Safety Planning in Outreach and Home-Based Settings

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Who are the people in your neighborhood…

Implicit and Explicit Bias

Implicit bias ("unconscious bias") refers to beliefs and attitudes that affect our understanding, actions and decisions in an unconscious way, making them difficult to control.

→ Examples: Race, gender, and sexuality

→ Media, culture, and upbringing may contribute to the development of such biases

→ Implicit bias is more subtle and can be in direct contradiction to one's openly held beliefs

→ Implicit bias may impact where, how, and which services are offered and who gets hired or promoted

Explicit bias refers to the demonstration of conscious preference or aversion towards a person or group.

→ Aware of the attitudes and beliefs we have towards others. These beliefs can be either positive or negative and can cause us to treat others unfairly.

→ Any aspect of an individual's identity can become the target of explicit bias: Age, gender, ethnicity, sexual orientation, socioeconomic status, and ability

→ Explicit bias is usually easier to identify

→ Manifestations of explicit bias may lead to discrimination, stereotyping, hate speech, violence, favoritism, lack of empathy and exclusionary practices

Types of Implicit Bias

- **Affinity Bias**: The tendency to prefer or like those like oneself; this type of bias is understood through the lens of race, age, gender, religion, etc.

- **Halo Effect**: A tendency to use one trait about a person or thing to make an overall judgment.

- **Truth Illusion:** As we are exposed to a message repeatedly, it becomes more familiar. Because of the way our minds work, what is familiar seems true.

- **Confirmation Bias:** The tendency to search for, interpret, favor and recall information in a way that confirms one's preexisting beliefs or hypotheses while giving disproportionately less consideration to, or ignoring, information that challenges preconceived notions.

- **Priming Effect**: Priming is an implicit memory effect in which exposure to a stimulus influences a response to a later stimulus.

Implicit and Explicit Bias

Attitudes towards homelessness…

1. Homelessness is caused by laziness
2. Homelessness is caused by substance abuse
3. Homelessness is caused by mental health issues
4. Homelessness is caused by a lack of governmental assistance
5. Homelessness presents a harmful impact on taxpayers
6. Being homeless means having an abundance of free time
7. I can identify a homeless person by appearance alone
8. Being homeless reduces everyday worries
9. The homeless are untrustworthy
10. The homeless are dangerous/engage in criminal behaviors
11. The homeless are deviant/scam artists
12. The homeless are dirty and they are hoarders
13. You can't be homeless and have a job
14. Homeless people deserve to be homeless due to their behaviors

© Rethink Homelessness/Youtube

EXHIBIT 5.4: **Demographic Characteristics of Veterans Experiencing Homelessness**
2022

	All Veterans		Sheltered Veterans		Unsheltered Veterans	
All Veterans	33,129	100%	19,565	100%	13,564	100%
Gender						
Female	3,440	10.4%	1,784	9.1%	1,656	12.2%
Male	29,372	88.7%	17,705	90.5%	11,687	86.2%
Transgender	141	0.4%	42	0.2%	99	0.7%
A Gender that is not Singularly 'Female' or 'Male'	118	0.4%	27	0.1%	91	0.7%
Questioning	38	0.1%	7	0.0%	31	0.2%
Ethnicity						
Non-Hispanic/Latin(a)(o)(x)	29,086	87.8%	17,897	91.5%	11,189	82.5%
Hispanic/Latin(a)(o)(x)	4,043	12.2%	1,668	8.5%	2,375	17.5%
Race						
American Indian, Alaska Native, or Indigenous	1,034	3.1%	414	2.1%	620	4.6%
Asian or Asian American	404	1.2%	159	0.8%	245	1.8%
Black, African American, or African	10,240	30.9%	6,733	34.4%	3,507	25.9%
Native Hawaiian or Pacific Islander	417	1.2%	153	0.8%	264	1.9%
White	19,355	58.4%	11,408	58.3%	7,947	58.6%
Multiple Races	1,679	5.1%	698	3.6%	981	7.2%

Note: The demographic data for unsheltered may not sum to the total because three CoCs did not report complete demographic information for the unsheltered data used in this report.

Disparities in Homelessness

STUDY: Analyzing Racial Disparities in the Homelessness System: What You Should Know

In 2017 the Homeless Programs Office (HPO) initiated an unannounced standardized Veteran (USV) project, commonly referred to as a "mystery shopper's program" at all CRRCs to identify and disseminate best practices to Veterans experiencing homelessness. A second round of visits took place in 2018.

Unconscious Bias

Case 1: Male, Caucasian, OEF Veteran with PTSD
Case 2: Female, Caucasian, Desert Storm Veteran with High Blood Pressure
Case 3: Male, African American, Vietnam Veteran with Alcoholism
Conclusion: The volunteer portraying an African American Vietnam Veteran with substance use issues experienced a statistically significant higher number of additional barriers to accessing care in comparison to the other volunteers

→ People experiencing homelessness often face higher rates of poor health outcomes than people with housing

→ Criminalization of Homelessness and criminalization of efforts to feed people in need

→ Homelessness and Domestic Violence

Social Determinants of Health

Social Determinants of Health (SDH) include, but are not limited to:
education, housing quality, and access to healthy foods

The Joint Commission published new and revised requirements to reduce healthcare disparities in 2023. Although health care disparities are often viewed through the lens of social injustice, they are first and foremost a quality-of-care problem.

Health-related social needs (HRSN) are frequently identified as root causes of disparities in health outcomes. Example: A care plan for tight control of diabetes may be unsafe for someone with food insecurity, and outpatient radiation therapy may be impractical for someone who lacks reliable transportation to treatment.)

Per TJC Standards, healthcare organizations must:

- Determine which health-related social needs to include in the [patient] assessment. Examples: **Access to transportation, Education and literacy, Food insecurity, Housing insecurity**
- Determine which sociodemographic characteristics to use for stratification analyses Examples: Age, Gender, Race and ethnicity
- Develop a written action plan that describes how it will address at least one of the health care disparities identified in its patient population.

Social Determinants of Health

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community, Safety, & Social Context	Health Care System
Employment Income Expenses Debt Medical Bills Support	Housing Transportation Parks Playgrounds Walkability Zip Code/ Geography	Literacy Language Early Childhood Education Vocational Training Higher Education	Food Security Access to Healthy Options	Social Integration Support Systems Community Engagement Stress Exposure to Violence/Trauma Policing/Justice Policy	Health Coverage Provider & Pharmacy Availability Access to Linguistically And Culturally Appropriate & Respectful Care Quality of Care

Health and Well-Being:
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF

Cultural Competence

Cultural Competence is the ability to effectively communicate with people of different cultures and backgrounds. The goal of cultural competence in community healthcare is to provide high-quality care to every patient, regardless of race, ethnicity, or culture. To be culturally competent, we need to be respectful and responsive to Veterans' beliefs and preferences and establish policies and procedures that promote cultural competence. *Curiosity is okay; ask questions to better understand.*

- Understanding family traditions and dynamics. When and how is it appropriate to communicate with family members? Which family member(s) plays the dominant role?
- Being aware of communication preferences. What is the Veteran's preferred form of address? How should family members be addressed? Which physical gestures are appropriate/inappropriate? Is eye contact acceptable, or should it be avoided?
- Understanding values related to health and wellness. How is medicine practiced in the Veteran's culture? Which practices are prohibited? How does the client view death and dying? This is especially important for our aging Veterans.
- Understanding the personal space and physical contact preferences. Which types of physical contact are acceptable or prohibited? What are the Veteran's expectations about personal space?
- Understanding dietary customs. Are certain foods prohibited for religious/personal reasons?
- Understanding social customs. What, if any, rituals are important to the Veteran and their family? What are important dates to them? How does this affect when and how the caregiver can deliver care?
- Understanding how time is viewed in the Veteran's culture. When are good or bad/inconvenient times, according to the Veteran?

Cultural competence improves health care experiences and outcomes!

Never Stop Learning! The progression to cultural proficiency

Continuum of Cultural Competency

Cultural Disruptiveness	Cultural Incapacity	Cultural Blindness	Cultural Pre-Competence	Cultural Competence	Cultural Proficiency
Forced Assimilation Rights and Privileges for Dominant Groups Only Attitudes, Policies, Programs, and Practices Within a System or Organization that are Destructive to a Cultural Group	Racism Maintenence of Stereotypes and Unfair Hiring Practices Inability of a System or Organization to Effectively Respond to the Needs of Diverse Groups	Differences are Ignored "Treat Everyone the Same" Philosophy Only Needs of the Dominant Group are Met	Explore Cultural Issues Committed Needs of Organization and Individuals are Asessed A Level of Awareness within Systems or Organizations of Their Strengths and Areas for Growth to Respond Effectively to Culturally and Linguistically Diverse Populations	Recognize Individual and Cultural Difference Seek Advice and Include Diverse Groups Hire Culturally Unbiased Staff Systems and Organizations That Exemplify Cultural Competence Demonstrate an Acceptance and Respect for Cultural Differences	Implement Changes to Improve Services Based upon Cultural Needs Continually Add to the Knowledge Base Within the Field of Cultural and Linguistic Competence Develop Organizational Philosophy and Practices Support and Mentor Other Organizations Actively Pursue Resource Development Advocate With and on Behalf of Those who are Traditionally Underserved Systems and Organizations Hold Culture in High Esteem and use this a Foundation to Guide all their Endeavors

Adapted from:

Cross et al (1989) . Toward A Culturally Competent System of Care, Volume 1,

Tawara D. Goode, National Center for Cultural Competence. Georgetown University Center for Child and Human Development, University Center for Excellence in Developmental Disabilities.

Trauma Informed Care in Homelessness

What makes an experience traumatic?

- A threat to physical or emotional well-being
- An event being viewed as "life-threatening"
- Feelings of being overwhelmed, lack of control, fear, helplessness
- Can change one's perspective of themself and others
- Remember: **People experience events differently!!**

Trauma in Homelessness:

- MST and/or PTSD
- Childhood Abuse (ACES)
- Intimate Partner Violence
- Loss of safe, stable housing
- Lack of or fixed income

Providing "trauma-informed" care involves using what we know about trauma and its impact to respond differently -constantly looking at all aspects of programming through a "trauma lens"

- **Understand** the trauma
- Promoting **Safety**
- Ensuring **Cultural Competence**
- Supporting Veteran **Choice** and **Autonomy… Self Determination!**
- **Integrated** Care (Whole Health Approach, Peer Support, Social Work, Nursing, Occupational Therapy)
- Promoting Recovery through **Harm Reduction**
- Providing permanent stable housing through a **Housing First Approach**

Trauma Informed Care

What others see…

Refusal

Substance Use

Non-compliance

Self-Harm or Suicidal Ideation

Avoidance

Anger

Aggression

What is hiding from self and others underneath ….

- Trauma
- Fear/ panic
- Resentment
- Hurt
- Vulnerability
- Loneliness
- Unmet needs
- Helplessness
- Abandonment
- Shame
- Guilt
- Panic
- Inability to cope
- Sadness
- Unloved
- Worthlessness

Adapted from Gottman Institute

Trauma during Childhood

Adverse Childhood Experiences (ACE’s) are “highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person’s safety, security, trust or bodily integrity.”

Examples of ACEs:

→ Physical abuse

→ Sexual Abuse

→ Emotional Abuse

→ Living with someone who abused drugs

→ Living with someone who abused alcohol

→ Exposure to domestic violence

→ Living with someone who has gone to prison

→ Living with someone with serious mental illness

→ Losing a parent through divorce, death, or abandonment

Source: Adverse Childhood Experiences (ACEs) and Attachment - Royal Manchester Children's Hospital (mft.nhs.uk)

Trauma during Adulthood

Examples of Traumatic Events:

- Sexual or physical abuse or assault
- Serious vehicle accidents
- Combat or war zone exposure
- Serious medical events
- Seeing death or dead bodies, including while at work
- Unexpected death of a loved one
- *Natural* disasters
- Arson or house fires
- Torture
- Intimate Partner violence
- Witnessing or experiencing violence, such as a homicide or suicide
- Terrorism or mass violence

Source: ISTSS - What Is Traumatic Stress?

- **Just How Prevalent Is PTSD in the Military?**
- The percentage of Veterans affected by PTSD varies:
- **Operations Iraqi Freedom and Enduring Freedom** → Between 11 and 20 percent of Veterans.
- **Gulf War** → About 12 percent of Veterans
- **Vietnam War** → Studies suggest about 15% of Veterans, yet it's estimated that about 30% have had PTSD in their lifetime
- Source: How Trauma in the Military Can Lead to PTSD — and How to Find Relief for Yourself or a Loved One (everydayhealth.com)

What the experts say…

PEOPLE WHO HAVE EXPERIENCED TRAUMA ARE:

4 Times More Likely To **Become An Alcoholic**

4 Times More Likely To Develop A **Sexually Transmitted Disease**

4 Times More Likely To **Inject Drugs**

3 Times More Likely To Use **Antidepressant Medication**

3 Times More Likely To Be **Absent From Work**

15 Times More Likely To **Commit Suicide**

2.5 Times More Likely To **Smoke Tobacco**

3 Times More Likely To Have **Serious Job Problems**

3 Times More Likely To **Experience Depression**

15x COMMIT SUICIDE

4x ALCOHOLISM

4x DEVELOP STD

4x INJECT DRUGS

3x USE ANTIDEPRESSANT

3x MISSING WORK

3x DEPRESSION

3x JOB PROBLEMS

2.5x SMOKING

Post Natural Disaster

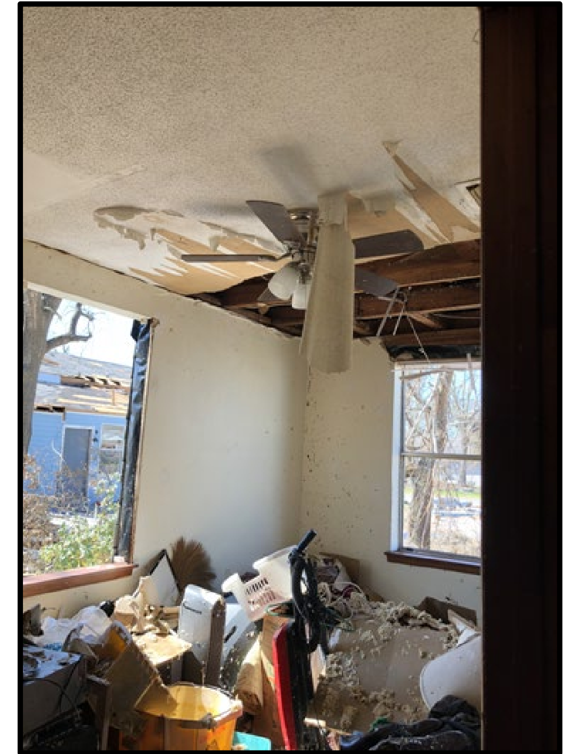
- **Work in teams**
  - Safety in numbers
  - Multiple places to visit (Command center, shelters, going door to door)

- **Maintain contact with Command Center and Emergency Management on road conditions**
  - If unsure, turn around
  - Wear pants, closed toed shoes, carry minimal personal belongings
  - Ensure cell phones are charged, bring a portable charger
  - Pack a change of clothes and shoes in the car

- **Coordination with FEMA, State Emergency Management, Red Cross, HUD, PHA's, SSVF, other VISNs, close monitoring of Homeless Hotline calls**

- **Utilize an agreed upon template for tracking to maintain consistency and ensure no Veteran is 'lost.' (see attached)**

Natural Disaster Worksheet



Personal Awareness

*<u>**Intuition**</u>**:** A vital protective mechanism never to be ignored, deemed “silly” or “irrational”

- Take into consideration lighting and security
- Elevators, parking lots and isolated areas
- Subtle indoor signs of previous drug manufacturing?
- Be cognizant of weapons of opportunity
- Communication planning and distress phrases
- Establish a protocol while visiting Veterans in higher risk/ rural locations
- Be knowledgeable about de-escalation techniques (PMDB), use emotional intelligence

“Awareness is the greatest agent for change” -Eckhart Tolle

“Four at the Door” Personal Safety Tips

1. Distance is Always Your Friend
Knock and step back several feet.
Simply putting space between you and the door gives you more space and time to react if something dodgy happens. Police refer to this as the “reactionary gap,” or “reactionary cushion.”

2. Stay off the Center Line
Moving to the side takes you off the center line – and out of the central line of sight – which leaves you less vulnerable to something like a dog charging out the door.

3. Stand on the Hinge Side of the Door
As you step to the side, try whenever possible to *stand on the hinge side of the door frame.* This allows you to see more of the room behind the person opening the door, than if you were on the door handle side.

4. **Partially “Blade” Your Body**
This means to position your body at about a 45-degree angle towards the door, as opposed to facing it squarely with your shoulders. “Blade**” your body once you’re back and off to the hinge side of the frame. The advantage in standing at an angle, or partial “blading” is that this allows you to monitor what is going on behind you (your **blind spot)** as well as keeping an eye on the door. This position also allows you to quickly turn away from the door and leave if you need to.

Source: Social Workers and Nurses Personal Safety | The Personal Safety Group

Condition Yellow

Condition White

A person that is oblivious of their surroundings. In this condition, the first time a person realized they are in trouble is when it’s too late.

Condition Yellow

This is a relaxed state of general alertness, with no specific focal point. You are not looking for anything or anyone in particular; you simply have your head up and your eyes open. In Yellow, you are “taking in” surrounding information in a relaxed but alert manner, like a continuous 360-degree radar sweep.

Condition Orange

Here you are in a heightened state of awareness and very focused on a potential threat or a situation that you feel could become more serious.

Condition Red

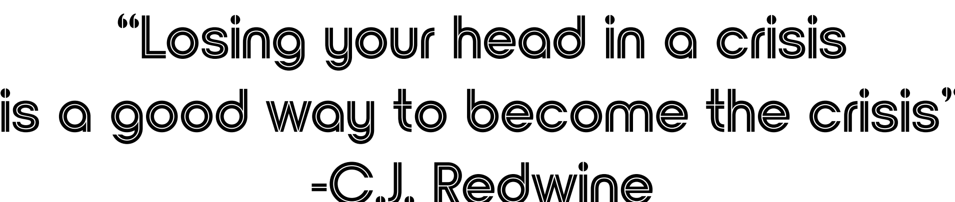
Here you are in “fight or flight” mode, and you are ready to do either. The potential threat is now very real and needs to be dealt with. In this state we will experience a full “adrenaline dump” which will dramatically enhance blood flow to large skeletal muscle groups and sharpen our special senses.

Maintain a Condition Yellow status

Source: [Paranoia versus Condition Yellow | The Personal Safety Group]

Techniques that May Help De-Escalate a Crisis

✓ Keep your voice calm
✓ Avoid overreacting
✓ Listen to the person
✓ Express support and concern
✓ Avoid continuous eye contact
✓ Ask how you can help
✓ Keep stimulation level low
✓ Move slowly
✓ Offer options instead of trying to take control
✓ Avoid touching the person unless you ask permission
✓ Be patient
✓ Gently announce actions before initiating them
✓ Give them space, don't make them feel trapped



✗ Don't make judgmental comments
✗ Don't argue or try to reason with the person
✗ If you can't de-escalate the crisis yourself, you can seek additional help from mental health

Source: Navigating-A-Mental-Health-Crisis (nami.org)

Real Case Scenarios -- What would you do?

- **What if a Client is found deceased in their home?**
- **What if a weapon is clearly displayed in the Client's home?**
- **What if the Client is clearly under the influence of alcohol or drugs?**
- **What if you walk in on a drug deal taking place in a Client's home?**

Post-Incident Support & Follow-Up

- **Reporting event**(s) through appropriate agency channels/processes
- Ensure the **Client** receives appropriate support/referral(s)
- Review safety measures to ensure the client/staff are supported when/if providing future care
  - 2-person visit
  - Visits in community settings, at the agency/organization, police-escort
  - Visits with specific staff to be present such as a nurse, LCSW, or supervisor
- Educate **Staff:**
  - Compassion Fatigue/awareness of your own trauma
  - EAP Counseling
  - Staff time off to process event(s)
  - Occupational Health/medical care if warranted
- Use the **team-approach** to elicit team learning and to encourage the support of one another
  - Allows the team to grow through traumas instead of feeling isolated/unsupported
- Review of processes to determine if new processes/safety measure should be added or changed using new information
- Review **Safety Guidelines** and update when needed to ensure they reflect current programmatic needs

Motivational Interviewing

What is Motivational Interviewing?

- A patient-centered counseling style based on the principles of the humanistic psychology of Carl Rogers. He argued that for a person to "grow," we need an environment that provides us with genuine openness that enables self-disclosure, acceptance that includes being seen with unconditional positive regard, and empathy where we feel like we are being listened to and understood.

- A technique for increasing motivation to change and has proven to be particularly effective with people that may be unwilling or unable to change.

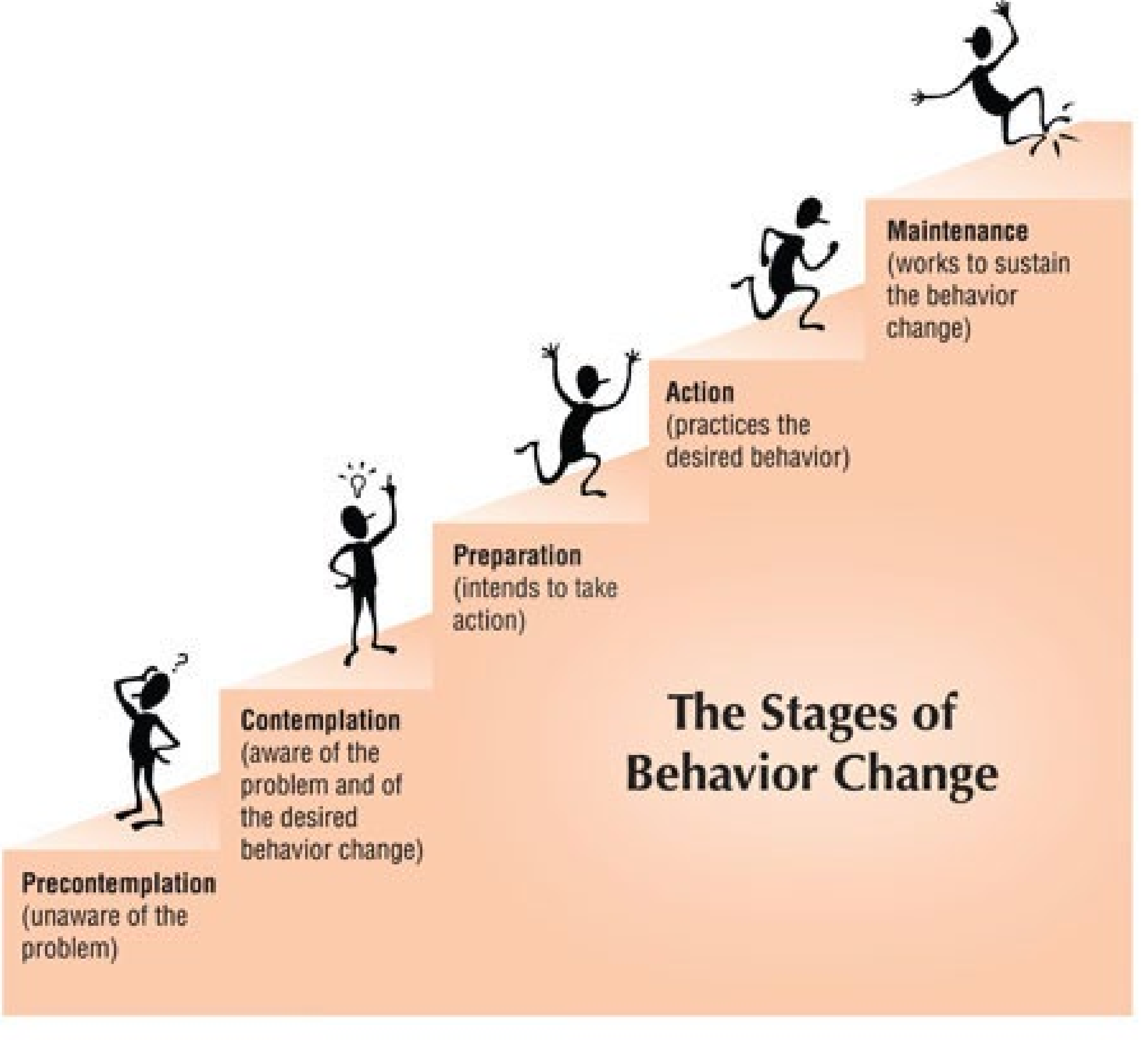
"*People are better persuaded by the reasons they discovered than those that come into the minds of others*"
-Blaise Pascal

- Rests on the assumption that we are ambivalent about change, not too weak or resistant to change.

"*The curious paradox is that when I accept myself just as I am, then I can change*" -Carl Rogers

- It's an **optimistic approach** to change aimed at resolving this ambivalence through eliciting and reinforcing change talk.

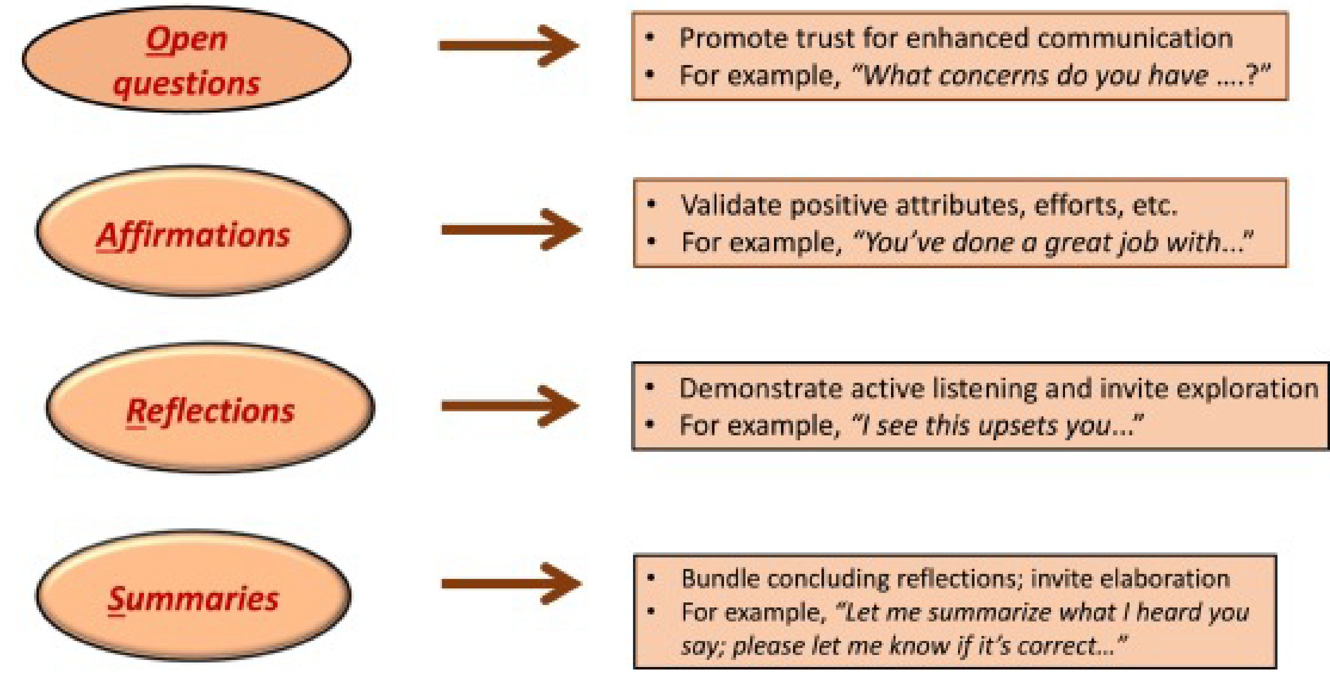
The Stages of Change – Transtheoretical Model



Sources: Grimley 1997 (75) and Prochaska 1992 (148)

Motivational Interviewing – Tell Us More…

Motivational Interviewing – Breaking it Down



Don’t forget to laugh along the way… ☺

How many social workers does it take to change a lightbulb?

One. But the lightbulb has to WANT to change.

VA S.A.V.E.

Teaching Communities how to help Veterans at Risk for Suicide

Acting with care/compassion if you encounter a Veteran in a suicidal crisis

» Signs of suicidal thinking should be recognized

» Ask the most important question of all

» Validate the Veteran’s experience

» Encourage treatment and Expedite getting help

Recognize Warning SIGNS of Suicidal Thinking

These signs requires immediate attention:

- Thinking about hurting or killing themselves
- Looking for ways to die
- Talking about death, dying, or suicide
- Self-destructive or risk-taking behavior, especially when it involves alcohol, drugs, or weapons

→ WARNING SIGNS:

- Hopelessness, feeling like there is no way out
- Anxiety, agitation, sleeplessness, or mood swings
- Feeling like there is no reason to live
- Rage or anger
- Engaging in risky activities without thinking
- Increasing alcohol or drug use
- Withdrawing from family and friends

ASKING the most important question…

Are you thinking about KILLING YOURSELF?

Do's	Don'ts
DO ask the question if you've identified warning signs or symptoms.	**DON'T** ask the question as though you are looking for a "no" answer. • "You aren't thinking of killing yourself, are you?"
DO ask the question in a natural way that flows with the conversation.	**DON'T** wait to ask the question when someone is halfway out the door.

VALIDATE the Veteran's Experience

- Talk openly about suicide: Use supportive listening and allow the Veteran to **express their feelings**
- Recognize that the situation is ***serious!***
- Practice acceptance: Use an approach with no judgement, pay attention to your own biases and watch your non-verbal communication to reflect compassion
- Reassure the Veteran: **help is available**

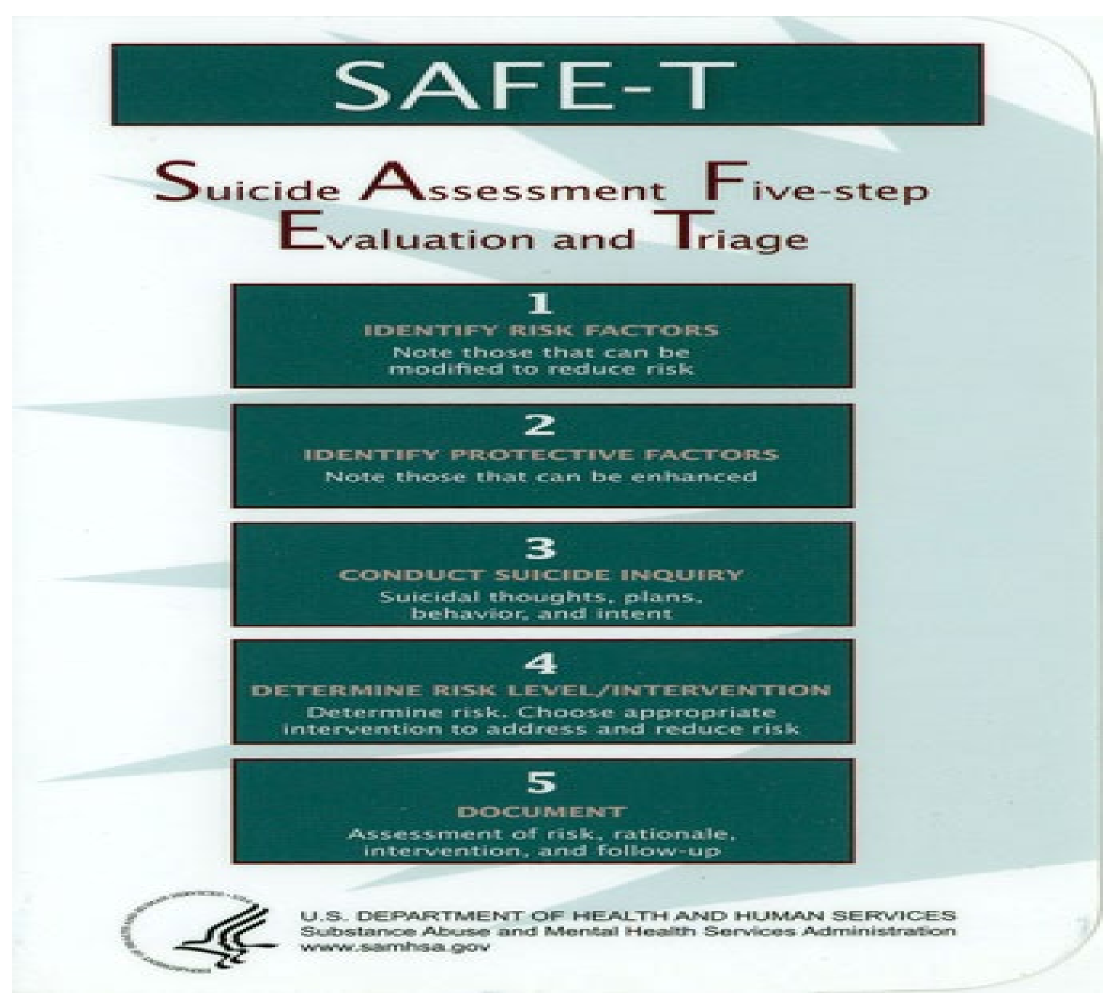
ENCOURAGE Treatment & EXPEDITE getting Help

- **What should I do if I think someone is suicidal?**
  - Don’t keep the Veteran’s suicidal behavior a secret
  - Do not leave them alone
  - Encourage the person to seek immediate help from their doctor or to go to the nearest hospital emergency room
  - Call 911
- Reassure the Veteran that help is available!!!
- Call the Veterans Crisis Line at **988 and Press 1**

Free, Confidential Support 24/7/365

- Veterans
- Service members
- Family members
- Friends

Suicide Prevention: SAMHSA Support



RESOURCES

- Download this card and additional resources at http://wwww.sprc.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide http://www.sprc.org/library/jcsafetygoals.pdf
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

HHS Publication No. (SMA) 09-4432 • CMHS-NSP-0193
Printed 2009

Suicide Prevention

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- ✓ **External**: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious.
  Explore ambivalence: reasons to die vs. reasons to live

* *For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition

* *Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

VA Staff Guidance on Completing Suicide Assessments

	C-SSRS Screener	CSRE	SBOR	Safety Plan
MD/DO	Yes	Yes	Yes	Yes
Licensed Psychologist (PhD/PsyD)	Yes	Yes	Yes	Yes
Clin. Pharm. Spec – Mental Health	Yes	Yes	Yes	Yes
Clin. Pharm. Spec.– Other	Yes†	No	Yes	Yes
LCSW/LMSW/LISW	Yes	Yes	Yes	Yes
LMFT	Yes	Yes	Yes	Yes
LPMHC	Yes	Yes	Yes	Yes
Addiction Therapist	Yes	No	Yes	Yes
LPN	Yes	No	No	No
RN	Yes	No	Yes	Yes
APRN: NP/CNS	Yes	Yes	Yes	Yes
PA	Yes	Yes	Yes	Yes
Peer Support Specialist	Yes	No	No	No
UAP	Yes	No	No	No
RT and MIT	Yes	No	No	No
PT/OT/KT	Yes	No	No	No
Vocational Rehabilitation Specialist	Yes	No	No	No
Rehabilitation Counselor	Yes	No††	Yes	Yes
Psych Tech (psychometrician)	Yes	No	No	No

Columbia-Suicide Severity Rating Scale (C-SSRS)

1) *Over the past month, have you wished you were dead or wished you could go to sleep and not wake up?*
   - ❑ Yes
   - ❑ No

2) *Over the past month, have you had any actual thoughts of killing yourself?*
   - ❑ Yes
   - ❑ No

3) *Over the past month, have you been thinking about how you might do this?*
   - ❑ Yes
   - ❑ No

4) *Over the past month, have you had these thoughts and had some intention of acting on them?*
   - ❑ Yes
   - ❑ No

5) *Over the past month, have you started to work out or worked out the details of how to kill yourself?*
   - ❑ Yes
   - ❑ No

6) *If yes to Question 5, at any time in the past month did you intend to carry out this plan?*
   - ❑ Yes
   - ❑ No

7) *In your lifetime, have you ever done anything, started anything, or prepared to do anything to end your life (for example, collected pills, obtained a gun, went to the roof but didn't jump)?*
   - ❑ Yes
   - ❑ No

8) *If yes to Question 7, was this within the past 3 months?*
   - ❑ Yes
   - ❑ No

Secondary Screener Scoring:

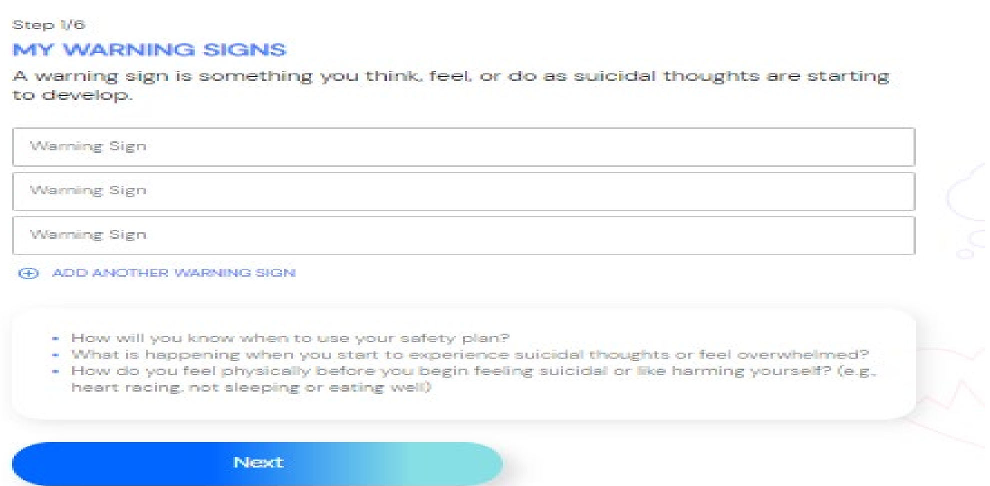
A positive C-SSRS (Columbia) score is a "YES" response to #3, 4, 5, or 8

If a positive screen has been determined, administration of the **Comprehensive Suicide Risk Evaluation** template must be completed **on the same day by an LIP**

Safety Planning

- **Who should have a Safety Plan?** Anyone can benefit from a Safety Plan
- **How does the Safety Plan work?** You create a Safety Plan to use when you're in a crisis. Having it written down and planned out means you don't have to develop a plan when the crisis is happening -- it'll be ready to go when you need it.
- **Do I have to stick to what I choose now for my Safety Plan?** No, the plan is flexible and you can add and change items as needed.

→ Example from **MySafetyPlan.org**:



Safety Plans Work

There is hope.

1. Write 3 warning signs that a crisis may be developing.

2. Write 3 internal coping strategies that can take your mind off your problems.

3. Who/What are 3 people or places that provide distraction? (Write name/place and phone numbers)
   Phone
   Phone
   Phone

4. Who can you ask for help? (Write names and phone numbers)
   Phone
   Phone
   Phone

5. Professionals or agencies you can contact during a crisis:
   Clinician: Phone
   Local Urgent Care or Emergency Department:
   Address Phone
   Call or text 988 or chat 988lifeline.org

6. Write out a plan to make your environment safer. (Write 2 things)

988 SUICIDE & CRISIS LIFELINE

Modified from Stanley & Brown (2021)

PEP22-08-03-007

Suicide Prevention – Know The Resources!

What are 988, 911, & 211?

988	Suicide and mental health crisis care New number for National Suicide Prevention Lifeline
911	Dispatching emergency medical services, fire and police
211	Suicide & mental health crisis care with emphasis on local community resources and care coordination

Coordinated Efforts & Beyond!

"OUR VETERAN"

Collaboration & Coordination between VA & SSVF

- Weekly Interdisciplinary Team Staffing's
- Bi-Monthly Meetings to review Veteran-Landlord Incentives
- Monthly Florida Partner Call
- Monthly VA/SSVF 2023 Homeless Goals/Monthly Office Hours Call
- Ongoing identification of gaps in care and enhancement of coordination

Questions??

~Thank you for having us!!

- Rocky H. Harrison, President of Operations, 90 Works
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- Jodie Picciano-Swanson, LCSW, ACSW, VISN 16 Network Homeless Coordinator
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  - Gwynavere.Schander@va.gov

Resources

17 Motivational Interviewing Questions and Skills (positivepsychology.com)

6m_AnalyzingRacialDisparities.pdf (va.gov)

988_SafetyPlan_Handout_r8_340px.png (340×476) (samhsa.gov)

About 988 - 211 Big Bend

Adverse Childhood Experiences (ACEs) and Attachment - Royal Manchester Children's Hospital (mft.nhs.uk)

Cultural Competence - KU CSL Community Engagement Toolbox

How Trauma in the Military Can Lead to PTSD — and How to Find Relief for Yourself or a Loved One (everydayhealth.com)

huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Part-1.pdf

Intuition: What It Is and How It Works | Psychology Today

mysafetyplan.org

Navigating-A-Mental-Health-Crisis (nami.org)

Paranoia versus Condition Yellow | The Personal Safety Group

r3_disparities_july2022-6-20-2022.pdf (jointcommission.org)

SAFE-T Pocket Card: Suicide Assessment Five-Step Evaluation and Triage for Clinicians | SAMHSA Publications and Digital Products

Social Workers and Nurses Personal Safety | The Personal Safety Group

Tracking Social Determinants of Health During the COVID-19 Pandemic | KFF

Using motivational interviewing and brief action planning for adopting and maintaining positive health behaviors – ScienceDirect

VA Homeless Programs