Navy Suicide Prevention Training for Providers

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Learning Objectives

1) Characterize components of risk assessment for suicide with a focus on military-specific risk and protective factors
2) Apply one psychological theory of suicide to the process of suicide risk assessment
3) Formulate clinical decisions with suicidal patients using the *VA/DoD Clinical Practice Guidelines for the Assessment and Management of Patients at Risk for Suicide*
4) Specify the steps used when developing a suicide prevention safety plan

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Suicide Statistics

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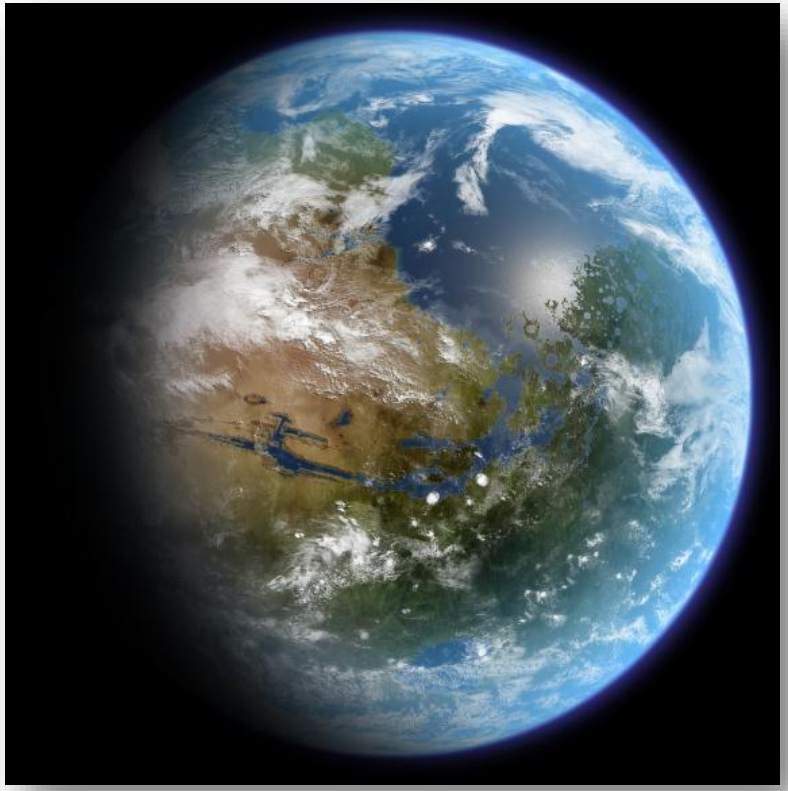
Every Year…



Public domain image courtesy of Wikipedia

Globally	Nationally
Almost 800,000 deaths	Steady rise since 1999
10.5 per 100,000	14 per 100,000
1 every 40 sec	1 every 11.1 minutes

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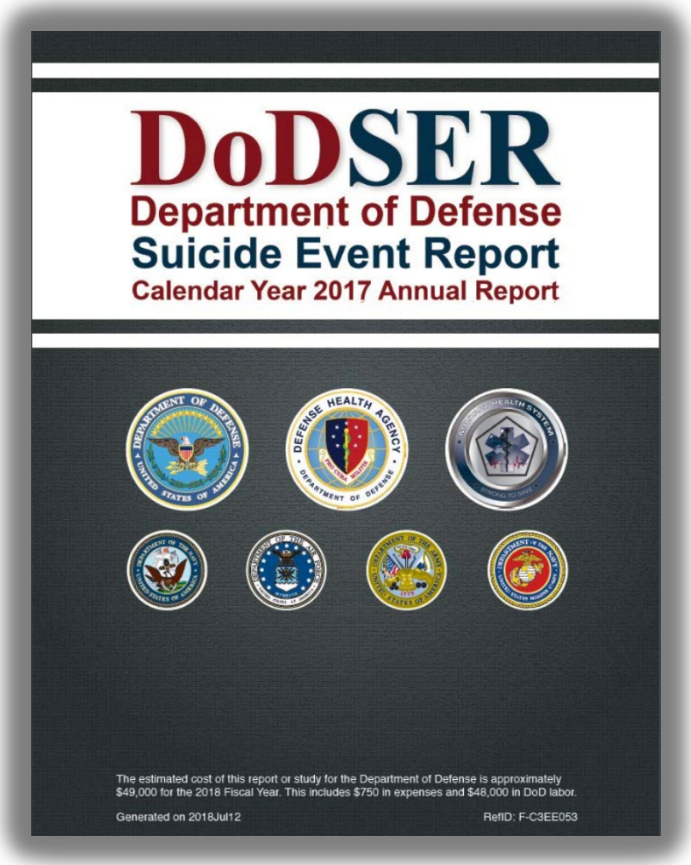
Hedegaard et al. (2018); Murphy et al. (2018); World Health Organization (2018)



DoD Suicide Event Reporting System (DoDSER) CY 2017

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DoDSER Reporting

- **Suicide DoDSERs** completed by:
  - Service member's (SM) command
- **Suicide attempt DoDSERs** completed by:
  - Unit/facility responsible for SM's evaluation
  - Military Treatment Facility (MTF) source of civilian referral
  - Reserve component medical rep

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DoD Suicides: Active Component

	All Services	Air Force	Army	Marine Corps	Navy	General Population (CY 2017)
Total Count	284	62	114	43	65	47,173
Rate/ 100K	21.9	19.3	24.3	23.4	20.1	14.0

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Murphy et al. (2018); Pruitt et al. (2019)

DoD Suicides: Reserve & NG

	National Guard	Reserve	Selected Reserves (non-duty status)
Total Count	130	92	190
Rate/100K	29.1	25.7	--

Pruitt et al. (2019)

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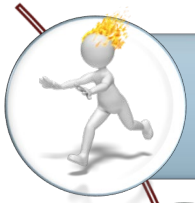
Common Myths



People often die by suicide on a whim

People who die by suicide don't make future plans

Suicide is selfish, a sign of excessive self-focus

If people want to die by suicide, we can't stop them

It's just a cry for help and doesn't indicate risk

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Barber & Miller (2014); Joiner (2010)

DoD and DoN Policies Addressing Suicide Prevention

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DoD and DoN Policies

DoDI 6490.08	Command notification
DoDI 6490.16	SP policies & procedures
BUMEDINST 6520.2	Pt evaluation & disposition
OPNAVINST 1720.4B	Navy suicide prevention
BUMED Memo: 21Mar19	Command notification
MCO 1720.2	Marine suicide prevention
NAVADMIN 208-16	SAIL program
USD Memo: 28Aug14	Reducing access/firearm storage

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Military Reporting Requirements

- Harm to:
  - Self
  - Others
  - Mission
- Substance abuse treatment
- Acute medical condition interfering with duty
- Special personnel
- Command-directed evaluation
- Inpatient care
- Other special circumstances

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Sharing MH Information

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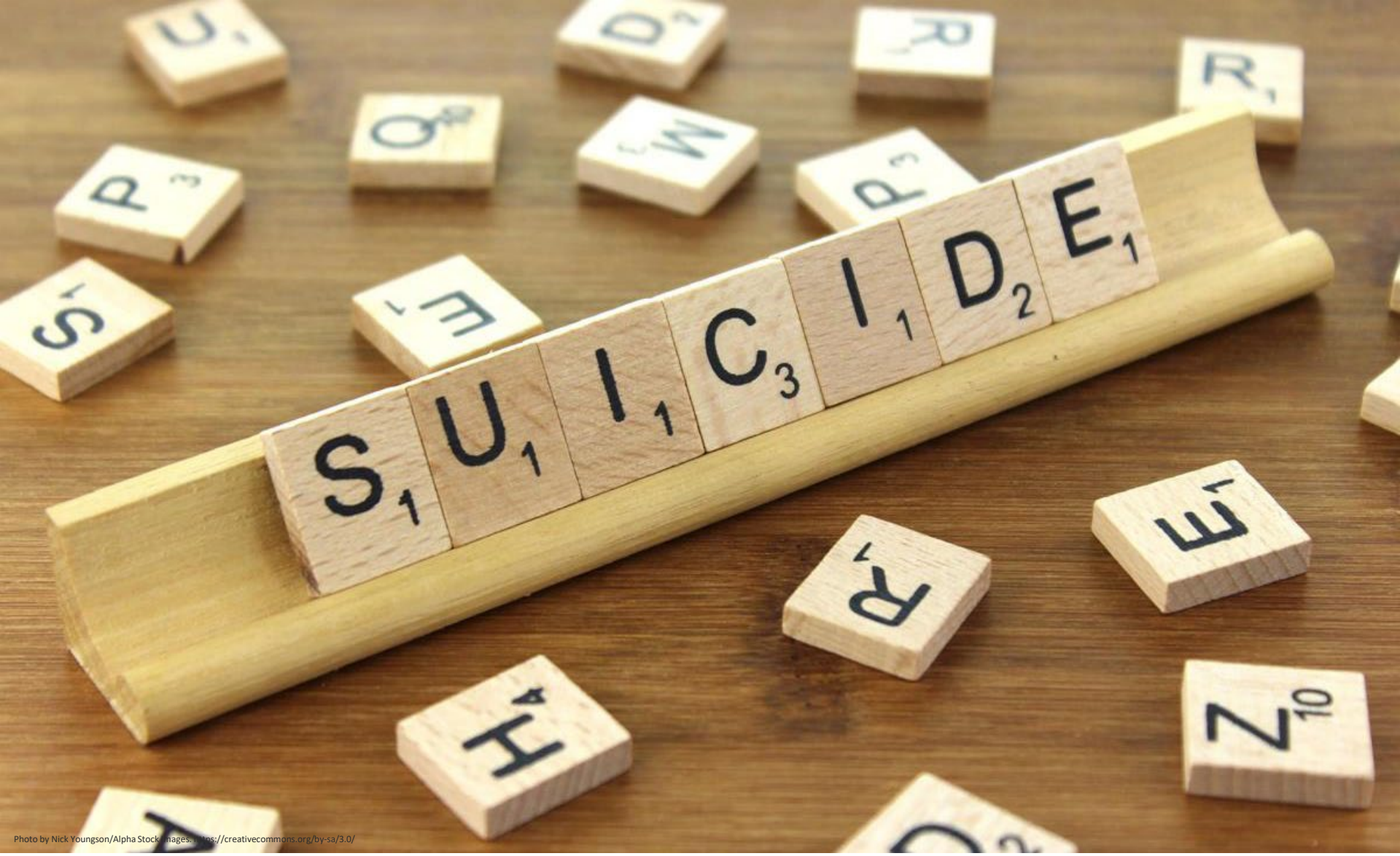
Command Involvement

- Providers should communicate with commanders or another person *specifically designated*
- Providers should document contact with commands

Suicide Prevention Coordinators

- Commanders designate at least one Suicide Prevention Coordinator (SPC)
- SPCs ensure regular suicide prevention trainings at their command
- SPCs submit SAIL referrals to OPNAV 171



Nomenclature for Suicide Thoughts and Behaviors

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Nomenclature

Brenner et al. (2011)

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Review of Terms

Not Recommended

- Co[illegible]tted Suic
- Suici[illegible]
- Parasu[illegible]
- Failed
- Succ[illegible]l Su
- Su[illegible]n Gestur

Recommended

- Suicide
- Died by Suicide
- Suicidal/ Non-Suicidal Self-Directed Violence
- Suicidal Thoughts/ Ideations

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Crosby et al. (2011)

Terminology

- Self-Directed Violence Classification System (SDVCS)
  - Collaboration between the Centers for Disease Control (CDC) & the Dept. of Veterans Affairs (VA)
  - Describes *thoughts* and *behaviors* associated with suicide
  - Many resources available on the Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC) website

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Brenner et al. (2011); Crosby et al. (2011)

SDVCS Clinical Tool

Self-Directed Violence (SDV) Classification System
Clinical Tool

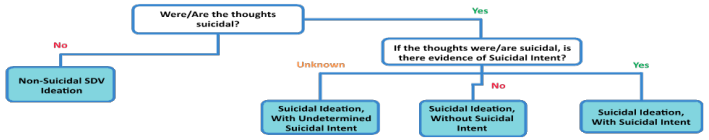
BEGIN WITH THESE 3 QUESTIONS:

1. Is there any indication that the person engaged in self-directed violent behavior that was lethal, preparatory, or potentially harmful? (Refer to Key Terms on reverse side)
   If NO, proceed to Question 2
   If YES, proceed to Question 3

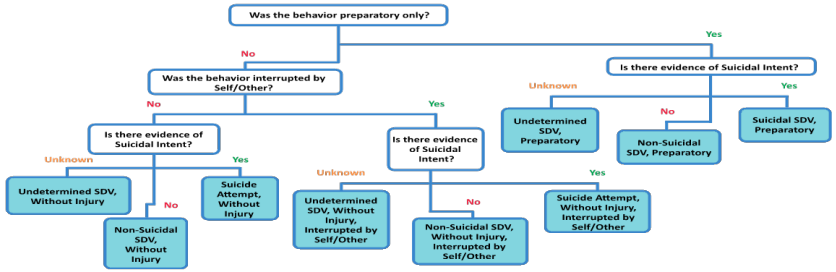
2. Is there any indication that the person had self-directed violence related thoughts?
   If NO to Questions 1 and 2, there is insufficient evidence to suggest self-directed violence → NO SDV TERM
   If YES, proceed to Decision Tree A

3. Did the behavior involve any injury or did it result in death?
   If NO, proceed to Decision Tree B
   If YES, proceed to Decision Tree C

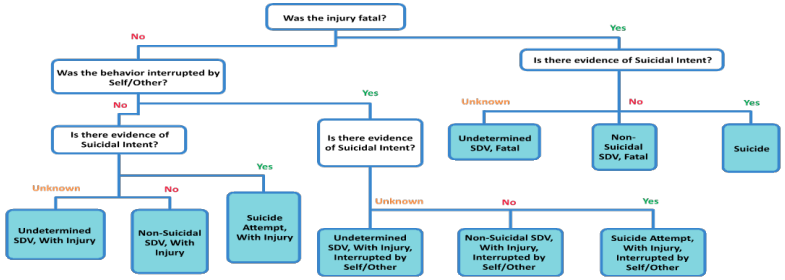
DECISION TREE A: THOUGHTS



DECISION TREE B: BEHAVIORS, WITHOUT INJURY



DECISION TREE C: BEHAVIORS, WITH INJURY



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Interpersonal-Psychological Theory of Suicide Risk

Dr. Thomas Joiner

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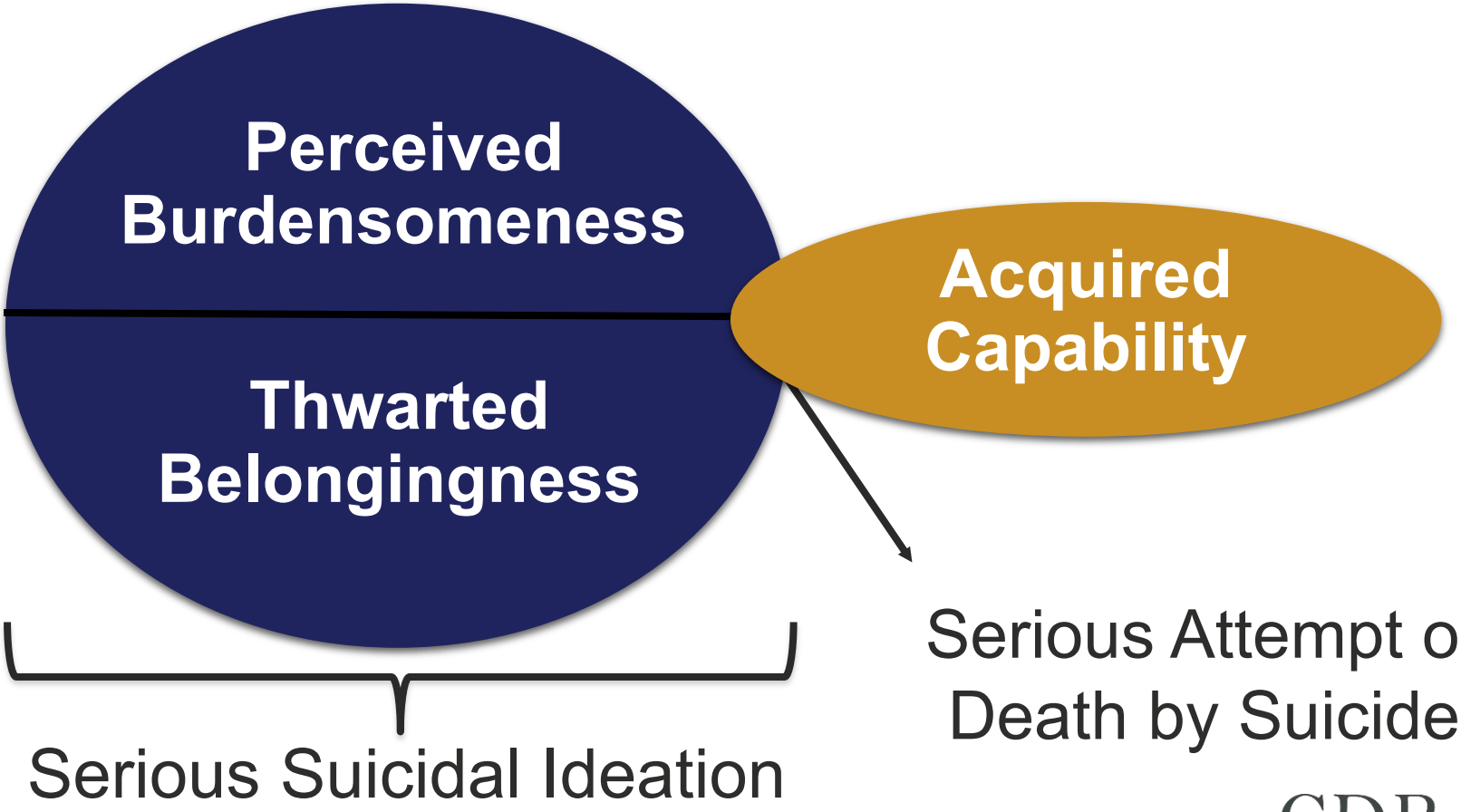
I-P Theory of Suicide Risk



Joiner (2005)

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Thwarted Belongingness

To maintain a sense of belongingness, one needs:

1. Frequent interaction with others
2. Persistent feeling of being cared about

Interactions must be both frequent and positive

Joiner (2005)

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Perceived Burdensomeness

- **Need**: Effectiveness or sense of competence/self-efficacy

- **Burdensomeness:** Involves feeling ineffective, plus the sense that loved ones are threatened and burdened

Joiner (2005)

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Acquired Capability:

- Reduction of fear through repeated exposure to pain or injury is necessary for serious suicidal behavior to occur (can occur in the short term or over the long term)

    1. Previous suicidal behavior
    2. Any experience that reduces fear of injury

Bryan et al. (2015); Joiner (2005)

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Acquired Capability: 3 Components

1. Acquisition of knowledge
2. Fearlessness of pain, injury & death
3. Increased tolerance of pain/injury

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Photo by Staff Sgt. Ryan Crane. Public domain, via Wikimedia Commons.

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Selby et al. (2010)

Fluid Vulnerability Theory of Suicide

Dr. David Rudd

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Fluid Vulnerability Theory (FVT)

A theory for understanding risk

1. Baseline risk
2. Acute risk

Photo by RForster. Owned by HJF.

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Rudd (2006a)

FVT Assumptions

- Suicidal episodes are time-limited
- Baseline risk is different for each person
- After acute episode, goal is to return person to baseline
- Risk is increased by stressors/ events

Rudd (2006a)

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Baseline Risk

Rudd (2006a)

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VA/DoD Clinical Practice Guidelines

- Recommendations for
  - Screening
  - Evaluation
  - Risk management
  - Treatment

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Patient Collaboration

- Focus on importance of **trust between patient and provider**
- Individualized care based on **patient needs and preferences**
- Shared decision making so patients can make **informed decisions**
- **Education for patients** and involved family members/support persons

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U.S. Air Force photo/Senior Airman Stephanie Sauberan. Public domain.

Assessing Risk

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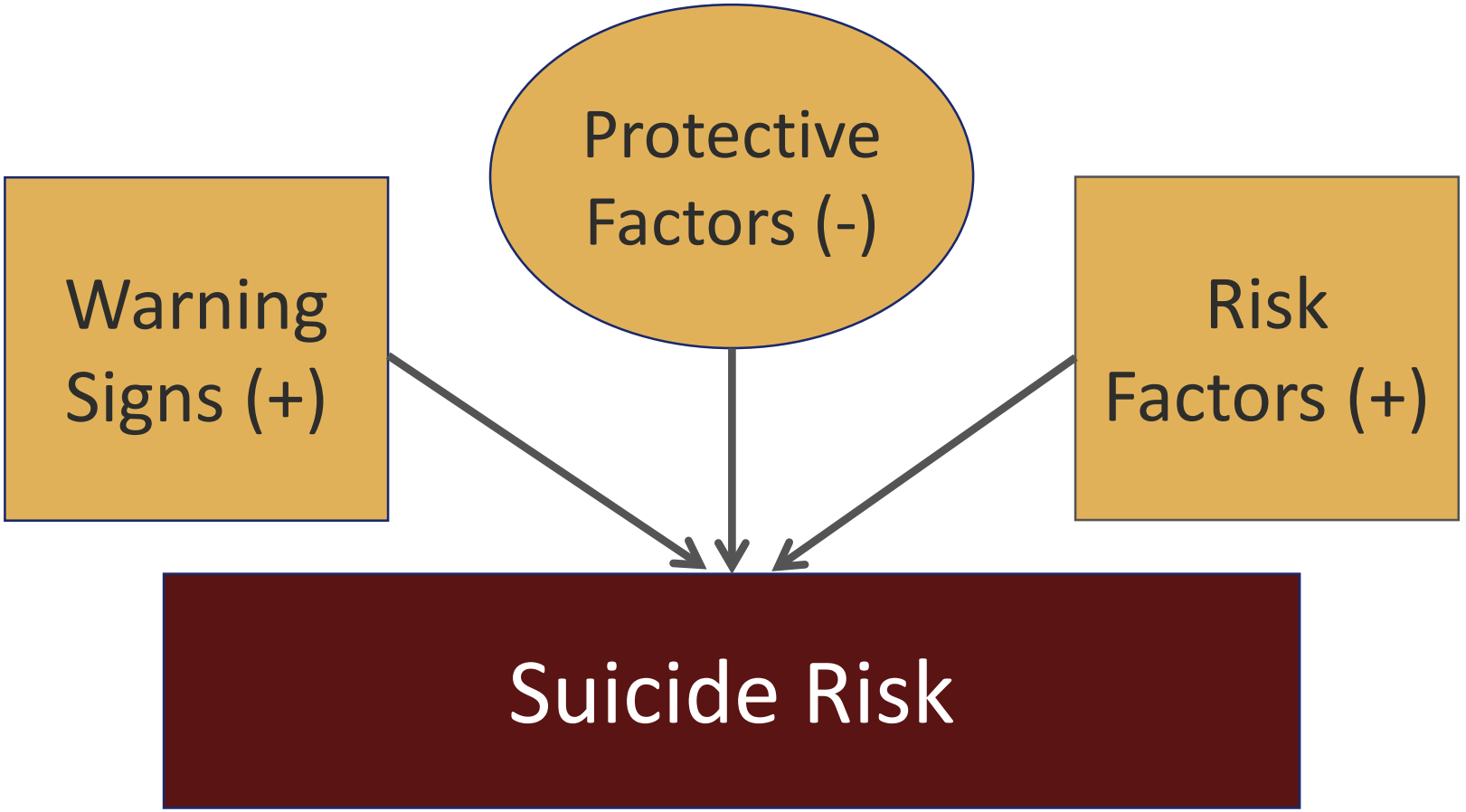
Conceptual Model of Suicide Risk



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Suicide Risk Assessment

- Neutral, non-judgmental, direct questions
- Structured suicide-focused
- Integrate all information to determine risk level and identify appropriate care setting

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Columbia Suicide Severity Scales

Multiple versions including brief screener and 3-page risk assessment

Structured questions using direct, plain language

Available in over 100 languages

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Patient Health Questionnaire (PHQ)

- Versions with two or nine questions
- Clinical Practice Guidelines (CPGs) suggest using PHQ-i9 as a universal screening tool to identify suicide risk
- Per Navy Primary Care guidance, if PHQ-2 is positive, follow-up with PHQ-9

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Risk Factor Categories

Health	Environment	History
• Mental health diagnosis • Physical health condition • TBI	• Access to lethal means • Stressful life event • Exposure to suicide	• Previous attempt • Family history (suicide, trauma, abuse)

American Foundation for Suicide Prevention (2018)

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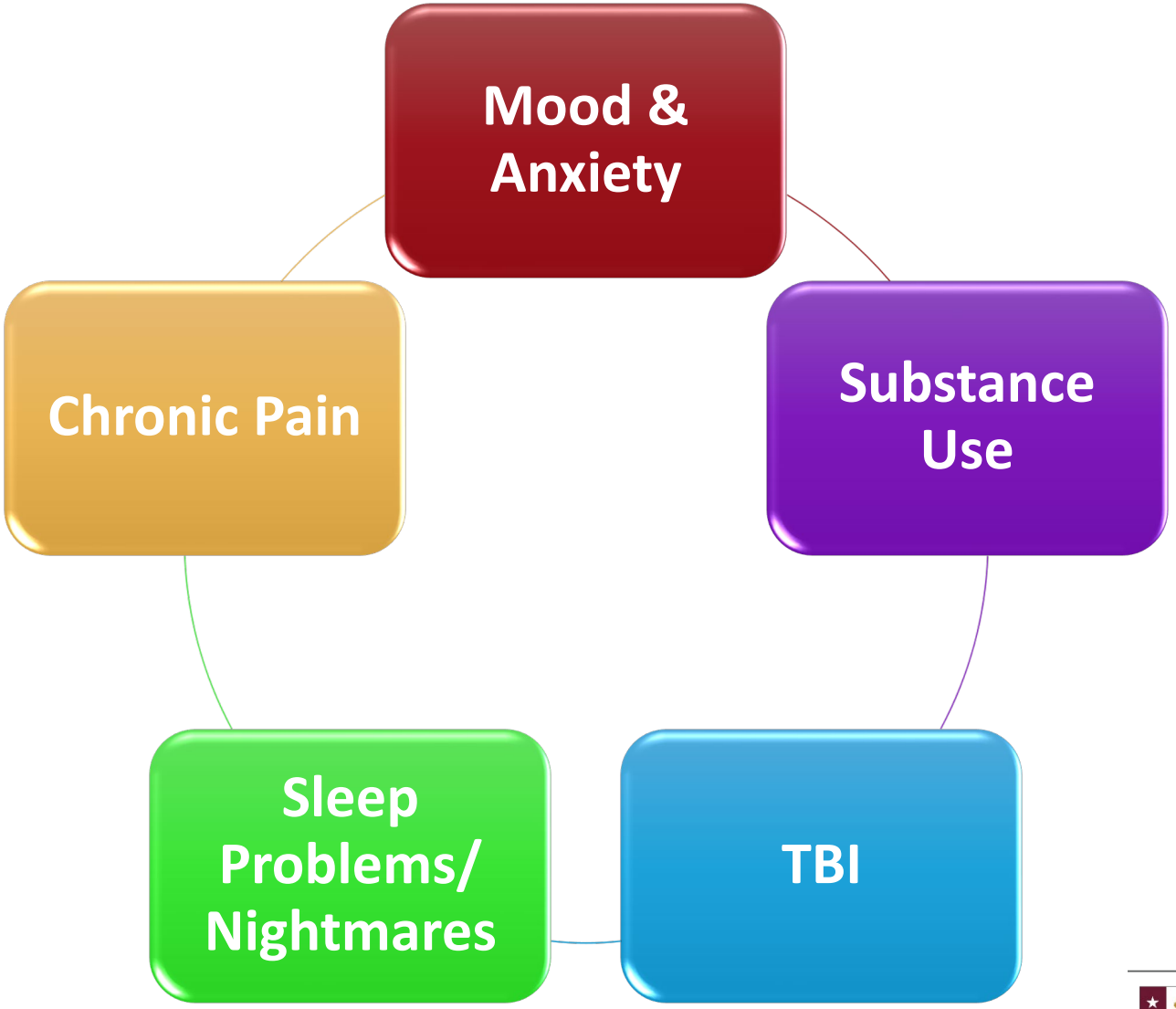
Comorbid Conditions



Brenner et al. (2011); Ilgen et al. (2008); Ilgen et al. (2012);
Jakupcak et al. (2010); Ribeiro et al. (2012); Department of Veterans Affairs/Department of Defense (2019)

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Challenges of Risk Assessment

- Reliance on client self-reports
- Difficulty predicting a specific behavior
- Point prediction
- Lethality
- Low base-rate behavior

Department of Veterans Affairs/Department of Defense (2013)

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Military Risk Factors

- Relationship Problems*
- Hopelessness/ Worthlessness
- Substance Misuse
- Feelings of Disgrace
- Stressful Military Life Events
- Separation from Service
- Easy Access to Firearms
- Moral Injury
- Unexplained Mood Change/Depression
- Financial, Legal, or Job Performance Problems
- Medical or Administrative Discharge Processing
- Sleep Problems
- Previous Suicide Attempts **

Bryan et al. (2015); Jones et al. (2012); Khazem et al. (2016); LeardMann et al. (2013); Litz et al. (2009); Martin et al. (2009); Reger et al. (2015); Ribeiro et al. (2012); Shen et al. (2016)

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Acute Warning Signs

U.S. Air Force photo by Master Sgt. Chris Botzum. Public domain.

The earliest detectable sign indicating heightened risk for suicide in the near term (within minutes, hours, or days).

Rudd et al. (2006)

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Acute Warning Signs

Tier 1

- Communicating suicidal thoughts/intent verbally or in writing
- Seeking access to lethal means like medications & firearms
- Demonstrating preparatory behaviors

Tier 2

- Hopelessness
- Rage, anger, seeking revenge
- Recklessness or engaging in risky activities
- Feeling trapped
- Increased alcohol and/or substance use
- Withdrawal
- Anxiety, agitation, insomnia/hypersomnia
- Dramatic mood changes
- No reason for living; no sense of purpose in life

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Department of Veterans Affairs/Department of Defense (2019); Rudd et al. (2006)

Protective Factors

- Accessible & available social support
- Hopefulness
- Having children/pets in the home
- Religious commitment
- Life satisfaction
- Intact reality testing
- Fear of death
- Fear of social disapproval
- Problem-solving ability and emotional self-control
- MH treatment & therapeutic alliance

Nock et al. (2013)

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Evaluation of Suicide Risk

- **Previous suicidal thoughts, intent, and behavior**
- **Current suicidal thoughts, intent, and behavior**
- **Precipitant stressors (acute and chronic)**
- **General psychiatric symptoms (including hopelessness)**
- **Previous psychiatric hospitalization**
- **Access to lethal means**
- Impulsivity and self-control
- Use of medications or substances
- Protective factors

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Department of Veterans Affairs/Department of Defense (2019); Rudd (2006b)

Risk Stratification Tool

ACUTE — Therapeutic Risk Management – *Risk Stratification Table*

ROCKY MOUNTAIN MIRECC

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**

CHRONIC — Therapeutic Risk Management – *Risk Stratification Table*

ROCKY MOUNTAIN MIRECC

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.

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Homaifar et al. (2013); Wortzel et al. (2013); Wortzel et al. (2014)

U.S. Air Force illustration/Senior Airman Nathan Maysonet. Public domain.

Addressing Safety

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Crisis Response Planning

- Match care level to risk level
- Complete safety plan
- Continue to monitor risk

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Additional Steps with Military

- Inform command when appropriate
- Address barriers to care (including stigma)
- Ensure follow-up during transition
- Enroll in risk management tracking

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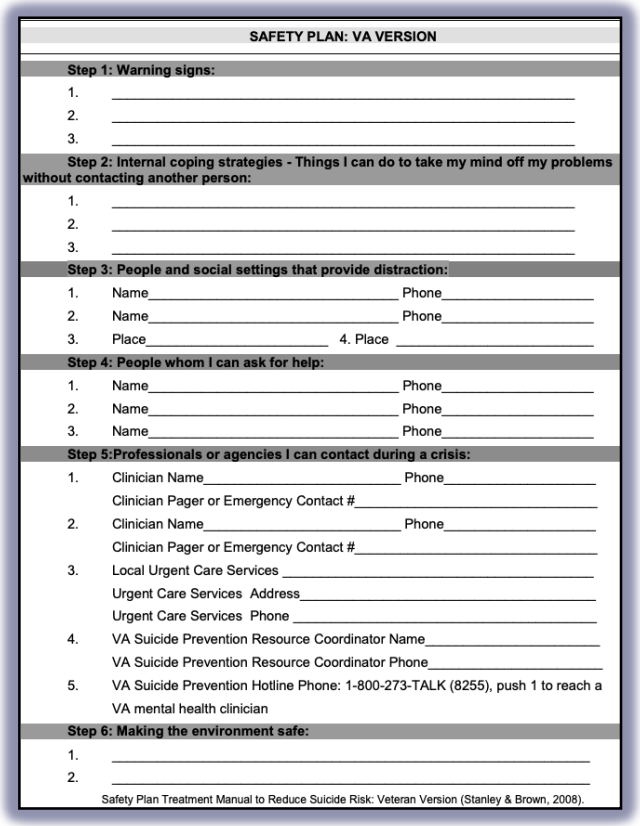
Safety Planning Intervention

- Prioritized list of coping strategies and sources of support including:
  - Mood regulation
  - Pleasant activities
  - Emergency numbers
- Developed collaboratively with patient
- Research efficacy



SAFETY PLAN: VA VERSION

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

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. VA Suicide Prevention Resource Coordinator Name_____
   VA Suicide Prevention Resource Coordinator Phone_____
5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

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Kayman et al. (2016); Rings et al. (2012); Stanley et al. (2008); Stanley et al. (2015); Stanley et al. (2018)

Safety Plan Research

- Safety planning is a brief intervention that can reduce risk
- May improve overall suicide prevention services in acute care settings
- Part of a comprehensive approach to safety in suicidal patients

Chesin et al. (2017); Kayman et al. (2016);
Rings et al. (2012); Stanley et al. (2008); Stanley et al. (2015); Stanley et al. (2018)

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Safety Plan Steps

- Step 1: Warning Signs
- Step 2: Internal Coping Strategies
- Step 3: Distractions
- Step 4: Family/Friends
- Step 5: Emergency Contacts
- Step 6: Safe Environment

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Jobes (2006); Stanley et al. (2008); Stanley et al. (2018); Wenzel at al. (2009)

Step 1: Warning signs

- Thoughts
- Images
- Thinking processes
- Mood
- Behaviors

Stanley et al. (2008)

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Step 2: Internal Coping

- Coping strategies they can employ without contacting anyone
  - Walking
  - Listening to music
  - Playing with pets

Stanley et al. (2008)

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Step 3: Distractions

- Goal to distract from thoughts and worries
  - People
  - Places
  - Activities

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Stanley et al. (2008)

Step 4: Family/Friends

- Informing family and friends they are experiencing a crisis and need help
- May want to weigh pros and cons on telling others

Stanley et al. (2008)

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Step 5: Emergency Contacts

VA/DoD

1-800-273- 8255

24/7 Crisis Line

838255

24/7 Text response

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Stanley et al. (2008)

Step 6: Safe Environment

- Access to means, especially firearms, increases risk
- Means safety intervention

Stanley et al. (2008)

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Lethal Means

1. Most suicidal crises are brief, difficult to predict and may escalate quickly
2. Identify ways to decrease/delay access
3. Discuss safe firearm storage with **ALL** suicidal patients regardless of identified means
4. Means Restriction Counseling or Counseling on Access to Lethal Means (CALM)

Barber & Miller (2014); Britton et al. (2016);
Bryan et al. (2011); Joiner (2010); Rudd & Bryan (2011); Rudd et al. (2015)

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USD Memo Guidance

- Addresses reducing access to lethal means
- Provides information to Commanding Officers and healthcare professionals regarding asking about firearms & ammunition as well as voluntary safe storage

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Implementation of Safety Plan

- Review each step and obtain feedback
- Likelihood of following through (1-100%)
- Specify location of safety plan
- Revise at subsequent meetings as new skills are learned or social network is expanded

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Jobes (2006); Stanley et al. (2008); Stanley et al. (2018); Wenzel at al. (2009)

Treatment Interventions

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VA/DoD CPGs for Treatment

- CBT-based interventions focused on suicide prevention for patients with:
  - Recent history of SDV
- Problem-solving based psychotherapy for patients with:
  - >1 incident of SDV
  - Recent history of SDV
  - Hopelessness and TBI

Department of Veterans Affairs/Department of Defense (2019)

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U.S. Air Force photo by Senior Airman Taylor Curry/Released. Public domain.

Suicide Postvention

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Principles of Postvention

- Organized response following a suicide:
  - To facilitate the healing of individuals from the grief and distress of suicide loss
  - To mitigate other negative effects of exposure to suicide
  - To prevent suicide among people who are at high risk after exposure to suicide

Survivors of Suicide Loss Task Force (2015)

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Guidelines

- Work to ensure safe reporting of the information
- Aid mourning in ways that avoid increasing the risk of contagion.
- Provide ongoing support and treatment, including professional and peer-support options, for those who need it.
- Provide support and guidance for friends and family members of the bereaved

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RESOURCES

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MIP/SAIL Programs

- For Sailors & Marines with suicidal ideation or attempts
- Case management services
- Provides contacts at pre-established intervals either in person or by phone
- Helps identify needs, monitor risk and connect with resources

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Additional Resources

- Defense Suicide Prevention Office (DSPO)
- Psychological Health Center of Excellence (PHCoE)
- Rocky Mountain MIRECC/VISN 19
- Navy Suicide Prevention Handbook (2019)
- Suicide Prevention Resource Center (SPRC)
- American Association of Suicidology (AAS)
- American Foundation for Suicide Prevention (AFSP)

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- Descriptions and schedules of upcoming training events
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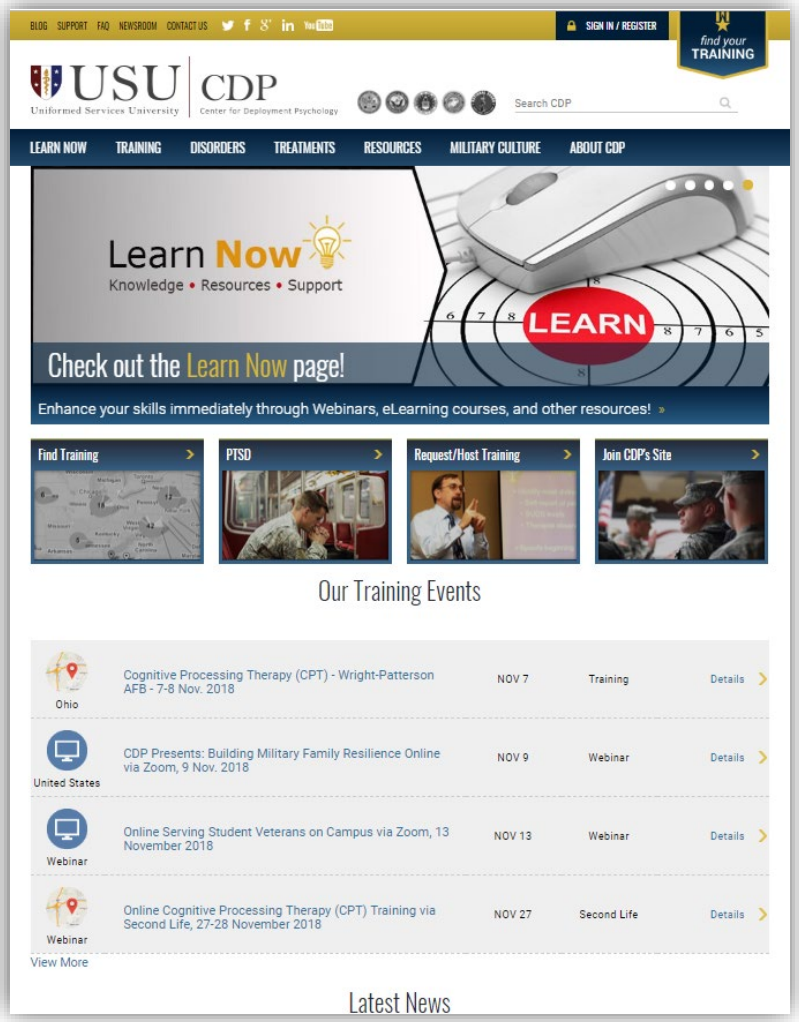

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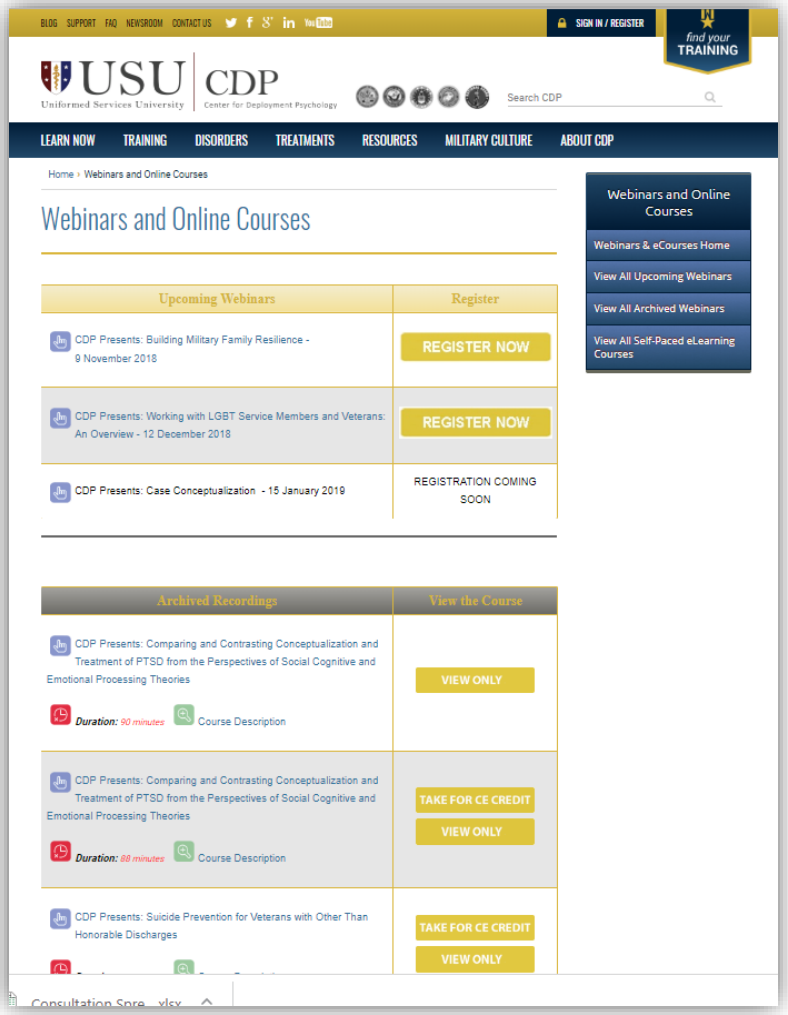
Other Learning Opportunities



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