted by the VA.

ESTABLISHING A GOOD THERAPEUTIC ALLIANCE

- Aligning with the patient is necessary to obtain accurate responses during your suicide risk assessment and ongoing management.
 - Rudd (2006) recommends the following:
 - Treat the therapeutic relationship as part of the process
 - Communicate clearly
 - Be aware of your own non-verbal communication
 - Manage countertransference
 - Provide a historical context for your relationship
 - Ask about interpersonal problems the patient had in previous treatment
 - Put the therapeutic relationship on your agenda

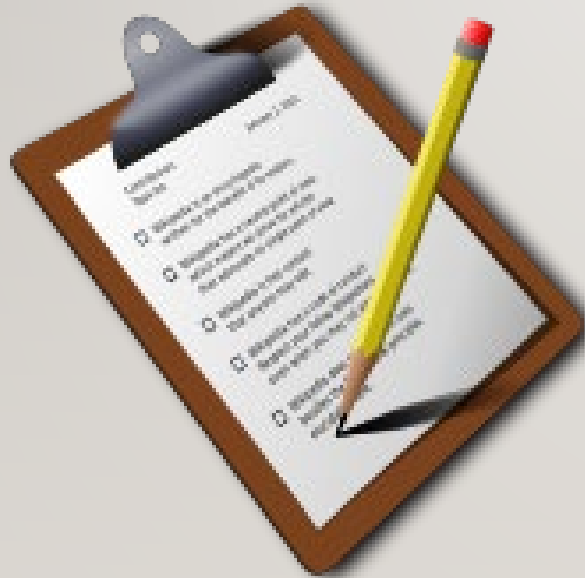
CHRONIC SUICIDE RISK

- Consider that patients may have a baseline, chronic level of suicide risk, with periods of heightened, or acute, concern that come & go
 - Chronic Risk:
 - Static and more difficult to alter
 - Past suicide attempts with clear intent (2 or more)
 - Personality factors
 - Cognitive style/schemas

ACUTE SUICIDE RISK

- Acute Risk:
 - Fluid or variable
 - Nature of suicidal thinking (including plans and rehearsal)
 - Severity of psychiatric symptoms and hopelessness
 - Degree of impulsivity
- Always Document
 - Acute crises
 - Presence or absence of chronic risk
 - Baseline, Acute, Chronic, Chronic with acute exacerbation
 - Note what makes the patient a chronic risk for suicide

ASKING ABOUT SPECIFIC SUICIDAL THOUGHTS & BEHAVIOR



- Precisely document the specifics about every suicide related ideation, communication, & behavior in the patient's history.
- Recommend beginning with past episodes & working toward the present crisis to quell patient anxiety.

ASKING ABOUT SPECIFIC SUICIDAL THOUGHTS & BEHAVIOR

- For past suicidal episodes clinicians should document:
 - Specific triggers
 - Exact nature of suicidal ideation and attempt
 - Query about thoughts at the time, method, intended outcome, perceived lethality vs. actual lethality
 - The actual outcome of the attempt
 - The patient's reaction to the outcome

ASKING ABOUT SPECIFIC SUICIDAL THOUGHTS & BEHAVIOR

- Clinician Checklist: Current Ideation
 - Suicidal Ideation
 - Ask: “Are you having suicidal thoughts?”
 - Document the specific thought
 - Document frequency, intensity, duration
 - Suicidal intent
 - Note what the patient says and what you observe
 - Suicide plan
 - Document when, where and how
 - Ask: “Have you thought of any other ways to end your life?”
 - Document access to means
 - Note if the patient has prepared for his/her death
 - Note if the patient has rehearsed his/her death (Have they habituated to the idea of their death?)
 - Document the patient’s reasons for dying/living
 - Ask about and document triggers

ASSESSING FOR ADDITIONAL SUICIDE RISK FACTORS

- A comprehensive suicide risk assessment includes the documentation of other well-established factors associated with increased risk.



ASSESSING FOR ADDITIONAL SUICIDE RISK FACTORS

- The American Psychiatric Association highlight the following additional risk factors:
 - Demographic Characteristics
 - Psychiatric diagnoses
 - Psychological features (rate symptom severity and note patient report vs. objective signs).
 - Physical illness
 - Trauma history
 - Family history
 - Cognitive features
 - Psychosocial features
 - Other: Access to firearms, substance intoxication, poor therapeutic alliance.

ASSESSING PROTECTIVE FACTORS & MENTAL STATUS



- Factors associated with protective effects for suicide include:
 - Presence of children
 - Pregnancy
 - Sense of responsibility to family
 - Life satisfaction
 - Good reality testing, coping and problem solving
 - Religiosity
 - Positive social support
 - Good therapeutic alliance
- All assessments should also include a mental status exam & DSM-5 diagnosis.

CATEGORIZING THE ACUTE LEVEL OF RISK

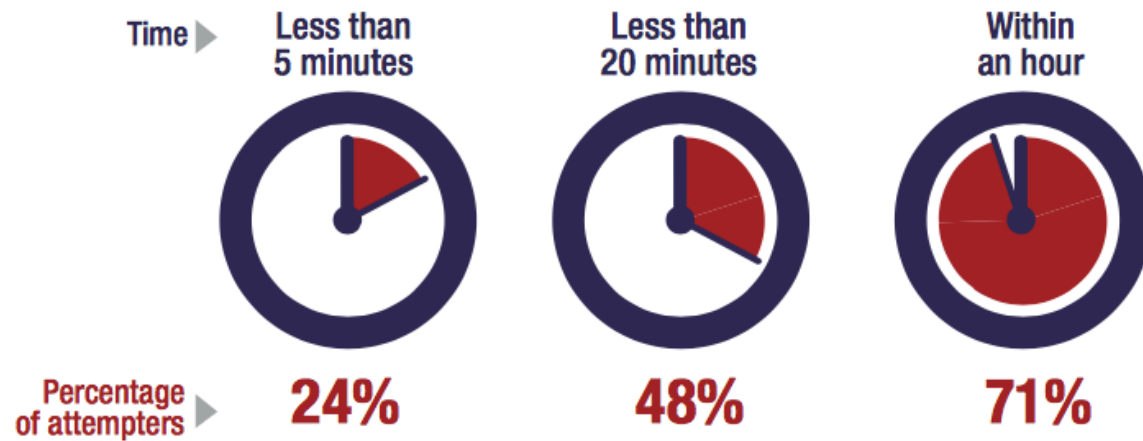
- Key points to remember:
 - What is the nature of your patient's suicidality?
 - Frequency, intensity, duration, & specificity (note specific thoughts & plans).
 - In regard to intent, weigh what the patient says against your objective observations.
 - How severe are the patient's psychiatric symptoms?
 - Are there other risk factors at play?
 - What about protective factors & social support?
 - Is the patient impulsive?
 - What is the patient's access to lethal means?



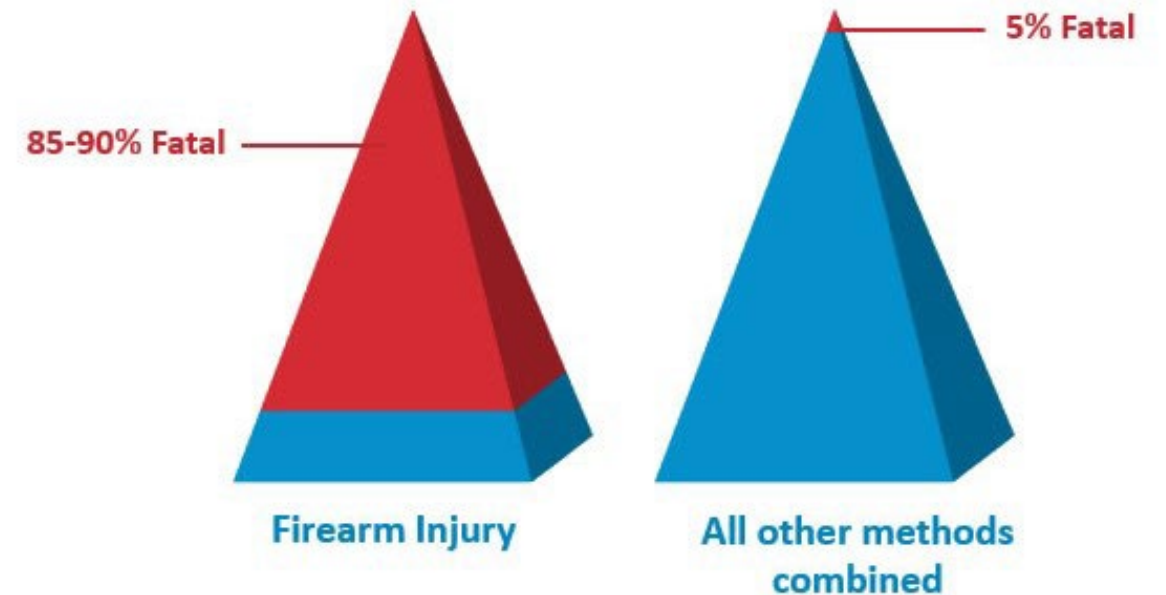
ACCESS TO LETHAL MEANS



TIME FROM DECISION TO ACTION < 1 HOUR



Source: Simon, T.R., Swann, A.C., Powell, K.E., Potter, L.B., Kresnow, M., and O'Carroll, P.W. Characteristics of Impulsive Suicide Attempts and Attempters. SLTB. 2001; 32(supp):49-59.



CDC WISQARS: Deaths from death certificate data; nonfatal incidents estimated from national sample of hospital emergency departments

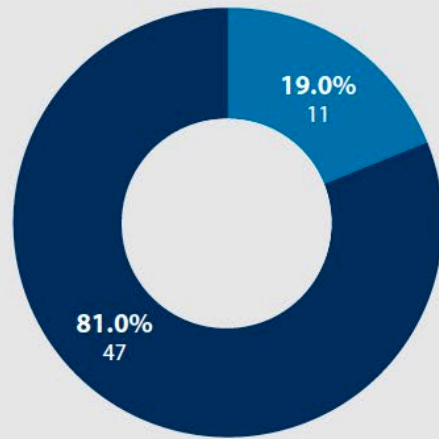
Table 1: Suicide Deaths, Methods Involved, 2020 and Difference From 2001*

	SUICIDE DECEDENTS, METHODS INVOLVED											
	Non-Veteran U.S. Adults		Veterans		Non-Veteran Men		Veteran Men		Non-Veteran Women		Veteran Women	
	2020	Change*	2020	Change*	2020	Change*	2020	Change*	2020	Change*	2020	Change*
Firearms	50.3%	-2.3%	71.0%	+4.5%	55.3%	-2.7%	72.1%	+4.8%	33.3%	-2.1%	48.2%	+11.2%
Poisoning	12.8%	-5.6%	8.4%	-4.8%	8.0%	-4.3%	7.5%	-4.9%	29.3%	-8.7%	26.8%	-16.0%
Suffocation	28.4%	+7.6%	14.9%	+0.9%	28.6%	+6.2%	14.7%	+0.6%	27.7%	+12.0%	19.2%	+8.8%
Other	8.4%	+0.3%	5.8%	-0.6%	8.1%	+0.8%	5.8%	-0.5%	9.6%	-1.1%	5.8%	-3.9%

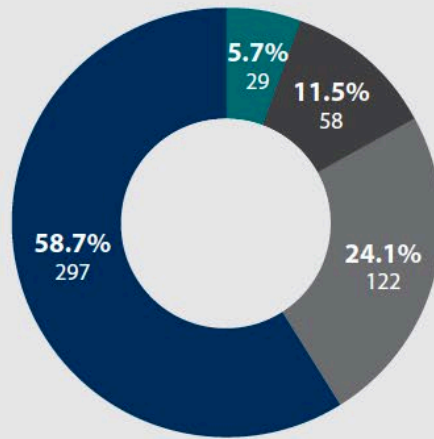
**Difference compared to suicide deaths in 2001*

**VETERAN SUICIDES MORE OFTEN RESULTED FROM
FIREARM INJURY**

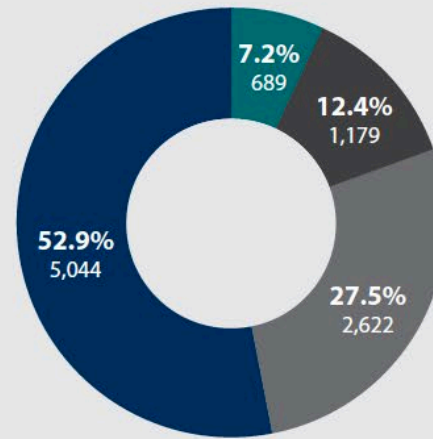
Kansas Veteran and Total Kansas, Midwestern Region, and National Suicide Deaths by Method,^d 2020



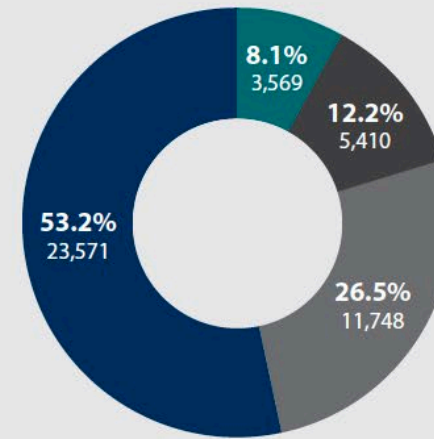
Kansas Veteran Suicides



Kansas Total Suicides



Midwestern Region Suicides



National Suicides

- Firearms
- Suffocation
- Poisoning
- Other Suicide
- Other and Low-Count Methods^e

FIREARM ACCESS AND SUICIDE

- More than 15 U.S. case-control and cross-sectional studies have found that firearm access is an independent risk factor for suicide
- Firearm ownership rates, independent of underlying rates of suicidal behavior, largely determine variations in suicide mortality across the 50 states

TEMPORARY OFF-SITE STORAGE FOR FIREARMS DURING AT-RISK PERIODS

- **Friend or relative**
 - State laws surrounding temporary transfer of firearms vary.
- **Storage facility**
 - Ammunition must be stored separately.
- **Police departments**
 - Some police departments will store temporarily at no charge.
- **Pawn shops**
 - Owners can temporarily pawn firearms for a very small loan amount.
- **Gun stores or gun clubs**
 - Some offer free or inexpensive storage options for members.

LOCKING OPTIONS



- Cable Lock
- Trigger Lock
- Lock Box
- Lifejacket
- Gun Safe / Cabinet

SUICIDE AND LETHAL MEDICATIONS

- Approximately 12 percent of non-Veteran and 8 percent Veteran suicides were due to intentional poisoning in 2020.
- Most attention (appropriately) is now on opiate medications
 - Prescribed and unprescribed
 - Particularly patients receiving opiates + benzos
- Other medications are commonly implicated:
 - Acetaminophen
 - Antipsychotic / antidepressant
 - Anti-seizure

The background of the slide is a close-up photograph of several red, oval-shaped pills in their blister packs. The pills are arranged in rows, and the blister packs are made of clear plastic with a metallic foil backing. The lighting is soft, highlighting the texture of the pills and the reflective surface of the blister packs.

LETHAL MEANS SAFETY FOR MEDICATIONS

- **Essential Medications**

- Blister packets for home medications
- For opioids: Nalaxone nasal spray to reverse overdose

- **Unneeded Medications**

- Medication disposal kits
- Medication disposal bins at VHA facilities, pharmacies

TABLE 4	Level of Risk For Suicide	
<i>Risk for Suicide Attempt</i>	<i>Indicator for Suicide Risk</i>	<i>Contributing factors †</i>
High Acute Risk	• Persistent suicidal ideation or thoughts • Strong intention to act or plan • Not able to control impulse OR • Recent suicide attempt	• Acute state of psychiatric disorder or acute psychiatric symptoms • Acute precipitating event(s) • Inadequate protective factors
Intermediate Acute Risk	• Current suicidal ideation or thoughts • No intention to act • Able to control the impulse • No recent attempt or preparatory behavior or rehearsal of act	• Existence of warning signs or risk factors ^{††} AND • Limited protective factor
Low Acute Risk	• Recent suicidal ideation or thoughts • No intention to act or plan • Able to control the impulse • No planning or rehearsing a suicide act • No previous attempt	• Existence of protective factors AND • Limited risk factors
Undetermined Risk	Due to difficulty in determining the level of risk or provider concerns about the patient despite denial of ideation or intent. The patient should be immediately referred for an evaluation by a Behavioral Health Specialty Provider.	

[†] Modifiers that increase the level of risk for suicide of any defined level:

- **Acute state of substance use:** Alcohol or substance abuse history is associated with impaired judgment and may increase the severity of the suicidality and risk for suicide act
- **Access to means:** (firearms, medications, toxins) may increase the risk for suicide act
- Existence of **multiple risk factors** or **warning signs** or lack of **protective factors**

^{††} Evidence of suicidal behavior warning signs in the context of denial of ideation should call for concern (e.g., contemplation of plan with denial of thoughts or ideation)

MAKING SURE YOUR TREATMENT PLAN CORRESPONDS TO THE LEVEL OF RISK

- Consider the **standard of care** & what would be deemed **reasonable & prudent** for each level of risk.

Options Given Risk Level		
No Risk	➡	Likely no change in tx plan
Mild Risk	➡	Ongoing continued assessment
Moderate Risk	➡	Several options available...
High Risk	➡	Evaluate for hospitalization

HIGH ACUTE RISK

Essential Features

- **Suicidal ideation with intent to die by suicide**
- **Inability to maintain safety independent external support/help**

Common Warning Signs

- A plan for suicide
- Recent attempt and/or ongoing preparatory behaviors
- Acute major mental illness (e.g., MDD episode, acute mania, acute psychosis, recent/current drug relapse)
- Exacerbation of personality disorder (e.g., increased borderline symptomatology)

Common Risk Factors

- Access to means
- Acute psychosocial stressors (e.g., job loss, relationship dissolution, relapse on alcohol)



Action

Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors.

These individuals need to be directly observed until on a secure unit and kept in an environment with limited access to lethal means (e.g. keep away from sharps, cords/tubing, toxic substances).

During hospitalization co-occurring psychiatric symptoms should also be addressed.

INTERMEDIATE ACUTE RISK

Essential Features

- **Suicidal ideation to die by suicide**
- **Ability to maintain safety, independent of external support/help**

These individuals may present similarly to those at high acute risk, sharing many of the features.

The only difference may be lack of intent, based upon an identified reason for living (e.g. children), and ability to abide by a safety plan and maintain their own safety.

Preparatory behaviors are likely to be absent.



Action

Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g. acute psychosis).

Outpatient management of suicidal thoughts and/or behaviors should be intensive and include:

- frequent contact,
- regular re-assessment of risk, and
- a well-articulated safety plan

Mental health treatment should also address co-occurring psychiatric symptoms.

LOW ACUTE RISK

Essential Features

- **No current suicidal intent AND**
- **No specific and current suicidal plan AND**
- **No preparatory behaviors AND**
- **Collective high confidence** (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety

Individuals may have suicidal ideation, but it will be **with little or no intent or specific current plan**. If a plan is present, the plan is general and/or vague, and without any associated preparatory behaviors (e.g., "I'd shoot myself if things got bad enough, but I don't have a gun"). These patients will be capable of engaging appropriate coping strategies, and willing and able to utilize a safety plan in a crisis situation.



Action

Can be managed in primary care.

Outpatient mental health treatment may also be indicated, particularly if suicidal ideation and psychiatric symptoms are co-occurring.

HIGH CHRONIC RISK

Essential Features

Common Warning Sign

- Chronic suicidal ideation

Common Risk Factors

- Chronic major mental illness and/or personality disorder
- History of prior suicide attempt(s)
- History of substance abuse/dependence
- Chronic pain
- Chronic medical condition
- Limited coping skills
- Unstable or turbulent psychosocial status (e.g. unstable housing, erratic relationships, marginal employment)
- Limited ability to identify reasons for living



Action

These individuals are considered to be at chronic risk for becoming acutely suicidal, often in the context of unpredictable situational contingencies (e.g., job loss, loss of relationships, and relapse on drugs).

These individuals typically require:

- routine mental health follow-up
- a well-articulated safety plan, including means safety (e.g., no access to guns, limited medication supply)
- routine suicide risk screening
- coping skills building
- management of co-occurring psychiatric symptoms

INTERMEDIATE CHRONIC RISK

Essential Features

These individuals may feature similar chronicity as those at high chronic risk with respect to psychiatric, substance abuse, medical and painful conditions.

Protective factors, coping skills, reasons for living, and relative psychosocial stability suggest enhanced ability to endure future crisis without resorting to self-directed violence.



Action

These individuals typically require:

- routine mental health care to optimize psychiatric condition and maintain/enhance coping skills and protective factors.
- a well articulated safety plan, including means safety (e.g., no access to guns, limited medication supply)
- management of co-occurring psychiatric symptoms

LOW CHRONIC RISK

Essential Features

These individuals may range from persons with no or little in the way of mental health or substance abuse problems, to persons with significant mental illness that is associated with relatively abundant strengths/resources.

Stressors historically have typically been endured absent suicidal ideation.

The following factors will generally be missing

- history of self-directed violence
- chronic suicidal ideation
- tendency towards being highly impulsive
- risky behaviors
- marginal psychosocial functioning



Action

Appropriate for mental health care on an as needed basis, some may be managed in primary care settings. Others may require mental health follow-up to continue successful treatments.

RISK STRATIFICATION TOOL

CHRONIC Therapeutic Risk Management – Risk Stratification Table	
HIGH CHRONIC RISK	
Essential Features Common Warning Sign - Chronic suicidal ideation Common Risk Factors - Chronic major mental illness and/or personality disorder - History of prior suicide attempt(s) - History of substance abuse/dependence - Chronic pain - Chronic medical condition - Limited coping skills - Unstable or turbulent psychosocial status (e.g. unstable housing, erratic relationships, marginal employment) - Limited ability to identify reasons for living	Action These individuals are considered to be at chronic risk for becoming acutely suicidal, often in the context of unpredictable situational contingencies (e.g., job loss, loss of relationships, and relapse on drugs). These individuals typically require: - routine mental health follow-up - a well-articulated safety plan, including means safety (e.g., no access to guns, limited medication supply) - routine suicide risk screening - coping skills building - management of co-occurring psychiatric symptoms
INTERMEDIATE CHRONIC RISK	
Essential Features These individuals may feature similar chronicity as those at high chronic risk with respect to psychiatric, substance abuse, medical and painful conditions. Protective factors, coping skills, reasons for living, and relative psychosocial stability suggest enhanced ability to endure future crisis without resorting to self-directed violence.	Action These individuals typically require: - routine mental health care to optimize psychiatric condition and maintain/enhance coping skills and protective factors. - a well articulated safety plan, including means safety (e.g., no access to guns, limited medication supply) - management of co-occurring psychiatric symptoms
LOW CHRONIC RISK	
Essential Features These individuals may range from persons with no or little in the way of mental health or substance abuse problems, to persons with significant mental illness that is associated with relatively abundant strengths/resources. Stressors historically have typically been endured absent suicidal ideation. The following factors will generally be missing - history of self-directed violence - chronic suicidal ideation - tendency towards being highly impulsive - risky behaviors - marginal psychosocial functioning	Action Appropriate for mental health care on an as needed basis, some may be managed in primary care settings. Others may require mental health follow-up to continue successful treatments.

ACUTE Therapeutic Risk Management – Risk Stratification Table	
HIGH ACUTE RISK	
Essential Features Suicidal ideation with intent to die by suicide Inability to maintain safety independent external support/help Common Warning Signs - A plan for suicide - Recent attempt and/or ongoing preparatory behaviors - Acute major mental illness (e.g., MDD episode, acute mania, acute psychosis, recent/current drug relapse) - Exacerbation of personality disorder (e.g., increased borderline symptomatology) Common Risk Factors - Access to means - Acute psychosocial stressors (e.g., job loss, relationship dissolution, relapse on alcohol)	Action Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors. These individuals need to be directly observed until on a secure unit and kept in an environment with limited access to lethal means (e.g. keep away from sharps, cords/tubing, toxic substances). During hospitalization co-occurring psychiatric symptoms should also be addressed.
INTERMEDIATE ACUTE RISK	
Essential Features Suicidal ideation to die by suicide Ability to maintain safety, independent of external support/help These individuals may present similarly to those at high acute risk, sharing many of the features. The only difference may be lack of intent, based upon an identified reason for living (e.g. children), and ability to abide by a safety plan and maintain their own safety. Preparatory behaviors are likely to be absent.	Action Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g. acute psychosis). Outpatient management of suicidal thoughts and/or behaviors should be intensive and include: - frequent contact, - regular re-assessment of risk, and - a well-articulated safety plan Mental health treatment should also address co-occurring psychiatric symptoms.
LOW ACUTE RISK	
Essential Features No current suicidal intent AND No specific and current suicidal plan AND No preparatory behaviors AND Collective high confidence (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety Individuals may have suicidal ideation, but it will be with little or no intent or specific current plan . If a plan is present, the plan is general and/or vague, and without any associated preparatory behaviors (e.g., "I'd shoot myself if things got bad enough, but I don't have a gun"). These patients will be capable of engaging appropriate coping strategies, and willing and able to utilize a safety plan in a crisis situation.	Action Can be managed in primary care. Outpatient mental health treatment may also be indicated, particularly if suicidal ideation and psychiatric symptoms are co-occurring.

*Overall level of individual risk may be increased or decreased based upon warning signs, risk factors and **protective factors**

MAKING SURE YOUR TREATMENT PLAN CORRESPONDS TO THE LEVEL OF RISK

- There is some evidence to suggest that a collaborative approach to suicide assessment, management & treatment planning is best (e.g. Jobes, 2006).

Problem	Description	Goals/objectives Evidence for attainment	Interventions (Type & Freq)	Estimated # of Sessions
I	Suicide plan w/out immediate subjective intent	Increased safety outside of hospital	Psychiatry consult Arrange PCP appt. Family meeting Dev. of a Safety Plan	2 sessions a week for 1 month

KNOWING WHEN TO ASK FOR HELP

- Monitor your own countertransference & consult with others on particularly challenging patients.
 - Consider process groups with other colleagues.
- When in doubt, consult.
 - Your colleagues are an excellent resource.
- Document formal consultation & be sure to inform your consultant that you are doing so.



MILITARY CULTURE & SUICIDE

MILITARY MOTTOES



Army: *Defendum Hoc*
– This We'll Defend



National Guard – *Semper Paratus Semper*
– Always Ready, Always There



Navy: *Semper Fortis*
– Always Courageous



Marine Corps: *Semper Fidelis*
– Always Faithful



Air Force – *Super Omnia*
– Above All



Coast Guard – *Semper Paratus*
– Always Ready

LETHAL MEANS STORAGE CONVERSATIONS & MILITARY CULTURAL COMPETENCE

- “... My rifle without me is useless. Without my rifle, I am useless...”
 - *Marine Corps Rifleman's Creed*
- “...I will always maintain my arms, my equipment and myself....”
 - *Army Soldier's Creed*

ADDITIONAL CONSIDERATIONS WITH SMVF

- Surrender vs. secure:
 - Service members are taught never to surrender their weapons (Article II, US Military Code of Conduct), but to always secure them
- Restricting access vs. exercising self-control:
 - Service members are taught safe storage of lethal means and to exercise self-control
- Gun control vs. self-imposed access limitations
 - The perception is that this is about gun control, but the reality is this is about helping the individual limit their own access to all lethal means during a crisis situation

HAVING THE CONVERSATION- SCENARIO I



I don't feel right. Can you hold onto a few things for me for a couple of days?

Sure... I've got you. What are we talking about?

My weapons and ammo... maybe a few of my pill bottles, if your cool with that.

No problem. Where are you? I'm on my way.

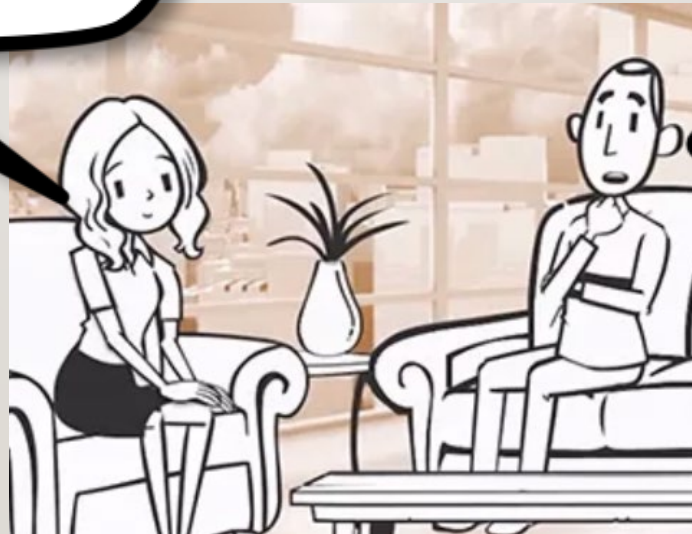
HAVING THE CONVERSATION- SCENARIO I IMPLICATIONS

- You only get one try at trust, are you ready?
- Are you a trained suicide intervention specialist?
- Are you willing to accept the responsibility?
- Can you safely secure what is being secured?
- Will you be comfortable when the person asks for it (them) back?

HAVING THE CONVERSATION- SCENARIO 2

So, um... I also heard
you say you have a
way to act on this.
Um, could you,
well... you know...
sorta think of ways
not to?

I wish she
would just tell
me what she
means

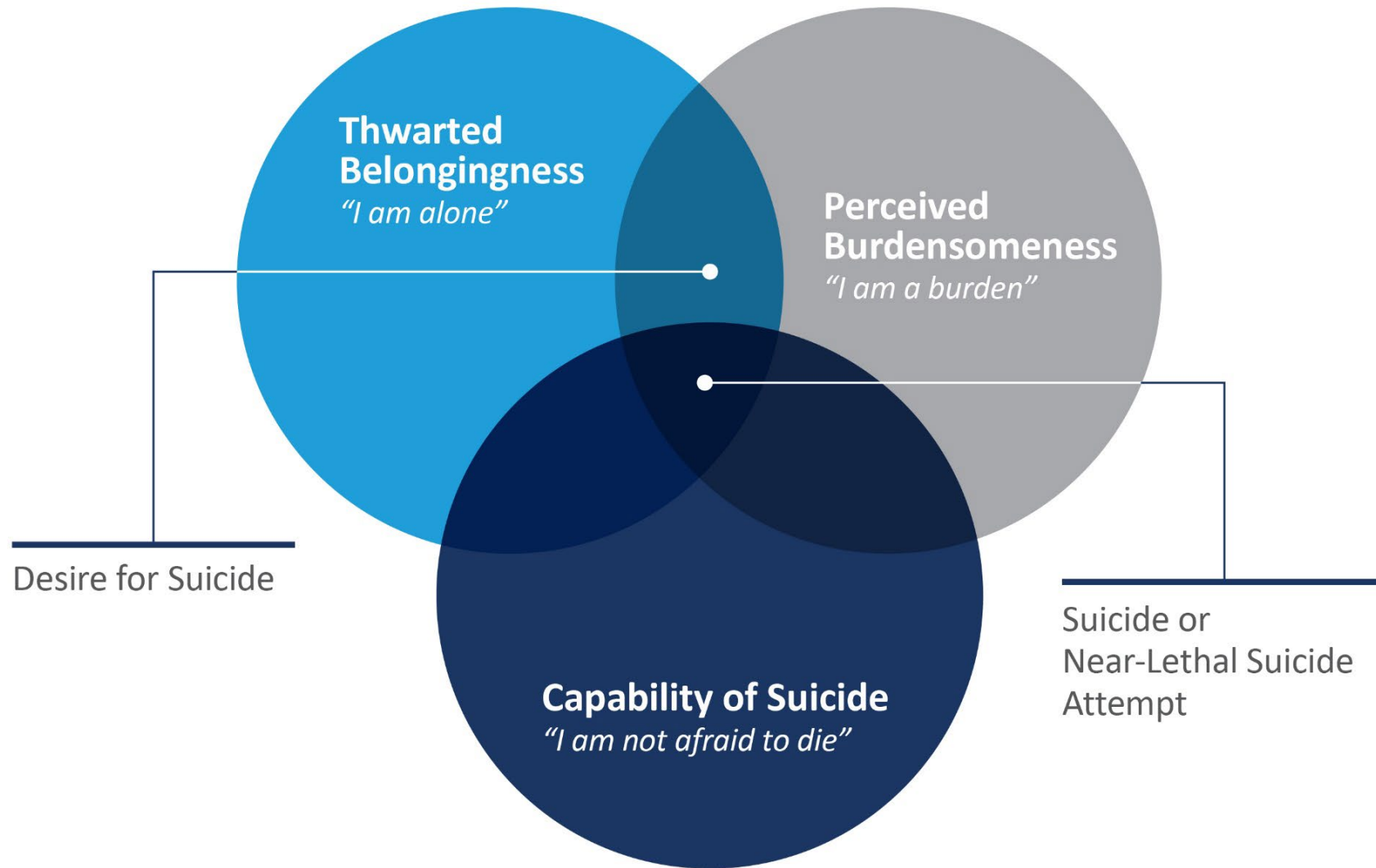


HAVING THE CONVERSATION- SCENARIO 2

IMPLICATIONS

- Service members and Veterans are very familiar with direct communications
- BLUF: Bottom Line Up Front
- Be genuine, calm, and supportive.
- You only get one try at trust. Are you ready?









QUESTIONS?

