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Suicide Prevention and Postvention Resources: What Psychiatry Residencies Can Learn from the Veteran's Administration Experience

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Abstract Suicide risk assessment and coping with the loss of a patient through suicide are two of the more challenging aspects of psychiatry residency. Over the last decade, the Department of Veterans Affairs has focused on a significant effort into the development of a comprehensive suicide prevention. This article aims to describe the initiatives and resources in place at the VHA to help address the issue of suicidal behavior in veterans and how residency programs can use this to enhance teaching of suicide prevention and postvention.

Keywords Suicide postvention · Veteran suicide · Resident education · Suicide education resources

Suicidality is the most significant symptom of most mental illnesses and one of the most challenging symptoms in all of medicine to treat. When compounded by the difficulty in assessing for suicidal intent, the negative social connotations with suicide, the difficult nature of studying suicide prevention, and the stigma toward mental illness, this challenge is immense. Additionally, psychiatrists who have lost patients to suicide commonly experience acute stress disorder symptoms or significant distress subsequently [1].

Training programs must prepare their residents to be able to thoroughly understand and assess suicide risk and to feel comfortable addressing suicidality-related conversations with patients and their families. As the science of psychiatry continues to build evidence-based practices in suicide prevention, residencies also need to prepare residents to cope with the potential suicide of patients. Psychiatry curricula on suicide prevention and postvention are taught in a variety of ways throughout different psychiatry residencies. A 2009 survey of psychiatry chief residents [2] found that 91 % of chiefs noted that this was part of their curriculum, most commonly taught through didactics and case conferences. Less than half of the time, it was taught through quality improvement forums, like morbidity and mortality conferences. Only 19 % of chief residents felt prepared to deal with the aftermath of a patient suicide [2].

Yet, 51 % of psychiatrists experience the suicide of a patient during their career [3]. Despite this, only about one third of programs have postvention programs in place for residents or clinicians who experience a patient's suicide [4]. The program at the Medical College of Wisconsin (MCW) was one of the two thirds who did not have a program. In 2012, MCW chief residents identified this as an area of improvement needed in our program and developed a workshop based on the work by Lerner et al. [5] to help residents talk about patient suicide and the emotional and professional effects on the treating clinician. Like many psychiatry residencies, the MCW program is affiliated with the Veterans Health Administration (VHA). We called upon their multidisciplinary suicide prevention team to help lead the discussion and through this, learned more about the suicide prevention resources and projects underway at the VHA on a national level. This article briefly reviews the VHA's comprehensive suicide prevention program and identifies the aspects of it that can be useful for enhancing suicide curriculum in psychiatry residencies.

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VA Suicide Prevention Resources

The Department of Veterans Affairs has taken a unique approach to suicide prevention, including the development of a comprehensive suicide prevention program throughout the VHA system. Suicide prevention initiatives formally began in June 2005 with the publication of the VA Mental Health Strategic Plan and the advent of targeted Mental Health Initiative Funding. The initial program began in response to the recognition that veteran suicides were increasing across the nation [6].

The VHA suicide prevention program uses an integrated approach to ensure that suicidal veterans receive ready access to high-quality mental health care. To that end, the program has multiple facets, including (1) the addition of a suicide prevention coordinator (SPC) at each VHA; (2) a flagging system in the standardized computer medical record system to identify veterans that are high risk for suicide; (3) a focus on safety planning and means restriction for veterans at high risk; (4) the development of the National Veteran's Crisis Hotline, which also includes online chat and text services; (5) mandated educational programs for staff concerning suicide; and (6) research on the biological and clinical aspects of suicide prevention.

In February 2007, as part of this important initiative, each VA Medical Center received funding for a suicide prevention coordinator (SPC). The creation of the SPC role was an integral component of the national suicide prevention strategy. The suicide prevention coordinator has the ability to "flag" veteran's charts if they are considered to be at high risk for suicide in order to adjust care to minimize risk. This allows every provider who is viewing that veteran's medical record the opportunity to assess for suicide, if clinically appropriate at the time of the visit. The SPC and/or team then tracks this list of high-risk veterans to ensure that they are receiving and engaged in mental health treatment. The suicide prevention coordinator's role is to ensure that the veteran maintains weekly contact and also develop a suicide prevention safety plan with the veteran.

The safety plan is a collaborative document developed by the patient and treatment team that is intended to help the patient cope with suicidal thoughts as they arise [7] (Fig. 1). Patients first identify warning signs (thoughts, behaviors, feelings) that a crisis may be developing. Warning signs are specific to the individual and may be something like "I am starting to yell at my spouse." They then identify and utilize internal resources that can help them cope when they feel that way (going for a walk, praying, meditating, etc.). The next step identifies places the patient can go or people to call if the internal strategies are not working, and they need to find ways to maintain their safety until the suicidal thoughts are alleviated. The next step is identifying who the patient feels close to and could call to talk about the suicidal thoughts—these people and their phone numbers are listed on the plan. Professional resources and phone numbers are also listed to call if needed—the number of the psychiatrist, therapist, and crisis lines. The final step of the safety plan focuses on means restriction, which is the process of restricting access to lethal means of suicide. This involves asking about and securing weapons, having family lockup medications, etc. The safety planning and means restriction curriculum is accessible on the Internet http://www.mentalheath.va.gov/docs/VA_Safety_planning_manual.pdf.

In July 2007, the VHA National Suicide Prevention Hotline opened at Canandaigua VA Medical Center. The VHA partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) and Lifeline in order to provide veterans and families with 24/7 availability of a trained professional to address a suicidal crisis. Veterans are also referred from the National Veteran's Crisis Hotline to the Suicide Prevention Team for follow-up. In 2011, the National Veteran's Suicide Hotline was renamed to The National Veteran's Crisis Hotline. The focus on "crisis" rather than on "suicide" was made to reach more veterans who may not necessarily be suicidal. Since it began in 2007, the National Veterans Crisis Hotline responded to more than 890,000 calls, prompting emergency intervention in over 30,000 of these. In the last several years, online chat and text-messaging services have been added in order to provide additional ways for veterans to access support [8].

Another important component of the VHA suicide prevention programming is education and outreach. All new VHA employees (clinical and nonclinical) attend face to face SAVE training. SAVE stands for signs of suicidal thinking, asking the question, validating the response, and encouraging treatment/expediting referral. This mandatory training teaches employees about warning signs, risk factors and protective factors for suicide, and how to refer to mental health treatment. Additionally, all new mental health employees complete online risk management training and the training in developing a safety plan and means restriction that is described above.

In addition, at the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin, psychiatrists also receive a more detailed training on the suicide prevention programming, including clinical interventions for the high-risk population, such as safety planning as well as information regarding clinical groups that are offered. The Zablocki VAMC is unique regarding the comprehensive clinical programming it offers for the high risk for suicide population of veterans. This includes multiple treatment groups specific for this population, including treatment groups based on the collaborative assessment and management of suicidality (CAMS). CAMS is an 8-week group series that encompasses both ongoing assessment and teaching skill-based coping strategies. Additionally, the Zablocki VAMC provides a

SAFETY PLAN

Step 1: Warning signs (thoughts, images, feelings, behaviors) that I am at risk of being "in crisis" or that a crisis in my life is starting to develop:

1. _____
2. _____
3. _____

Step 2: Things that I can do to take my mind off of my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and places that can help distract me from thinking about my problems:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Place: _____
4. Place: _____

Step 4: Family or friends whom I can ask for help when I am in crisis:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____

Step 5: Professionals or agencies I can contact for help:

1. Clinician name: _____ Phone: _____
2. Clinician name: _____ Phone: _____
3. Local Urgent Care Services: VA Mental Health Urgent Care Clinic (MHUCC)
   Address: Clement J. Zablocki VAMC, Room 1252 Phone: 414-384-2000 X 45760
4. Local Suicide Prevention Coordinator name: Gina Kangas
   Local Suicide Prevention Coordinator phone: X 42724
5. Veterans Crisis Line:
   Dial 1-800-273-8255, and push 1 to reach a VA Mental Health Clinician
   Text to 838255
   Chat: VeteransCrisisLine.net

Step 6: Steps I can take to make myself safe in my environment:

1. _____
2. _____

Fig. 1 Safety plan revision Milwaukee specific

support group for high-risk veterans entitled coping, understanding, support, and prevention (CUSP), a problem-solving group for veterans with suicidal ideation, and new perspectives, a group focusing on suicide related to interpersonal conflict [9]. Means restriction is integral in preventing suicide [1], and free gun locks are available to veterans as needed.

Lastly, in August 2007, the VHA developed the Center of Excellence for Suicide Prevention whose primary goal is to reduce suicide and suicide-related behaviors using a public health approach [10]. Examples of some of the resulting researches can be found in the American Journal of Public Health, Supplement 1 2012 [11].

A Resource for Residency Training

In 2011 alone, over 36,000 residents trained at a VA Medical Center [12]. Most psychiatry residencies are affiliated with the VHA system. Given the unique approach and resources available at the VA, it makes sense to use this system to help educate our residents about suicide.

At the Zablocki VAMC, we initiated collaboration with the VA's suicide prevention team into the residency program at MCW. Below are some of the examples of what we have learned through this collaboration:

- Safety planning quality improvement project—in our Introduction to Quality Improvement class, we chose to focus on the development of a safety plan for patients admitted to inpatient units with suicidal ideation as our target initiative. On review of their inpatient caseload, residents found that they had completed a safety plan together with a patient 10 % of the time (Pheister, unpublished data). One quality improvement intervention focused on improving education. Residents reviewed the Safety Planning and Means Restriction Training that is required of all VHA mental health staff (available online at http://www.mentalheath.va.gov/docs/VA_Safety_planning_manual.pdf). The residents' group integrated several published safety plan templates to develop a one-page form that could be used easily in multiple settings. Subsequent to the interventions, residents increased the frequency with which they created written safety plans with their patients to 52 % (Pheister, unpublished data).
- Means restriction education—as part of the same project, residents reviewed the VHA's suicide risk management training for clinicians also to learn about means restriction.
- Suicide postvention workshop—as mentioned, we involved the entire suicide prevention team in our suicide postvention workshop, modeled after the workshop described in the Lerner paper [5]. This was intended to help residents talk about patient suicide and the emotional and professional effects on the treating clinician. During our workshop, residents were divided into small groups, each led by an attending who had experienced the suicide of a patient. Residents asked questions like how they found out that their patient had died by suicide, their emotional response, and how they dealt with this, if they contacted the family, if they attended the funeral, how their hospital or program responded, and what the legal concerns were. While medical legal issues of suicide were mentioned, we tried instead to focus on the emotional and professional aspects. Our VA suicide prevention team then spoke with the group as a whole about their experience with families who lost loved ones to suicide. The workshop concluded with a discussion led by two people (one of whom was a well-known and well-liked professor) who had lost family members to suicide. Feedback from residents showed that they appreciated talking openly about this subject and that those who had already experienced the suicide of a patient felt less isolated and more supported. We plan to repeat this workshop every 2 years, in order to continue open dialogue and to help prepare incoming residents.
- Quality care rounds (morbidity and mortality)—based on the literature [13, 14] and discussion with the residents, it was clear that fear and stigma often prevented residents from talking openly about patient suicide. After losing a patient to suicide, we focused one of our quality care rounds on the emotional aspects of a clinician's response to suicide. The main purpose of the discussion was to decrease the stigma by talking more openly about completed suicides. The discussion also served to provide support for the resident clinician, as she started to process some of the emotions involved, including countertransference issues that arose during treatment.

Future plans include the following:

- Developing a competency for suicide assessment and safety planning that is assessed through demonstration with a simulated patient.
- Having residents join the VA's suicide prevention coordinator in debriefings—discussions related to the potential for emotional distress after losing a patient to suicide.
- Having residents work with the research investigators on projects which focus on suicidality. One example is the study entitled Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment (SAFE VET). SAFE VET is a national eight-site suicide mitigation study using the Safety Planning protocol. The study is designed to determine the efficacy of providing a suicide prevention case manager directly in

emergency or urgent care departments. Milwaukee VAMC is a control site for this study.
- Sharing the websites and education resources available for survivors of suicide.

A drawback to implementing some of the ideas above could be that the focus is on the veteran population and VHA system while not fully appreciating other community-based resources. It is important to consider that most residents will not be practicing in this setting after graduation. However, the skills taught—safety planning, means restriction, postvention—can be applied regardless of setting. While it is important to diversify training and draw on resources in multiple settings, the VHA has multiple initiatives and significant resources in place to help address the issue of suicidal behavior in veterans. A significant number of psychiatry residencies are affiliated with the VHA, providing a wealth of information and data that could enhance the way we teach suicide prevention, intervention, and postvention to psychiatry residents.

Implications for Educators
- Fifty-one percent of psychiatrists experience the suicide of a patient during their career [3].
- Residents need to learn not only how to assess suicide risk but also how to cope when and if they lose a patient to suicide.
- The VHA has a robust suicide prevention program that addresses suicide through various avenues.
- Many psychiatry residencies are affiliated with the VHA and have access to a wealth of resources.

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