Dr. Marjorie W.:
Welcome. My name is Dr. Marjorie Weinstock. My colleague and co-presenter for today's webinar, Dr. Sharon Birman, and I are both psychologists with the Center for Deployment Psychology. Today's webinar is titled Navy Suicide Prevention Training for Providers. The views that will be expressed in today's webinar are those of myself and Dr. Birman, and do not necessarily reflect the opinions of the Uniformed Services University of the Health Sciences, the Department of Defense, or the U.S. government. Additionally, neither myself nor Dr. Birman have any relevant disclosures to make.

Dr. Marjorie W.:
These are the learning objectives for today's webinar. By the end of the webinar, you will be able to characterize the components of risk assessment for suicide, particularly military-specific risk and protective factors, apply one psychological theory of suicide to the process of suicide risk assessment, formulate clinical decisions with suicidal patients using the VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide, and specify the steps used in developing a suicide prevention safety plan.

Dr. Marjorie W.:
First, we are going to discuss the burden of suicide, thinking about global, national, and military suicide rates. If you think about the worldwide burden of suicide, it is about one million people per year. Globally, it is estimated that about 800,000 people die from suicide each year, which is one person every 40 seconds. However, suicide is a sensitive topic. It is illegal in some countries, and in others there is no reliable tracking or registration of deaths, meaning that it is very likely under-reported, thus the idea that it's close to one million people. Despite those numbers, suicide is considered to be a low base rate phenomenon, which means that it occurs with very low frequency in almost all settings and populations. Even the most suicide-prone populations have prevalence rates no greater than 1% or 2% each year. Because of this, we tend to talk about suicide rates in N per 100,000 rather than percentages, which makes it easier to compare and contrast.

Dr. Marjorie W.:
Globally, 800,000 people translates into a suicide rate of 10.5 per 100,000, so despite the low base rate, suicide is still a major problem. Worldwide, the suicide rate has increased 60% in the last 45 years. According to the World Health Organization, in 2016 suicide accounted for 1.4% of all deaths worldwide, making it the 18th leading cause of death. This figure does not include suicide attempts, which are up to 25 times more frequent than suicide deaths.

Dr. Marjorie W.:
Suicide occurs throughout the lifespan, and was the second leading cause of death among 15 to 29-year-olds in 2016. We also know that males die by suicide 1.8 times more than females. When looking at rates in the United States, we see a slightly different picture. On average, there are about 129 suicides per day, which is one person dying by suicide every 11.1 minutes. According to the Centers for Disease Control, in 2017 there were about 47,000 suicides in the U.S., which is a suicide rate of 14 per 100,000. Suicide is the 10th leading cause of death in the United States. It is the second leading cause of death for ages 10 to 34, and the fourth leading cause for ages 35 to 54. As a frame of reference, this means that in calendar year 2017 there were more than twice as many suicides, 47,000, as there were homicides,

19,000, in the United States.

Dr. Marjorie W.:
Again, these numbers may be an under-representation. Sometimes the nature of a death is unclear, and coroners may choose to label a death as something else, so as not to stigmatize. The general population suicide rate has been on the rise since 2000. Nationally, the suicide rate increased 33% between 1999 and 2017. While historically service members had lower suicide rates than civilians, that has changed since 2007. While we hear a lot about an increase in military suicides, it's important to remember that there has been a steady rise in the general population suicide rate as well.

Dr. Marjorie W.:
It is also important to recognize that for every person who dies by suicide, there are 278 who think seriously about suicide annually, but do not die. A frequently-reported number is that there are 25 attempts for every one suicide death. Here's some additional data about suicide rates in the U.S. The suicide rate is about 3.54 times higher in men, 22.4 per 100,000 in 2017, than it is for women, which was 6.1 per 100,000 in 2017. Firearms are used in more suicides than homicides. Death by firearms is the most common method of suicide, accounting for a little more than half, 51.01%, of all suicide deaths. For the first year in history, in 2015 firearms was the most common method of suicide among both males and females. In previous years, suffocation was the most common method for females. 90% of people who die by suicide have a diagnosable and treatable psychiatric disorder at the time of their death, however most people with mental illness do not die by suicide. Additionally, the economic cost of suicide death in the United States is estimated to be $50.8 billion annually.

Dr. Marjorie W.:
Now let's talk a little bit about the epidemiology of military suicides. We're going to start by talking about the DoDSER, which stands for the DoD Suicide Event Report. The DoDSER is an annual quantitative report that compiles information about suicides and suicide attempts reported in the active duty and reserve component of all military branches. In other words, it is a suicide reporting system for the military. Historically, all the service branches used idiosyncratic suicide surveillance systems. In 2008, the DoDSER was launched as a Department of Defense solution to standardize suicide surveillance efforts across all branches of the military in support of the DoD's suicide prevention mission.

Dr. Marjorie W.:
The DoDSER program used to fall under the National Center for Telehealth and Technology, but as of October 2017, it now falls under the Psychological Health Center of Excellence, which operates under the governance of the Defense Health Agency. A few additional pieces of information about the DoDSER. Prior to January 2010, only deaths by suicide were included, however as of January 2010 it includes suicide attempts as well as suicide deaths. Also, beginning in calendar year 2012, it includes reserve component data as well as active duty data, whereas previously only reserve component data for service members who died by suicide while serving on active duty was included. The DoDSER is released annually, and it can be accessed online at the Defense Suicide Prevention Office website.

Dr. Marjorie W.:
DoDSER data is completed by trained behavioral health providers or command officials on military

installations, and at Military Health System hospitals. Each medical unit should have a DoDSER point of contact. Consistent with DoDSER reporting requirements, suicide DoDSERs are completed by the service member's command, with support and coordination with the treating provider, if needed. Suicide attempt DoDSERs are completed by the facility or operational unit responsible for the service member's evaluation for suicide. If the evaluation occurs at a civilian facility, then the DoDSER is completed by the MTF responsible for the TRICARE referral. For the reserve component, if a reservist is not on active duty, the DoDSER is completed by the reserve component command medical representative. If you don't know much about completing a DoDSER report, and would like to learn more about it, training on it can be found at the reporting website. You will need a CAC card in order to access the site.

Dr. Marjorie W.:
The data on this slide and the next comes from the 2019 DoDSER report, and reflects calendar year 2017. This slide shows the active duty suicides and suicide rates by service for calendar year 2017. The actual counts are on the top, and the rates per 100,000 are on the bottom. As you can see, there were 284 suicide deaths in the active component, and the suicide rate for all services was 21.9 per 100,000. The rate per 100,000 for the Navy in calendar year 2017 was 20.1. Comparing the rates per 100,000 to other branches of service, and to the civilian rate, is helpful. As we saw earlier, the civilian rate for the general population is 14.0. However, this rate includes all age groups, and is not age and gender matched to the DoD military population. If we look at the suicide rate for adults age 17 to 59, which is the comparable age range of the military population, in calendar year 2017 it was 17.4.

Dr. Marjorie W.:
The rates per 100,000 for the active components of the other three services were 19.3 for the Air Force, 24.3 for the Army, and 23.4 for the Marine Corps. As you can see, there are differences when you look at the individual branches. It's important to pay attention to the rate versus the count, as the raw numbers can be misleading due to the significant differences in branch strength. For calendar year 2017, the Army's rate was the highest, followed closely by the Marine Corps. These numbers do change slightly every year, but it is not uncommon to see the Army and the Marine Corps with the highest numbers.

Dr. Marjorie W.:
These are the reserve and National Guard suicides and suicide rates for calendar year 2017. Again, the actual counts are on the top, and the rates per 100,000 are on the bottom. There were an additional 222 suicide deaths in the reserves and National Guard, 92 in the reserves, and 130 in the National Guard. The corresponding suicide rates are 25.7 per 100,000 in the reserves, and 29.1 per 100,000 in the National Guard. If you recall, the rate was 21.9 for active duty and 14.0 for the general population, so 29.1 is a particularly worrisome number. It is also noteworthy that 190 of those deaths were among reserve and Guard members who were not in a duty status at the time of their death. Identifying and collecting data on non-duty suicides has been a major challenge for the military services, and as previously noted, historically data was not collected on Guard and reserve members not in a duty status. However, evolving policy has directed the incorporation of surveillance of these groups.

Dr. Marjorie W.:
The most common demographic profile of suicide decedents in the military as a whole, as well as in the

Navy specifically, are male, white, non-Hispanic ethnicity, age between 20 and 24, an enlisted rank of E-1 to E-4, with a high school education only, and this is generally consistent over time. A summary of the DoDSER data shows that personal firearms are the most common mechanism of injury, accounting for 65.4% of all calendar year 2017 suicides, and drug and alcohol overdose was the most common method of attempted suicide, accounting for 55.5% of recorded suicide attempts.

Dr. Marjorie W.:
While approximately half, 50.8%, of all those who died by suicide in calendar year 2017 did not have a documented behavioral health diagnosis, the most common behavioral health diagnoses for suicide decedents were adjustment disorders, substance use disorders, and mood disorders. Failed relationships, mostly intimate in nature, administrative and legal issues, and workplaces difficulties were the most frequently cited psychosocial stressors.

Dr. Marjorie W.:
Before moving on, let's talk for a moment about some common beliefs or myths about suicide that we often hear. The myths that you see listed on this slide come from a book called Myths about Suicide by Dr. Thomas Joiner. The first myth is that people often die by suicide on a whim. In fact however, there is almost always evidence of prior planning. Mental preparation for the eventual act of suicide is considered to be an essential characteristic of the phenomenon, although in some cases the planning may get shelved for a period of time. Moreover, those who die by suicide are actually the most deliberate in their plans. In regard to impulsivity, when clinicians hear patients describe an attempt as impulsive, they may assume that means it occurred without warning, but the data suggests this is not necessarily the case. While impulsivity is an important consideration, particularly with teenagers and young adults, clinicians are at risk of missing important information about their patient's suicidality history without further follow-up assessment. We will discuss this more later during the section on risk assessment.

Dr. Marjorie W.:
Another myth is that people who die by suicide don't make future plans. The suicidal mind is actually characterized by ambivalence. You can think of it as a tug of war between the wish to live and the wish to die, so people make plans for both options. They have a plan A, suicide, and a plan B, to continue on in their current job, relationship, et cetera. While the plans and dreams that patients describe in the future are real, the will to live may eventually lose out in the struggle with the desire for death. Thus since people who die by suicide often do have future plans, we don't recommend considering this as a protective factor clinically. In other words, it is not recommended to document future orientation as a protective factor. However, if someone is unable to make future plans, that is very informative and should be seen as a risk factor.

Dr. Marjorie W.:
A third common myth is that suicide is selfish, or a sign of excessive self-focus. This is something we often hear from loved ones, or from those trying to talk someone out of a suicide attempt. This is an understandable belief, as those who are left behind are often convinced that those who died by suicide did not consider the impact of their deaths on others. However, those who die by suicide do consider the impact of their deaths on other people, but they see it differently, as a positive instead of a negative.

Dr. Marjorie W.:
Another common belief is that if people want to die by suicide, we can't stop them. We want to dispel the myth that there's nothing that can be done to reduce suicide deaths, as it can lead to inaction with prevention efforts. This is in no way a reference to blame if a loved one has died, but rather in regard to public health initiatives. We know that there are things that can be done to decrease the likelihood that someone will attempt or die by suicide. Many people believe that removing someone's access to one method, for example a gun, will result in that person simply finding another method, for example pills. However, empirical evidence on restriction of means tells us that this is not actually correct. There are numerous instances where restricting access to one method had a significant impact on reducing suicide. Public health data, much of it from other countries, shows that the suicide rate decreases when public health barriers or campaigns are in place, which demonstrates that lives can be saved.

Dr. Marjorie W.:
The final common belief we will touch on is that suicidal statements are just a cry for help, and don't represent risk. It is a myth that all suicide talk should be considered low-risk. Too many people believe that someone who is expressing verbal threats won't go on to attempt suicide, and they therefore avoid taking steps to address safety. When people make suicidal statements, it is a serious situation and it should be addressed as such. Imagine dismissing someone who says they're having severe chest pain. While this could be a symptom of a benign condition, it could also be that the person is having a heart attack, and dismissing this symptom could be deadly. In the case of severe chest pain, it's relatively rare for the response to be they're faking or just trying to get attention, however in the case of a suicide threat it's common for the threat to be dismissed, but someone who is making suicidal statements should be taken seriously, or the results could be deadly.

Dr. Marjorie W.:
When people talk about suicide, it likely reflects the fact that they're thinking about actually enacting suicide. It's during the times of indecision that suicidal people often talk to others about what they're going through. It represents a reaching out to others, and a simple word or two from a caring other can make a real difference. In fact, the American Association for Suicidology has listed talking about suicide at the very top of its list of suicide warning signs. We'll discuss warning signs in more detail during the section on risk assessment as well.

Dr. Marjorie W.:
Next, we're going to briefly highlight some of the Department of Defense, Department of the Navy policies addressing suicide prevention. These are the primary DoD and Department of the Navy policies that BUMED wants you to be familiar with. The left-hand side of the slide lists the specific policies, and the right-hand side of the slide gives a brief description of each policy's content. We will briefly introduce each of the eight policies here, and we'll touch on a few of them more specifically throughout the training.

Dr. Marjorie W.:
DoD Instruction 6490.08, dated August 2011, details command notification requirements when providing mental health care to service members. We'll discuss this policy in more detail on the next

three slides. DoD Instruction 6490.16, dated November 2017, establishes policies and procedures for the DoD Suicide Prevention Program. It also establishes policies for reporting suicides and suicide attempts of service members and their dependents. BUMED Instruction 6520.2, dated March 2011, provides guidance regarding the evaluation and disposition of patients presenting with suicidal ideation or behavior. OPNAV Instruction 1720.4B, dated September 2018, provides policies and procedural guidance for the Navy Suicide Prevention Program.

Dr. Marjorie W.:
The BUMED memo dated 12 March 2019 discusses command notification for mental health conditions to maintain operational readiness while minimizing stigma. Marine Corps Order 1720.2, dated April 2012, provides policy and procedural guidance for the Marine Corps Suicide Prevention Program. NAVADMIN 208-16, dated September 2016, is a Navy Administrative Message that raised the awareness of existing suicide prevention programs, and announced the Sailor Assistance and Intercept for Life, or SAIL Program. Finally, the USD memo dated 28 August 2014 is a memorandum from the Under Secretary of Defense for Personnel and Readiness that provides guidance for commanders and health professionals in the DoD on reducing access to lethal means through the voluntary storage of privately-owned firearms.

Dr. Marjorie W.:
As mentioned, the information on the next three slides comes from DoDI 6490.08. There is a corresponding handout, labeled handout number one, and referred to as the line leader placemat, that summarizes this information as well. This Instruction provides guidance to healthcare providers regarding communicating with commands about mental health care, and it lists criteria to indicate when providers should notify a service member's command. Specifically, the Instruction states that healthcare providers shall follow a presumption that they are not to notify a service member's command when a service member obtains mental health care or substance abuse education services, unless disclosure is authorized for one of the reasons listed on this slide.

Dr. Marjorie W.:
However, healthcare providers shall notify the commander concerned when a service member meets the criteria for one of the listed mental health and or substance misuse conditions or related circumstances. These instances include when a provider believes there is a serious risk of self-harm or harm to others by the service member, either as a result of the condition itself or the medical treatment of the condition. This also includes any disclosures concerning child abuse or intimate partner abuse. When the provider believes there's a serious risk of harm to a specific military operational mission, which may include disorders that significantly impact things like impulsivity, insight, reliability or judgment. When the service member has either entered into or is being discharged from a formal outpatient or inpatient treatment program for substance abuse or dependence. When the service member is experiencing an acute mental health condition, or is engaged in acute medical treatment regimen that impairs their ability to perform assigned duties.

Dr. Marjorie W.:
When the service member is in the Personnel Reliability Program, or is in a position that has been pre-identified as having mission responsibilities of such potential sensitivity or urgency that normal

notification standards would significantly risk mission accomplishment. When the mental health services are obtained as a result of a command-directed mental health evaluation. When the service member is admitted or discharged from any inpatient mental health or substance abuse treatment facility, as these are considered critical points in treatment, and support nationally-recognized patient safety standards. And when the notification is based on other special circumstances in which the execution of the military mission outweighs the interests served by avoiding notification. This is something that is determined on a case-by-case basis by a healthcare provider or other authorized official of the MTF, or a CO at the O-6 or equivalent level or above.

Dr. Marjorie W.:
To promote an environment that provides support and minimizes stigma for service members receiving mental health services, DoDI 6490.08 instructs healthcare providers to give only a minimum amount of information to commands, while ensuring that they have enough understanding to make mission decisions. That information should include a diagnosis, a description of the prescribed treatment and the prognosis, ways that the command can support the treatment, and any duty restrictions or limitations related to the service member's rate or occupation, for example, any limits on carrying weapons.

Dr. Marjorie W.:
If a patient is at risk for any reason related to safety of self or others, provide an explanation of why and what the risk is, as well as what steps can be taken currently to control the risk, and steps the command and provider can take to minimize risk in the future. Providers should also be aware of factors impacting patients, such as their current job, their unit's mission and status in the training and deployment cycle, and any possible significant upcoming transitions the patient may experience, for example an upcoming transfer to a different unit, or separation from service. This information was also emphasized in the BUMED memo dated 21 March 2019. This memo indicates the command should always receive timely information about deployment-limiting mental health conditions, and it reiterated the importance of creating a culture of readiness and awareness, ensuring that processes are put in place to notify commanders of these conditions, while also providing only the minimum amount of information necessary to satisfy the purpose of the disclosure.

Dr. Marjorie W.:
Having cooperative discussions with commanding officers, within the boundaries of what...

Dr. Marjorie W.:
If discussions with commanding officers within the boundaries of what is allowed has the potential to markedly improve care and ensure that high risk personnel are identified or appropriately monitored. These discussions ensure a positive relationship between the commander and mental health provider; both of whom are concerned about the health and wellbeing of their service members.

Dr. Marjorie W.:
According to DoD 6490.08 notification to the command, so being made to the commander personally or to in another person's specifically designated by the commander for this purpose. Included in the instruction is guidance to commanders indicating that they should protect the privacy of information

provided to them just as they would with any other health information. Commanders are also instructed to reduce stigma through positive regard for those who seek mental health assistance to restore and maintain their mission readiness. Again, just as they would view someone seeking treatment for any other medical issue. It is also important to remember that all communications with command around these issues should be documented.

Dr. Marjorie W.:
According to OPNAV instructions. 1720.2B commander should designate at least one suicide prevention coordinator for their unit. That person's duties include: scheduling and coordinating regular suicide prevention trainings using the most current guidance, ensuring that suicide prevention materials are accessible at the command, and making referrals to the SAIL program as directed by the command. For those of you who may not be familiar with the SAIL program, which again stands for Sailor Assistance and Intercept for Life, it was established to support sailors with suicidal ideation or attempts by providing outreach and case management services. We'll hear more about this program when we discuss suicide prevention resources toward the end of the webinar.

Dr. Marjorie W.:
Similarly, according to Marine Corps, order 1720.2 in the Marine Corps, all CO's that are battalion or squadron level and above appoint a Marine to serve as the suicide prevention officer. In the Marines, this is an administrative collateral duty that involves coordinating resources as part of the command suicide prevention program.

Dr. Marjorie W.:
Now we are going to shift gears and talk about nomenclature or the language we use around suicide. Consistent accurate nomenclature is important in both clinical as well as research and public health settings. In clinical practice, it's important to accurately complete risk assessments for accurate documentation to evaluate progress and treatment and to collaborate with other providers who may be treating the same patient.

Dr. Marjorie W.:
In research settings, it's important to be able to measure and describe suicide rates and to compare studies and analyze suicide statistics across cohorts. It's difficult, for example, to compare studies when the definition of a suicide attempt differs from one study to the next.

Dr. Marjorie W.:
In terms of surveillance, it's important in order to accurately report suicide attempts, deaths and other forms of self-directed violence. It's impossible to truly track suicidal behavior. If we don't have the same definitions.

Dr. Marjorie W.:
On this slide, we will cover some terms and explain a bit about them. Historically, the field of suicidology has struggled with the lack of a universally agreed upon definition for suicide and associated terms, which has resulted in confusion and misunderstanding. This can become even more problematic given the stigma and judgment that's frequently been associated with suicide.

Dr. Marjorie W.:
On the left hand side of the slide are some terms that used to be a part of the language in suicidology, but that are no longer recommended by the CDC. Committed suicide is probably the most frequently used term across multiple settings, but it has negative connotations. The origin of this phrase is from the legal system where committed implies criminal intent. Also, the verb commit, when followed by an act is generally reserved for actions viewed as either sinful or immoral. For example, committing a burglary, murder, et cetera. To portray suicide as a crime or a sin stigmatizes those who experienced suicidal thoughts or attempt suicide, which can deter people from seeking help, which is exactly the opposite of what we're hoping to do.

Dr. Marjorie W.:
Suicidality is a vague term. It often refers simultaneously to both suicidal thoughts and suicidal behavior. It's important particularly in the context of clinical documentation to make clear whether a patient manifests ideations versus behaviors and they should each be addressed separately. Parasuicide and suicide gesture or threat are terms that incorporate a value judgment, and they could potentially be seen as minimizing or pejorative.

Dr. Marjorie W.:
Parasuicide used to be used to refer to all non-fatal suicide behavior. Whether or not the individual actually had intent to die, but the term was deemed to be confusing and the World Health Organization now recommends not to use it. Failed attempt sounds like a failure to achieve a desired outcome. For many patients struggling with self esteem issues who may already see themselves as failures, a suicide attempt not resulting in death can seem like another failure; and it's important not to feed into this. While this language generally isn't used directly with patients, it is important to avoid it in documentation as well, especially with DOD patients since they may access their medical records fairly readily. Similarly, successful and completed, both imply achieving desired outcomes and we don't want to make suicide sound like an achievement.

Dr. Marjorie W.:
On the right hand side of the slide are alternate terms that are recommended. It's preferable to use descriptive, nonjudgmental terms to describe suicidal thoughts and behaviors such as suicide, die by suicide, suicidal and non-suicidal self-directed violence, suicidal thoughts, and suicidal ideations.

Dr. Marjorie W.:
Due to this lack of consistency, the CDC in collaboration with the VA's visit 19 Rocky Mountain MIRECC or Mental Illness Research, Education and Clinical Center in Denver, Colorado, developed a standard nomenclature to describe suicide related behavior. This collaboration resulted in the Self-Directed Violence Classification System or SDVCS for short, which is a classification system for both suicidal and non-suicidal self-directed violence.

Dr. Marjorie W.:
Suicidal ideation, while not a behavior, is also included in this classification system. The VA has adopted this system, it has trained VA providers in the SDVDCs. Basically the SDVCS is a taxonomy of terms and

corresponding definitions for thoughts and behaviors related to both suicidal and non-suicidal self-directed violence. The system also includes a modifiers to address intent injury and whether or not the act was interrupted. And in this way we start to have a shared language.

Dr. Marjorie W.:
The SDVCS clinical tool was created to aid clinical decision making using a decision tree model. A copy of this SDVCS clinical tool is provided as handout number two. This clinical tool consists of three different decision trees that help you walk through making a determination as to the appropriate term to use. Decision tree A is used when there are suicidal thoughts, decision tree B, when there are suicidal behaviors without injury, and decision tree C, when there are suicidal behaviors with injury.

Dr. Marjorie W.:
At the top of the tool, there are three questions that are very helpful, that can help you determine which of the three decision trees you should be looking at. The first question is, is there any indication that the person engaged in self-directed violent behavior that was lethal, preparatory or potentially harmful? If the answer is no, you proceed to question two, and if yes to question three.

Dr. Marjorie W.:
The second question is, is there any indication that the person had self-directed violence related thoughts? If the answer is no to both questions one and two, there's insufficient evidence to suggest self-directed violence, which means that no SDV term is applicable. If yes, you proceed to decision tree A, related to suicidal thoughts.

Dr. Marjorie W.:
The third question is, did the behavior involve any injury or did it result in death? If no, you proceed to decision tree B, suicidal behaviors without injury, and if yes, you proceed to decision tree, C suicidal behaviors with injury. Definitions of key terms are also included on the second page of the clinical tool.

Dr. Marjorie W.:
Here's a brief overview of the types of suicidal and the related thoughts and behaviors that are covered in this system. First, let's look at the nomenclature related to suicidal thoughts. Non-suicidal self-directed violence ideation is the desire to engage in self inflicted injurious behavior, but with no evidence of intent to die. These individuals may engage in self harm ideation to attain some other end. For example, to seek help regulate negative mood, punish others, receive attention, et cetera. And suicidal ideation is what we traditionally think of as suicidal thoughts.

Dr. Marjorie W.:
In regard to behavior, the nomenclature includes the following terms, preparatory behavior. It is behavior that occurs before a potential injury has begun. For example, assembling a method, perhaps buying a gun or stockpiling medication, or saying goodbye. For example, writing a suicide note, giving things away, or taking out a life insurance policy.

Dr. Marjorie W.:
Non-suicidal self-directed violence, is behavior that results in injury, but there is no suicidal intent. This

is the behavioral equivalent of non-suicidal self-directed violence ideation.

Dr. Marjorie W.:
Undetermined self-directed violence is also behavior that results in injury, but the intent is unclear. For example, when the person is unconscious, incapacitated, intoxicated, disoriented, acutely, psychotic or dead from something like a car crash or an overdose, or the person is reluctant to admit the intent to die. And self-directed violence and suicidal self-directed violence is a suicide attempt.

Dr. Marjorie W.:
Even though a common nomenclature is helpful in shaping our thinking and as such as a critical component of risk conceptualization, it's important to remember that classification is not equivalent to risk assessment. Again, as a reminder, we'll be talking more about risk assessment later in the webinar.

Dr. Marjorie W.:
While we are not going to go into any greater detail about the terminology, I encourage you to go to the Rocky Mountain MIREC website to learn more about the SDVCS. This website has many training tools and videos that can help you become familiar with this list of terms and their definitions, including slides of the training that was given when the VA rolled out this nomenclature, as well as five training vignettes featuring videos of the SDVCS.

Dr. Marjorie W.:
Now we're going to transition to a discussion of some of the theoretical underpinnings of suicide risk. The field of suicidology is delayed compared to other mental health issues, but there have been remarkable advances in the past 10 years. Although we have known about demographic risk factors for a long time, for example, being an older white male puts one at higher risk, the field of suicidology was relatively devoid of theory for many years. Things began to change in the 1990s when psychological theories of suicide risk began to be developed.

Dr. Marjorie W.:
Initially, theories were of depression versus suicide. You would often read one of these theories and think, this sounds an awful lot like a theory of depression. How does this help me distinguish risk from depression, from risk for suicide? Many of these were overwhelming to interpret and too complicated to really be useful. For example, 20 risk factors all pointing to suicide.

Dr. Marjorie W.:
Because of the difficulty in studying suicide as an outcome, suicidal thoughts and or behaviors are often looked at as proxies for suicide. However, most clinical correlates of suicidality appear to be best conceptualized as coreless of suicidal ideation. Most often cited risk factors for suicide, things like depression, homelessness, most mental disorders, and even impulsivity predict suicidal ideation, but they don't distinguish those who have made a suicide attempt from those who've experienced ideation without attempts. This is important because most people with suicidal ideation don't go on to make suicide attempts. Thus, it becomes critical from the field to understand the progression from suicidal ideation to behavior.

Dr. Marjorie W.:
In response to this need, Klonsky and May, two suicide researchers, proposed the ideation to action framework, which states the development of suicide ideation and the progression from ideation to suicide attempts are distinct processes with distinct explanations. Dr. Thomas Joiner's Interpersonal Psychological Theory of suicide risk or IPT for short, can be thought of as the first theory based off of the ideation to action framework. It's a theory that attempts to address some of the limits of these prior models.

Dr. Marjorie W.:
Dr. Joiner is a suicide researcher who's been instrumental in the area of suicide prevention research. He's both a researcher and he lost his own father to suicide, and he includes personal stories in much of his writing. Dr. Joiner wanted to answer the question of why it is some people choose to die by suicide while others don't? He developed IPT in 2005, and with this theory he attempted to answer that question. As you will see, IPT is a theory that is both specific to suicide and parsimonious. And while applicable to a military population, this theory is not specific to service members.

Dr. Marjorie W.:
Joiner theorized that to die by suicide, you need both the desire to die and the ability to do so. The left hand side of this model depicts the desire to die, with a risk for suicidal ideation. Joiner hypothesized that the two most significant contributors to serious suicidal ideation are thwarted belongingness, with the feeling that you don't belong or fit in, and perceived burdensomeness; with the feeling that you were a burden to others.

Dr. Marjorie W.:
The right hand side of this model depicts the ability to die by suicide. Joiner believed that in order to die by suicide, in addition to having a desire to die, someone who also must've acquired the capability to do so, which goes against our innate self-preservation instinct. It's when these two elements occur together, that someone is at risk for a serious attempt or death by suicide.

Dr. Marjorie W.:
According to this model, if we think about patients with chronic suicidal thoughts but no attempts, the contributors on the left hand side of the model, thwarted belongingness and perceived burdensomeness are coming into play, but they have no acquired ability, which is needed in order to be able to overcome instinct and take one's own life. Let's look a little bit more closely at each piece of this model.

Dr. Marjorie W.:
First, we're going to talk about the left hand side of the model or that desire to die. Remember that according to the model, this includes thwarted belongingness and perceived burdensomeness. In regards to thwarted belongingness, in order to feel as if they belong, someone needs both frequent interactions with others and persistent feelings of being cared about. In other words, interactions with others must be both frequent and positive.

Dr. Marjorie W.:
In regards to perceived burdensomeness, this means feeling ineffective and sensing that your loved

ones are threatened or burdened by this in effectiveness. In essence, what this means is that someone has done the mental calculation that their death is worth more than their life to their family and loved ones. One of the key things to remember that this is perceived burdensomeness, they perceive themselves as a burden and that this state is permanent and stable.

Dr. Marjorie W.:
Now let's look at the right hand side of the model or acquired capability. According to this theory, fear is reduced through habituation or repeated exposure to pain or injury, either over the short or the long term. Previous suicidal behavior is the clearest example of an experience that would provide an opportunity for habituation to suicidal behavior. However, Joiner and others have made the case that any experience that reduces the fear of injury also has the potential to increase one's ability to engage in suicidal behavior.

Dr. Marjorie W.:
One example of this is, non-suicidal self-injury, which is self-directed deliberate behavior that results in injury to oneself without evidence of suicidal ideation. This has been found to be a significant risk factor for suicide attempts among active duty personnel in an outpatient setting.

Dr. Marjorie W.:
This slide shows the three main components that lead to acquired capability. In addition to fearlessness of pain, injury or death. The acquisition of knowledge regarding the lethal means for suicide and an increased ability to tolerate physical pain and injury can also lead to an increased ability to engage in suicidal behavior. As noted earlier, IPT was not developed specifically for a military connected population. It is not difficult to see how it might apply to service members and veterans. For example, they may have an increased exposure to pain, injury and death, an increased comfort with firearms, and they may have learned to pain as part of their military training.

Dr. Marjorie W.:
Next we are going to talk about Dr. David Rudd's Fluid Vulnerability Theory of suicide risk or FVT for short, which is specific to risk assessment. Dr. Rudd is also a suicide researcher, and he developed FVT in 2006. Fluid Vulnerability Theory is a theory that explains the fluctuating nature of suicide risk. It explains the variability of suicidal thoughts and behaviors throughout a person's life. It's a way of understanding the onset of a suicidal episode, which is also referred to as the activation of the suicidal mode.

Dr. Marjorie W.:
This theory can be particularly helpful in trying to understand patients who may have low risk when assessed one day, and then move quickly into an acute state a few hours or days later. Like the IPT theory, this theory is also not specific to service members.

Dr. Marjorie W.:
The primary tenant of FVT is that suicide risk is inherently dynamic and changes over time. Thus, suicidal episodes are time limited. In other words, someone is not actively suicidal all of the time. FVT conceptualizes suicide risk is an interaction of two dimensions, baseline risk and acute risk.

Dr. Marjorie W.:
Baseline risk is based on an individual's predisposing vulnerabilities. For example, genetic predispositions or history of abuse that elevate their overall likelihood for experiencing a suicidal crisis over the longterm. These are risk factors that may be best treated in longterm therapy. Acute risk corresponds to those short term changes and triggers your aggravating factors that lead to the onset of a suicidal episode. These triggers might be environmental stressors. For example, a relationship breakup or even basic training, or internal stressors. For example, thoughts of being a failure. And these are things that you can work on in a therapy session with patients. Overall, suicide risk takes both baseline risk and acute risk into account. In essence, it's the cumulative effect of baseline risk and acute risk.

Dr. Marjorie W.:
Let's look a little bit more closely at some of the assumptions of Fluid Vulnerability Theory. As mentioned, suicidal episodes are conceptualized to be time limited. Someone can't remain in a state of acute risk or actively suicidal 100% of the time. While everyone has some level of baseline risk, it varies from person to person. Baseline risk is determined by static variables and personal history, such as genetic predispositions, personal history of abuse, family history of suicide, history of non-suicidal self-directed violence, or exposure to killing or death, which in a military population could be combat exposure.

Dr. Marjorie W.:
Basically, baseline risk is someone's level of risk when they are asymptomatic. Some people have a lower baseline risk or a higher threshold, such that they're suicidal mode is almost never activated. While others have a higher baseline risk or lower threshold, such that a particular stressor, for example, the loss of a relationship can easily trigger a suicidal crisis.

Dr. Marjorie W.:
According to FVT, those individuals with many static vulnerabilities to suicide, or high baseline risk experience, what's known as chronically elevated suicide risk. These individuals remain at relatively elevated risk for suicide despite the resolution of their active suicidal crisis. So while everyone has a baseline risk, it's a not comparable for everyone. Of note multiple attempters, those with two or more past attempts, are considered to be at an increased vulnerability for suicidal behavior. In other words, they have an increased level of baseline risk and correspondingly, a lower threshold of activation.

Dr. Marjorie W.:
Acute risk, on the other hand, reflects triggers or aggravating factors that may vary in intensity and duration but eventually subside. Thus, acute risk is always time limited. Once a suicidal episode resolves, people return to their baseline risk level, not to zero.

Dr. Marjorie W.:
In essence, FVT is a diaphysis stress model. Suicidal episodes result from the interaction of a predisposition; in this case, baseline risk, and aggravating factors; acute risk. When an underlying vulnerability is strong, less stress is needed to trigger a suicidal episode and vice versa. One way to conceptualize this is to think of a bucket of rainwater. When the bucket is full and overflowing, a person may have suicidal thoughts and or behaviors.

Dr. Marjorie W.:
Imagine that each of us has a bucket with a certain amount of water in it that we carry around with us from day to day. Some of us have a lot of water in our bucket, while others have only a little. In this example, the concept of rain is analogous to the stressful life events we all experience. For some people, it only takes one or two rain events to make the bucket overflow, because their bucket already has a lot of water in it. This could be the result of something like into trouble at work, an argument with a spouse or even just a disappointment. For other people whose bucket may have only a few drops of water in it. It could take a huge amount of rain to even come close to filling their bucket.

Dr. Marjorie W.:
As noted earlier, Fluid Vulnerability Theory was also not developed specifically for military connected population. But there are researchers who have attempted to look at how FVT applies to the military population. These studies have found that those service members with pre-military suicidal thoughts or attempts, in other words, those with the full bucket, with the same individuals with post enlistment, suicidal ideation and attempts.

Dr. Marjorie W.:
Pre-military suicide attempts are one of the most prominent predictors of suicide attempts that occur after joining the military. Those service members are six times more likely to make a suicide attempt. Pre-military self-injurious thoughts and behaviors are also associated with an increased risk for suicide attempts and more severe suicidal ideation. You can think of these service members with pre-military suicidal thoughts and attempts as having elevated baseline risk that increases their likelihood of future attempts as they're exposed to new stressors. In other words, they have a lower threshold for activation. This also makes sense in the context of Joiners IPT theory, as more suicide attempts leads to an increased level of acquired ability.

Dr. Marjorie W.:
Before moving on to the section on assessing risk, we want to briefly mention the VA DoD Clinical Practice Guideline for the assessment and management of patients at risk for suicide. The current version of which was published in 2019. The Clinical Practice Guideline or CPG provides a general guide to best practices for addressing suicide with military connected patients. It's intent is to facilitate consistent practices and provide a structured framework to help improve patient outcomes. The guideline reviews all available research and makes recommendations to assist with decision making in the areas you see listed on the slide.

Dr. Marjorie W.:
Screening, research is presented on suicide screening tools, as well as the discussion of risks and harms of suicide screenings. Evaluation, the CPG uses the suicide risk evaluation to describe the overall process of risk determination, all components of risk assessment, warning signs and protective factors are included. Risk management, which includes addressing safety during times of crisis. And treatment with pharmacologic and nonpharmacologic treatments are presented. The CPG's are publicly available and easy to access besides suicide. Other topics with VA DoD Clinical Practice Guidelines include depression, substance use disorders, PTSD and concussions.

Dr. Marjorie W.:
The 2019 CPG places an emphasis on the importance of collaboration between the patient and provider as well as those who support the patient, including family or anyone the patient identifies. As part of the CPG development process, patient focus groups were conducted to further understand and incorporate the perspective of patients at risk for suicide.

Dr. Marjorie W.:
Some important recommendations that came from these focus groups include: to recognize the importance of trust between the patient and provider as well as the necessity for the patient to have consistent, open and respectful communication in the management of their care. That individualized care should be based on patient needs and preferences. It's especially important in this patient population for providers to be aware of the patient's history and to provide care that is sensitive to their experiences. To provide patients with comprehensive and understandable information regarding available interventions and treatment options, so they can make an informed decision about their care. And to involve family members and other support persons in the patient's care, in accordance with patient preferences, whenever.

Dr. Marjorie W.:
... In the patient's care in accordance with patient preferences whenever possible. Next, my co presenter, Dr. Berman, will discuss conducting risk assessments with this population.

Dr. Marjorie W.:
Thank you, Marjorie. In this next section, we'll examine some components of a risk assessment. Patients identified through screening or clinical evaluations as having suicidal thoughts or intent should be further assessed for risk for suicide. The conceptual model of suicide is a framework to help providers conceptualize the person's overall level of risk for suicide. While most people are familiar with the concept of protective factors, it is important that we take some time to distinguish between risk factors and warning signs. What we tend to see is a temporal relationship between risk factors and warning signs.

Dr. Marjorie W.:
In general, risk factors tend to be more distal and static in nature. They tend to be nonspecific and are often non-modifiable characteristics that are associated with risk at the population level, so we might be looking at things like demographic variables. We might be looking at things like people's historical experiences, things like history of suicide attempts, history of hospitalizations, history of suicide in family members. In other words, these tend to be factors that increase the likelihood of some negative outcome occurring, but they do not necessarily indicate that this risk is imminent.

Dr. Marjorie W.:
Warning signs on the other hand tend to be more proximal and fluid in nature. These are symptoms and behaviors that can signal an increase in the probability that an individual intends to engage in suicidal behavior in the immediate future. Let's use the example of a heart attack. Risk factors for heart attacks can include things like tobacco use, obesity and high cholesterol. Warning signs might be things like

chest pains, shortness of breath, and nausea.

Dr. Marjorie W.:
The purpose of a careful suicide-focused risk assessment is to identify ways to increase a patient's overall safety, to reduce their risk and to promote wellness and recovery. To most effectively do this, you want to make sure to first, gain a complete understanding of the medical, social and mental health history, can be helpful to utilize structured suicide risk assessment instruments in conjunction with a clinical interview whenever possible.

Dr. Marjorie W.:
It is important to obtain collateral information from family, friends, unit, commanders and the medical records to support the subjective report of the patient. And of course, you want to ensure that you're using a direct nonjudgmental and collaborative approach. It is particularly important to establish rapport when working with suicidal patients so that you can gather the most reliable information and help to cultivate hope.

Dr. Marjorie W.:
The Columbia Suicide Severity Rating Scale, or for short the CSSRS, is a questionnaire used for suicide assessment developed by Columbia University with NIMH support. The scale is evidenced supported and is part of a national and international public health initiative involving the assessment of suicidal thoughts and behaviors. The scale has been successfully implemented across many different settings including both primary care and military settings.

Dr. Marjorie W.:
There are a number of versions of the CSSRS. The first is the lifetime or recent version, which allows practitioners to gather lifetime history of suicidality as well as any recent suicidal ideation or behavior. This form has a military specific version. The since the last visit version of the scale assess the suicidal thoughts and behaviors since the patient's last visit and is intended for use with patients who have completed at least one lifetime CSSRS assessment.

Dr. Marjorie W.:
The screener version of the CSSRS is a condensed form of the full version. It is three to six questions in length and is commonly used for clinical triage by first responders in emergency department settings and crisis call centers as well as for non mental health users such as primary care providers, teachers or clergy. Lastly, the risk assessment page provides a checklist for protective and risk factors for suicide, focusing specifically on those factors supported by empirical research in assessing suicidal ideation and behavior clinically.

Dr. Marjorie W.:
The PHQ item number nine has been recommended in the VA DOD clinical practice guidelines as a preliminary screening tool to identify suicide risk. The PHQ is the validated self or interviewer administered instrument that assesses DSM five criteria and symptoms and effects on functioning. The PHQ can be administered quickly and is simple to score, easily understood and available in multiple languages. In some settings, the PHQ-2, plus item number nine from the PHQ-9, has been utilized as a

primary screening tool to identify suicide risk. According to the current Navy primary care guidance, a PHQ-2 must first be administered, which will then be followed by a PHQ-9 for any positive PHQ-2 screens.

Dr. Marjorie W.:
When conducting a thorough suicide risk evaluation, there are many different risk factors to be aware of and which should be included during a risk assessment. It might be helpful to think about them in terms of different categories. Let's first talk about health considerations. When considering health conditions, you want to make sure to consider mental health conditions, but there's depression, substance use disorders, bipolar disorder, psychotic spectrum disorders and anxiety disorders, among others. You want to also make sure to consider physical health conditions such as chronic pain, traumatic brain injury, sleep disorders or chronic illnesses.

Dr. Marjorie W.:
In your suicide risk evaluation, you want to make sure to consider environmental situations such as access to lethal means, stressful life events like divorce, relationship difficulties, financial problems or losses, occupational problems such as difficulties at work, unemployment or transition out of the military, and even exposure to somebody else's suicide. Lastly, you want to consider historical factors such as any history of previous suicide attempts as well as history of non-suicidal self-directed violence, family members' history of suicide, and any history of abuse, trauma, or neglect.

Dr. Marjorie W.:
In this slide, you can see the co-occurring health conditions that can impact overall risk as well as influence a patient or providers treatment priorities or clinical decisions. Let's first talk about mood and anxiety disorders. A large scale epidemiological chart review study out of Ann Arbor, Michigan VA, looked at almost 6 million veteran records and found that the conditions with the strongest relationships to suicide deaths in the sample included bipolar disorder, substance use disorder, depression and anxiety disorders other than PTSD.

Dr. Marjorie W.:
When we consider substance use disorders, we know that increased substance use can lead to decreased inhibition and thereby increased impulsivity, which can increase overall suicide risk. It is therefore important to assess for substance use, including things like increased alcohol use and to ensure appropriate referrals for treatment are made.

Dr. Marjorie W.:
When we consider TBI, it's important to keep in mind that service members have greater exposure to events that can lead to TBI, especially to repeated TBI exposures. In fact, TBI has been considered the signature injury of our OEF and OIF wars. A recent meta analysis shows that concussion and/or mild traumatic brain injury is associated with a twofold higher risk of suicide. It's important to keep in mind that suicide risk is associated with TBI severity, with the cumulative symptoms of TBI and with the numbers of TBIs.

Dr. Marjorie W.:

When we consider sleep disturbances, we know that many service members experience sleep problems. In one study, sleep problems outperformed depression and hopelessness as current and future predictors of suicide ideation and behavior in young adults in the military. Chronic pain like TBI is a risk factor for suicide in service members, particularly as there is an increased likelihood of exposure to events that can lead to the experience of chronic pain. Head pain and pain classified as other non arthritic has been associated with increased suicide risk.

Dr. Marjorie W.:
Risk assessment is crucial when working with suicidal patients. That said, many challenges exist when trying to determine risk and identify which patients are most at risk for dying by suicide. Suicide risk assessment is not an exact science. There is no litmus test or mathematical formula which will tell us with precision who will go on to engage in suicidal behaviors.

Dr. Marjorie W.:
First of all, we need to keep in mind that we're reliant on our patients to be honest and forthcoming with us during times of acute risk. The truth is is that we can ask all of the right questions, document, engage the literature, consult, and sometimes our patients may choose not to share with us. There's an element of freewill and patients sometimes might feel reluctant to share everything. You also want to keep in mind that suicide is not a specific diagnosis, but rather we're looking at a specific behavior, which can occur in the context of numerous different disorders across the DSM. In other words, suicide is considered trans diagnostic in nature.

Dr. Marjorie W.:
In essence, we're aiming to intervene and predict an event which could in theory occur at any point in time. In other words, we're trying to engage a point prediction. As we just saw earlier in the fluid vulnerability theory, suicide risk is dynamic and can fluctuate by weeks, days, or even just hours. As a result, it can be incredibly difficult to predict the moment at which risk is most elevated. We also know that there can be legal consequences of false negative assessments of risk and at the end of the day, suicide is a relatively low base rate behavior, making it particularly challenging to study.

Dr. Marjorie W.:
Military members are susceptible to the same risk factors as the general public, but also have distinct features associated with their profession and lifestyle. Relationship problems are very common psychosocial stressor and risk factor for many military members. Relationship problems is a very common psychosocial stressor and risk factor for many military members. In the past several [inaudible 00:13:23], family and relationship stressors during the past 90 days were the most common type of stressor reported.

Dr. Marjorie W.:
Separation from service has also been found to be a risk factor. In a recent retrospective cohort study examining the association between deployments and suicide among almost 4 million US military personnel who served in OEF/OIF, the researchers found an increased rate of suicide associated with separation from military service. This was found regardless of whether service members had deployed or not.

Dr. Marjorie W.:
Rates of suicide were particularly elevated for service members who separated with less than four years of military service or who did not separate with an honorable discharge. The highest risk was found in the first year after separation for both those that had deployed and those who had never deployed, but this risk was found to continue up to six years post separation from the military. Demotion has also been found to be a significant response or for suicide.

Dr. Marjorie W.:
Firearm access is something important to consider. Researchers have found that the relationship between suicide ideation and future suicide attempts was greater among service members who had easy access to firearms. In other words, those service members who had their firearms stored, loaded, and unsecured were at higher risk for suicide than those service members who had store their firearms unloaded and locked.

Dr. Marjorie W.:
Stressful military life events has also been found to increase risk among military service members. in a meta analysis of 22 published studies, there was a significant relationship between suicide-related outcomes and specific combat experiences such as killing or exposure to death, suggesting that certain types of experiences that happened while deployed, such as exposure to death and killing, may explain suicide related outcomes in the military. Clinically, this means the whether or not a service member or veteran has deployed can be less important than knowing what he or she specifically experienced during that deployment.

Dr. Marjorie W.:
Acute warning signs are important to detect because they point to a patient that may be at heightened risk or even at imminent risk of engaging in suicidal behaviors. When comparing warning signs to risk factors, warning signs are considered to be the earliest detectable signs that might indicate heightened risk for suicide in the near term future. So we're really looking at minutes, hours or days.

Dr. Marjorie W.:
In 2003, the American Association for Suicidology, or for short AAS, convened a working group to examine the issue of warning signs. The goal was to reach a consensus on creating an identifiable set of warning signs that would be in hierarchical form depending on the immediacy of risk. In the new clinical practice guidelines, warning signs are divided into two categories called direct and indirect warning signs.

Dr. Marjorie W.:
According to the American Association for Suicidology, the tier one warning signs that were identified by the working group include circumstances that require immediate intervention such as calling 911 or seeking immediate professional help. These include communicating suicidal thoughts or intent verbally or in writing, seeking access to lethal means such as medications or firearms. The 2019 CPGs include demonstrating preparatory behaviors such as putting affairs in order as a direct warning signs, which also included in the tier one list.

Dr. Marjorie W.:
The tier two warning signs identified by the AAS working group includes circumstances that direct an individual to seek mental health care services. These can include things such as hopelessness, anger, rage, recklessness, feeling trapped, increased substance use, withdrawal, agitation, anxiety, insomnia, or hypersomnia, dramatic mood changes or even purposelessness.

Dr. Marjorie W.:
Is path warm is a mnemonic to help remember these warning signs. I stands for ideation. S stands for substance abuse. P stands for purposelessness. A stands for anxiety. T stands for feeling trapped. H stands for hopelessness. W stands for withdrawal from friends, family and society. A stands for anger. R stands for recklessness and M stands for mood changes.

Dr. Marjorie W.:
Protective factors include capacities, qualities, environmental and personal resources that increase resilience. They tend to drive individuals towards growth, stability and health. Ultimately, protective factors increase coping with different life events and decrease the likelihood of suicidal behavior. This is a simple list of some protective factors that have been identified in the literature.

Dr. Marjorie W.:
Assessment of risk factors should be a core component of a comprehensive risk evaluation. When evaluating suicide risk, the clinical practice guidelines suggest against using a single instrument or method. Rather, it is suggested to use multiple tools including a clinical interview to gather information. The following are considered the broad areas for suicide risk assessment. According to the current clinical practice guidelines, the first six categories, which you can see are bolded, have the most evidence indicating increased risk for suicide, previous suicidal thoughts, intent and behavior. Keep in mind the previous suicide attempts is our most reliable predictor of future suicide attempts.

Dr. Marjorie W.:
It is important to assess for current ideation, including frequency, intensity and duration, level of intent, planning, rehearsal behaviors, preparatory behaviors, specificity of method, and recent self injurious behaviors. These are considered observable warning signs, acute and chronic life stressors, especially things such as losses of relationships, a loss of a job, exposure to suicide or other traumatic events, social isolation and legal disciplinary issues.

Dr. Marjorie W.:
General psychiatric symptoms such as depressed mood, anxiety, panic, insomnia, problem solving difficulties, agitation, anger, rumination, impulsivity, psychotic symptoms and very importantly, hopelessness. Previous psychiatric hospitalizations and access to lethal means, the CPG specify asking specifically about access to firearms, medications and household poisons.

Dr. Marjorie W.:
The Risk Stratification Tool was developed by the Rocky Mountain MIRECC in Denver, Colorado, using a medical-legal informed practice. Using this tool is consistent with an appropriate standard level of care

and is designed to help clinicians more effectively assess risk to ensure they make the best clinical decisions for their patients. This tool is consistent with the clinical practice guidelines and stratifies risks in terms of both severity and temporality. So in other words, chronic and acute risk are each determined independently, allowing providers to identify each patient's acute and chronic risk to come up with the most accurate clinical picture.

Dr. Marjorie W.:
For example, it helps to more accurately describe a patient who has a history of previous suicide attempts, many risk factors, but who presents with very few to no warning signs and denies any current or suicide ideation or intention with this risk stratification. In the past, clinicians may have wanted to elevate the overall level of risk because it might've seemed clinically imprecise to label that person low or even moderate risk as a result of the risk factors and history of suicidal thoughts or behaviors.

Dr. Marjorie W.:
But now using this tool, clinicians can indicate their awareness of multiple chronic risk factors by placing someone at a high chronic risk while also recognizing only few or no warning signs by indicating a lower, moderate acute risk. In this way, this tool can be incredibly helpful. For example, in your documentation you might write something like, "Although the patient carries many static risk factors, placing him or her at a high chronic risk for engaging in suicidal behaviors, his or her present mood, stable housing, sustained sobriety and suicide ideation below baseline with no current intent suggests low acute or imminent risk for suicidal behaviors."

Dr. Marjorie W.:
At this time, I would like to transition our discussion to the initial management of a suicidal patient. Once acute and chronic risk levels have been identified, the clinical practice guidelines recommend crisis response planning in order to ensure addressing safety concerns. We always want to make sure that we take care to match the level of care to the level of risk that's identified.

Dr. Marjorie W.:
As you're working to mitigate risk and ensuring patient safety, you want to consider ways to restrict access to legal means. You want to ensure completion of a safety plan and we want to assess patient's level of social support and consider how to address any needs for increase in social supports. Consider using command as a potential source of support and start asking yourself what might be some other resources, chaplains, friends, is there anybody else who can be a part of their network? Lastly, you want to make sure to work with patients to increase their coping skills and help them to most effectively manage the acute suicidal crisis. Regardless of which actions are taken, risks should always continue to be monitored over time.

Dr. Marjorie W.:
When working with service members, you always want to make sure to inform command when clinically appropriate and determine the utility of command involvement in the patient's care. You want to address any barriers to care including stigma. You can do this by educating the patients and others if needed about suicide, about stigma, about treatment options, and about management strategies.

Dr. Marjorie W.:
You want to ensure follow up during transition periods as well as enroll the patient in risk management packaging. Both safety plans and crisis response plans are predetermined, prioritized written list of coping strategies and sources of support that patients can use during times of crisis. Safety plans are effective for many reasons. They're brief so it doesn't take much time to complete them. They are collaborative in nature and therefore engage the clients an active participation. They are proactive as they employ, build upon and teach coping skills and mood regulation techniques. They make use of pleasant activities and they employ supports and emergency contact numbers. There has been evidence demonstrating the efficacy of safety planning as a standalone intervention, both when conducted in an individual and group format.

Dr. Marjorie W.:
The ED safe studies examined the use of safety plan construction in emergency departments of five geographically dispersed VA facilities. Specifically, these studies examined service utilization outcomes after emergency room visits for 96 suicidal veterans with two or more visits to the emergency department in a six month period.

Dr. Marjorie W.:
On the first emergency room visit, the veteran received usual care, but on the second emergency room visit, which included safety planning, that was followed up with supportive telephone calls from the clinician who collaboratively developed the safety plan with the veteran during their visit at the emergency department. Each call included a brief assessment of risk for suicide, review and revision of the safety plan and identification and resolution of barriers to treatment. The first call was made within one week of the veteran's discharge from the emergency room. Additional calls were made weekly until the veteran attended his or her first two appointments for outpatient mental health or substance use treatment.

Dr. Marjorie W.:
Utilization of behavioral health services was significantly greater after receipt of this low component intervention then after receipt of usual emergency department care. In fact, what we saw in this study was that intervention significantly increased behavioral health treatment attendance three months after intervention as compared with treatment attendance in the three months after the previous emergency department visit without any intervention. The trend was also found for decreased hospitalization rates.

Dr. Marjorie W.:
There are six steps in a safety plan and we will review each one in detail to ensure you're familiar with the purpose and goal of each. I really want to encourage you all to think of this not just as another form to complete, but rather as an intervention to help you and the patient plan for a situation in which they're distressed or feeling suicidal. You can really think of a safety plan as an instructional sheet using the patient's own words regarding how they can best cope during periods of acute crisis.

Dr. Marjorie W.:
In step one, you want to work with a patient to identify warning signs. One of the most effective ways of averting a suicidal crisis is to address the problem before it even reaches a crisis. To help patients

identify their warning signs, you want to ask open ended questions such as how will you know when the safety plan should be used? Or what do you experience when you start to think about suicide?

Dr. Marjorie W.:
What do you experience when you start to think about suicide or feel extremely distressed?

Dr. Marjorie W.:
Often, patients are primed to think of behavioral warning signs such as isolation and withdrawal, avoiding people, not engaging in pleasurable activities, using substances, experiencing sleep problems. While all of these are great to recognize, you also want to make sure to assess warning signs beyond just behaviors. Make sure to ask about thoughts that might trigger suicidal ideation or intent. This can include thoughts such as, "I can't cope anymore. I'm a failure. I don't make a difference. I'm worthless. I can't take it anymore. Things aren't going to get better."

Dr. Marjorie W.:
You want to ask about images such as flashbacks, vivid memories or nightmares. You also want to ask about thinking processes such as racing thoughts, not seeing a way out or feeling like your brain can't process what's going on, and, lastly, you want to ask about emotions, perhaps feelings of sadness, hopelessness or depression or, sometimes, when somebody is feeling scared, anxious or worrying a lot. Others might be triggered for suicide when they're experiencing guilt, shame or embarrassment.

Dr. Marjorie W.:
During the second step, the goal is for patients to identify coping strategies or activities that they could do on their own without contacting any other person. These activities function as a way to help patients cope with the emotional intensity of suicidal thoughts or intent and can also act as a way to prevent suicide ideation from escalating. A question to ask the patient to elicit this information can include something like, "What can you do on your own if you become suicidal again to help you not act on your thoughts or urges?"

Dr. Marjorie W.:
In this step, you really want to use a collaborative problem-solving approach to identify adaptive and helpful coping strategies. Adaptive coping strategies can include anything from going for a walk, exercising, engaging with a hobby or playing with a pet to reading, listening to music, watching TV or even praying. It's important to keep in mind that this step is not just about making a long list of possible suggestions. Rather, you want to work together with the patient to really explore what will work for them during times of crisis and make sure that the patient is writing those down.

Dr. Marjorie W.:
If internal coping strategies are ineffective and do not reduce suicidal thoughts or urges, patients should identify people and/or social settings that might help distract them from their suicidal thoughts and urges. In this step, suicidal thoughts or feelings are not necessarily revealed to the people who are identified on the list. Rather, you want to work with the patient to really identify social settings or individuals who might serve as good distractors from their own thoughts, urges or distress. Places can include anything from coffee shops, gyms, parks or even places of worship.

Dr. Marjorie W.:
Socializing with friends or family members without explicitly informing them of the suicidal state may assist in distracting patients from their problems, including distraction from their own suicidal thoughts. A suicidal crisis might also be alleviated if patients feel an increased sense of connectedness with other people they care about. It might be helpful to ask the patient questions such as, "Who helps you feel good when you socialize with them?" or, "Who helps you to take your mind off your problems at least for a little while?" or even, "Where can you go where you'll have the opportunity to be around other people?"

Dr. Marjorie W.:
If internal coping strategies or social context for the purpose of distraction and connectedness offer little benefit to alleviating the suicidal crisis, service members may choose to inform family members or friends that they are experiencing a suicidal crisis. This step is distinguished from the previous step in that service members explicitly identify that they are in crisis and need support and help.

Dr. Marjorie W.:
Given the complexity of deciding whether or not a patient should or should not disclose to others that they're thinking about suicide, you really want to work with the patient collaboratively to formulate an optimal plan. You can ask the patient, "Among your family and friends, who do you think you could contact for help during a suicidal crisis?" You also want to make sure to ask about their likelihood to actually follow through and contact these people. You can ask something as simple as, "How likely would you be willing to contact these individuals?"

Dr. Marjorie W.:
You want to work with the patients to list several people in case they cannot reach the first person on the list. If service members are struggling to identify several people to put on their list, you might want to consider suggesting others they haven't thought about such as chaplains or a senior NCO.

Dr. Marjorie W.:
The fifth step consists of professionals who could assist service members during a time of crisis and the corresponding telephone numbers or locations to obtain support. Patients are instructed to contact a professional or agency if the previous strategies have not been effective for resolving the suicidal crisis. The safety plan emphasizes that appropriate professional help is accessible in a crisis and, when necessary, indicates how these services can be obtained.

Dr. Marjorie W.:
Service members might feel reluctant to contact professionals and disclose their suicidal thoughts or intent. It's important to discuss with the service member their expectations about when they can contact professionals and agencies for assistance and discuss any roadblocks or challenges in doing so. Possible questions to ask a service member might include, "Who are the mental health professionals that we should identify to be on your safety plan?" or, "Are there other healthcare providers that you're working with who you can reach out to during a period of crisis?"

Dr. Marjorie W.:
In this last step, providers should ask patients which means they would consider using during a suicidal crisis and collaboratively identify ways to secure and limit access to lethal means during periods of acute crisis. The risk for suicide is increased when patients report a specific plan to kill themselves that involves a readily available lethal method.

Dr. Marjorie W.:
Even if no specific plan is identified, a key component in safety planning involves limiting or eliminating access to any potential lethal means in a patient's environment. This might include safely storing medications, implementing gun safety procedures or restricting access to knives or other lethal means.

Dr. Marjorie W.:
Possible questions to ask regarding means can include, "What means do you have access to, and are you likely to make a suicide attempt or to kill yourself, and how can we go about developing a plan to limit your access to these means and ensure that we increase your safety?"

Dr. Marjorie W.:
As discussed in the Fluid Vulnerability Theory, most suicidal crises are brief, difficult to predict and might escalate quickly. As a result, identification of ways to decrease or delay access to specific means can reduce risk during these periods of acute crisis. Due to the high risk that's associated with suicides involving firearms, it is important to ask specifically about access to firearms.

Dr. Marjorie W.:
In CDP's two-day training, participants are introduced to means safety counseling, an evidence-informed intervention that provides a structured approach to limiting a patient's access to lethal means. However, there's also additional trainings. One of them is offered by the Suicide Prevention Resource Center. This training is called Counseling on Access to Lethal Means or, for short, CALM, and provides information on discussions with patients about reducing access to lethal means.

Dr. Marjorie W.:
A 2014 memorandum from the Undersecretary of Defense provides guidance for commanders and health professionals in the DoD on reducing access to lethal means through voluntary self-storage of privately-owned firearms. The memorandum states that DoD component, as a general rule, will not prohibit or issue any requirements relating to lawful ownership of firearms, ammunitions and other weapons on the property that is not owned or operated by the DoD. However, COs and health professionals may inquire about a service member's privately-owned firearm if the provider has reasonable grounds to believe that that service member is at risk for suicide or harm to others.

Dr. Marjorie W.:
For situations involving the potential for imminent danger, DoD personnel will take action to reduce risks and ask members to voluntarily store their weapons for safekeeping. This must be entirely voluntary for the service member. It is important to keep in mind that this is different than the guidance regarding possessions of firearms on military installations which requires commanding officers to consult with staff judge advocates before taking any steps.

Dr. Marjorie W.:
When implementing a safety plan with patients, you want to make sure it's a collaborative process to most effectively engage the patient and increase commitment to the plan. Each step in the plan should be brief, easy to read and use the client's own words. You want to work with patients to determine the likelihood that a patient will follow through with each step in the plan on a Likert scale from zero to 100. Ideally, each item should be rated above 80% likelihood to be maintained on the safety plan.

Dr. Marjorie W.:
You then want to specify the location of the safety plan, make copies for the patient, ensure that they have them in numerous locations. I also recommend taking a picture with a smartphone if a patient has one. Lastly, you want to review the safety plan and make sure to revise at subsequent meetings as new skills are learned or social networks are further expanded. You can ask the question, "Did you use your plan at all since our last meeting? Was it helpful? Is there anything we need to add or change in your safety plan?"

Dr. Marjorie W.:
At this time, I would like to transition to a brief discussion of treatment interventions recommended by the Clinical Practice Guidelines for the Treatment of Suicidal Thoughts and Behaviors. A number of clinical trials focusing on reduction of suicidal behaviors is very low. Exclusion of suicidal individuals from clinical trials has arguably crippled the field of suicide intervention research. In addition, methodological problems with even the most rigorous trials have resulted in low quality of evidence.

Dr. Marjorie W.:
Despite these barriers, the 2019 Clinical Practice Guidelines have put forth some great recommendations. First, there is strong evidence to recommend using cognitive behavioral therapy-based interventions focused on suicide prevention for patients with a recent history of self-directed violence in order to reduce incidents of future self-directed violence. The focus should be on suicidal thoughts and behaviors rather than any particular diagnosis.

Dr. Marjorie W.:
In addition, there's evidence to suggest problem-solving-based psychotherapies for patients with a history of more than one incident of self-directed violence in order to reduce repeat incidents of such behaviors. Problem-solving-based psychotherapies are also recommended for patients with a history of recent self-directed violence to reduce suicide ideation, as well as for patients with hopelessness and a history of moderate to severe traumatic brain injury.

Dr. Marjorie W.:
Work by Cerel and colleagues suggests that, on average, 135 individuals are exposed to the effect of each suicide death. This impact often includes increases in the prevalence and severity of symptoms of depression and anxiety, as well as thoughts about suicide, all of which really highlight the importance of engaging in postvention interventions.

Dr. Marjorie W.:

In 2015, the Survivors of Suicide Loss Task Force of the National Action Alliance for Suicide Prevention released their report entitled Responding to Grief, Trauma, and Distress after a Suicide, US National Guidelines. One of their recommendations was that all settings should incorporate postvention as a component of a comprehensive approach to suicide prevention in order to facilitate the healing of individuals from grief and distress due to a suicide loss, in order to mitigate other negative effects of exposure to suicide, and in order to prevent suicide among people who might be at high risk after exposure to a suicide.

Dr. Marjorie W.:
In the published Guidelines for Responding to Suicide, a number of recommendations were made to organizations for providing support during postvention. First, you want to ensure safe reporting of the information. Since the suicide of a group member can immediately produce intense curiosity and anxiety about the nature and the death, questions might arise such as, "Who died? When and how did that person die?" Rumors might circulate quickly. As a result, it's crucial that somebody provides factual and accurate information while also being sensitive to the needs of the deceased family members and others who are dealing with grief and bereavement issues.

Dr. Marjorie W.:
Second, you want to aid in mourning in ways that avoid increasing the risk of contagion. To do that, you want to work to provide opportunities for healthy grieving while working with people to minimize the risk of suicide contagion or other negative reactions to the death. People need to understand and process what has happened after the traumatic event occurs. Often, they might want to grieve collectively over the loss of the community member regardless of the cause of death.

Dr. Marjorie W.:
You want to make sure to provide ongoing support and treatment, including professional and peer support options for those who need it. Many responses to suicide are short term and crisis-oriented. While helpful, focusing only on the immediate aftermath of the suicide can be insufficient for some community members who might experience longer-term reactions to the death.

Dr. Marjorie W.:
Postvention planning should include outreach to high-risk individuals over time, providing an assessment of any changing needs for assistance and ensuring resources are available. Lastly, you want to provide supporting guidance for friends and family members who are grieving. Here, you want to identify and reach out to those who may have significantly been affected by the suicide death. It is especially important to identify and offer assistance to those individuals who are at high risk of complications or difficulties. Be prepared with referral information for those individuals who might be experiencing stress, relationship difficulties, health or mental health problems.

Dr. Marjorie W.:
The Defense Suicide Prevention Office, or DSPO, has published a Leader Guide and Postvention Checklist that military organizations might find helpful using after a suicide has occurred. DSPO is included in the resource handouts that we've provided in your packets. There are multiple resources available that provide excellent sources of additional information on suicide prevention.

Dr. Marjorie W.:
Two programs have been established to support Sailors and Marines with suicide ideation or attempts. The Marine program is called the Marine Intercept Program, or MIP, and the Navy program is called the Sailor Assistance and Intercept for Life, or SAIL Program. Services provided in these programs are not considered to be therapy and are not intended to replace therapy. Rather, they are outreach and case management services that use evidence-informed tools to assess for risk, establish or review safety plans, and address any barriers to identifying or accessing needed services. The services are voluntary. For example, about 50% of Sailors accept SAIL services.

Dr. Marjorie W.:
In the MIP Program, contacts are made via telephone, while in the SAIL Program, contacts are provided predominantly by face-to-face meetings. These contacts are referred to as caring contacts. Since the research shows that the highest risk for repeated suicide-related events occur within 90 days of the first suicidal crisis, caring contacts are provided within specific intervals during the first 90-day period. Collaboration with the Sailor and Marines command is an integral part of the program and will occur after each contact or attempted contact with all program participants.

Dr. Marjorie W.:
The Defense Suicide Prevention Office, or DSPO, was established in 2011 and is part of the Department of Defense's Office of the Undersecretary of Defense for Personnel and Readiness. DSPO provides data surveillance, advocacy, policy oversight, and education and outreach on all matters of suicide within the DoD. Many tools and resources are available on their site, including the Leader Guide and Postvention Checklist to assist leaders in guiding their response to suicides and suicide attempts within their commands.

Dr. Marjorie W.:
The Psychological Health Center of Excellence, or PHCoE, holds the goal of improving the lives of service members, veterans and their families by advancing excellence in psychological healthcare, readiness and prevention of psychological health disorders. They provide links to reports and information, including the Clinical Practice Guidelines and the DoDSER Reports.

Dr. Marjorie W.:
The Rocky Mountain MIRECC/VISN 19 is another great resource. MIRECC stands for Mental Illness Research, Education and Clinical Center. MIRECC was created to generate new knowledge about the causes and treatments of mental disorders, apply new findings to model clinical programs and widely disseminate new findings through education to improve the quality of veterans' lives and their daily functioning in their recovering from mental illness.

Dr. Marjorie W.:
The VISN 19 MIRECC specializes in research on suicide prevention, and their site includes information about the therapeutic risk management tool, as well as the self-directed violence nomenclature that we've talked about earlier in this training.

Dr. Marjorie W.:
The Navy Suicide Prevention Handbook, recently published in 2019, was designed as a ready reference for policy requirements, program guidance, and educational tools to strengthen and sustain local community command and individual efforts.

Dr. Marjorie W.:
The Suicide Prevention Resource Center, or SPRC, is the only federally-supported resource center devoted to advancing the implementation of the National Strategy for Suicide Prevention. Funded by the US Department of Health and Human Services, Substance Abuse and Mental Health Service Administration, or SAMHSA, it includes the Counseling on Access to Lethal Means, or CALM training, which can be reached online.

Dr. Marjorie W.:
The American Association of Suicidology, or AAS, was founded in 1968 by Edwin Shneidman. AAS promotes research, public awareness programs, public education and training for professionals. They also have an annual conference and publish the Journal of Suicide and Life-Threatening Behaviors.

Dr. Marjorie W.:
Lastly, the American Foundation of Suicide Prevention, or AFSP, began as a research organization dedicated to finding the best ways to prevent suicide and fund research across multiple scientific disciplines.

Dr. Marjorie W.:
The next few slides provide a list of all of the references that were utilized in developing the training that we've provided to you in the last couple of hours.

Dr. Marjorie W.:
Thank you for joining us in today's training, and we certainly hope that this training content has proved to be helpful in working with patients that may present with suicidal thoughts or behaviors.