Consultation as a Means of Veteran Suicide Prevention

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The development and implementation of a suicide consultation service being run by an interdisciplinary team in a metropolitan Veteran’s Administration (VA) medical center is described. This service is grounded in a collaborative theoretical framework. An overview of the consultation process and theoretical and empirical literature to support the framework used by the service are provided. Some of the interventions commonly recommended to referring clinicians to reduce client suicide risk are reviewed. Although there are many challenges to running a service such as this, the authors conclude that the model presented is flexible enough to be applied in a variety of settings.

Keywords: suicide, veterans, consultation, assessment, collaboration

What options exist for mental health providers to increase clinical competence in working with high-risk suicidal patients? To whom can clinicians turn for help with case conceptualization and treatment planning? By what means can clients become increasingly engaged in their own treatment? In order to address these clinical issues within a Veteran Affairs (VA) Medical Center setting, a novel suicide prevention consultation service was developed. This service was organized by an interdisciplin-
nary group of clinicians with expertise in suicide and provides assistance with diagnostic and treatment conceptualization to an outpatient mental health clinic and a psychiatric inpatient unit.

We begin with a discussion of the reasons for starting our service and a summary of the conceptual model on which the service is based. An overview of the consultation process is provided to illustrate the evaluation model. Next, we discuss the potential impact on clients. Recommendations made to referring clinicians are then summarized, followed by an overview of lessons learned. We conclude with considerations for those thinking of starting their own service.

The main reason for establishing this service was to improve the care available to suicidal veterans and decrease the risk of negative and potentially fatal outcomes. This is in part accomplished by addressing the needs of clinicians. Working with a suicidal client can be quite stressful, in part because of the underlying concern that the individual will engage in injurious or fatal behavior. The literature clearly documents that there can be serious emotional consequences for clinicians who have clients die by suicide, such as feelings of anger, failure, guilt, shame, and a loss of self-esteem (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1989; Kleespies, 1993). These reactions lasted anywhere from a week to a month after the occurrence (Chemtob et al., 1989; Kleespies, 1993).

On a theoretical level, our service is best understood from the perspective of Caplan’s (1970, 1995; Caplan, Caplan, & Erchul, 1994) work in mental health consultation. Caplan’s (1970, 1995) model emphasizes systemic and institutional nuances and acknowledges how such factors impact the consultation process. Central to this framework is the recognition that consultation is an inherently complex process involving a triadic relationship amongst the client, consultee, and consultant. Effective consultation requires the consultant to attend to the interpersonal dynamics of each of these relationships and to cultivate trust throughout every stage of the consultation process.

Fostering a collaborative relationship between the consultee and consultant is critical (Caplan, 1970, 1995). Underlying our approach is the assumption that the relationship between the consultant and consultee is voluntary and noncoercive, implying that the consultee is free to accept or reject our recommendations (Caplan, 1970, 1995). The primary objective of our work is to provide a service that assists the consultee in solving a particular work-related problem (i.e., assessing suicide risk and related treatment planning) and to offer a didactic element that helps consultees function with increased autonomy (i.e., clinical competence when working with suicidal clients) when encountering a similar scenario in the future (Caplan, 1970, 1995).

Equally important is the establishment of a cooperative alliance between the consultant and client (Allen, 1981; Finn & Tonsager, 1997). Extending invitations to the client to collaborate in the consultation process communicates respect for the subjective personal experience of the client, while providing important data regarding the manner and extent to which the client is willing or able to engage in their own treatment. Emphasis on this relationship dyad provides the client opportunities for exploring mechanisms and alternatives to suicide during the process.

The Suicide Consultation Process

The service is an interdisciplinary group of mental health providers with broad backgrounds. The current team is comprised of clinical psychologists, psychiatrists, a clinical nurse specialist/nurse practitioner, clinical psychology postdoctoral fellows, and predoctoral interns. The referrals we receive encompass diagnostic and treatment questions, such as the extent to which cognitive impairment is contributing to suicide risk, the relationship between trauma history and suicidality, and therapeutic (e.g., psychotherapy, medication) options for managing chronic suicidality and/or psychiatric distress. The assessment model employed involves a flexible combination of extensive medical record review, comprehensive clinical interview, psychological and neuropsychological testing including self-report measures of suicide-related constructs, and collateral data collection (e.g., interview with the client’s significant other).

One of the clinical psychologists serves as the coordinator for the service to ensure that team member case loads are balanced, and that referral questions can be best answered. For example, when the primary referral question regards the extent to which sequelae of traumatic brain injury (TBI) are contributing to risk, a team member with expertise in neuropsychological assessment or neuropsychiatry takes the lead. The initial consultation objectives are to meet with the referring clinician to clarify both the reason for the referral (i.e., their specific concerns regarding the client’s suicidality) and the consultee’s expectations and gain a working understanding regarding the current nature of the therapeutic relationship (Caplan, 1970). This includes obtaining information regarding what interventions have already been tried with or without perceived success. It is important to have the consultee engage the client in the process of requesting the consultation, and if this has not already been achieved it is discussed during this meeting. Once this has occurred, the consulting team member contacts the client to make an initial appointment.

In addition to assessing imminent risk for suicidal behavior, the goals of the initial session with the client include demystifying the consultation process. This is in part accomplished by obtaining informed consent (Jobes, Rudd, Overholser, & Joiner, 2008). Other tasks include establishing consultation objectives and building rapport. We explain that our hope is to assist both the clinician and client gain greater understanding regarding current circumstances, and to, in turn, help the client remain safe as they engage in further therapy. Clients are provided the opportunity to articulate questions they have about themselves and asked how the assessment could be most helpful (Allen, 1981; Finn & Tonsager, 1997). The initial session lays the groundwork for developing collaborative relationships among the client, referring clinician, and consultee and provides a model for the client and clinician to use after completion of the consultation.

Background information is gathered via medical record review and a semistructured clinical interview. Psychological and neuropsychological testing is then conducted. A set of suicide-specific self-report measures is used to provide quantitative data on risk and protective factors. The measures used by the service (e.g., Beck & Steer, 1988; Beck, Steer, & Brown, 1996; Linehan, Goodstein, Nielsen, & Chiles, 1983) were selected based on psychometric properties, appropriateness for use with adults receiving mental health services, ability to assess a range of risk and pro-
ective factors, and to provide convergent validity for the interview data. See Table 1 for a summary of domains assessed and the potential sources for each, as we employ a flexible battery tailored to each referral. As executive dysfunction, including aggression and impulsivity, has been linked to suicide risk (Dougherty et al., 2004; Jollant et al., 2005; Keilp et al., 2001), we find it useful to assess this domain in all clients.

The consultant discusses preliminary findings with the consultee throughout the assessment, and enters a progress note in the client’s medical record at each appointment. VA electronic medical records allow the inclusion of additional providers as signers on notes. This function facilitates efficient information sharing with the referring clinician and other treatment team members, with the goal of encouraging consultees to remain active participants throughout the consultation process (Brown, Pryzwansky, & Schulte, 2001). This frequent information sharing and discussion provides a significant safety net during the process. In addition, cases are discussed during consultation service team meetings, thereby allowing for processing of issues ranging from strategies to decrease suicide risk to consultant reactions to working with large numbers of suicidal clients (Linehan, 1993).

Depending on the nature of the case and the treatment setting (inpatient or outpatient), the consultant and client meet for an average of 8 to 10 hr. With outpatient consults this process may occur over the course of up to 10 weeks. Because of the acute nature of the question, inpatient consults are typically completed within a week. During the process a wealth of information is obtained and integrated with (1) current theory (e.g., Joiner, 2005; Mann, Watermaux, Haas, & Malone, 1999; Rudd, 2006), (2) empirical evidence from the literature (e.g., Bullman & Kang, 1996; Kaplan, Huguet, McFarland, & Newsom, 2007; Kotler, Iancu, Efroni, & Amir, 2001), and (3) clinician experience working with clients at high risk for suicide. We consider how historical events, medical comorbidities, psychopathology, personality structure, cognitive functioning, and current stressors interact to shape the nature and severity of the client’s risk for suicide. This information is tempered by how responses to treatment; available supports; and religious, spiritual, and cultural beliefs may lower overall risk (Early, 1992; Jobes & Mann, 1999; Malone et al., 2000; Quinnett, 2000; Simpson & Tate, 2007). Although we believe that assessing the balance of risk and protective factors is an important part of the formulation, risk factors are for the most part empirically derived and population dependent (clinical and nonclinical) and as such may have limited utility (Rudd, Berman, et al., 2006). Moreover, Joiner et al. (2007) have cautioned that the role of protective factors may not be as strong as risk factors. Therefore, special emphasis is placed on identifying client-specific warning signs which are defined as the “earliest detectable sign that indicated heightened risk for suicide in the near term (i.e., within minutes, hours, or days)” (Rudd, Berman, et al., 2006, p. 258). Treatment recommendations often focus on targeting factors most likely to be amenable to intervention with modalities suited to meeting treatment goals. Warnings signs are also discussed with clients and consultants as a way to identify potentially imminent risk and facilitate safety planning (Stanley, Brown, Karlin, Kemp, & VonBergen, 2008).

The consultant incorporates information into a final written report. Upon completion of the document, a feedback meeting is typically scheduled with the referring clinician and other members of the treatment team (Caplan, 1970). When a face-to-face meeting cannot be scheduled in a timely manner, a telephone conversation or conference call is held instead. During the meeting a summary of the consultant’s findings and recommendations is provided, any remaining questions are addressed, and strategies for how to share feedback with the client are generated. The final process includes a feedback meeting with the client, the consultant and referring

### Table 1

**Key Domains Assessed During Suicide Consultation Process**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Representative primary sources</th>
<th>Additional sources</th>
</tr>
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<tbody>
<tr>
<td>Psychiatric symptoms/diagnoses</td>
<td>Clinical interview</td>
<td>Medical record</td>
</tr>
<tr>
<td></td>
<td>M.I.N.I.¹</td>
<td>Collateral data</td>
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<td></td>
<td>MMPI²</td>
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<td></td>
<td>Trauma Symptom Inventory³</td>
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<tr>
<td>Medical history</td>
<td>Clinical interview</td>
<td>Diagnostic imaging</td>
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<tr>
<td></td>
<td>Medical record</td>
<td>Neuropsychological testing</td>
</tr>
<tr>
<td>Severity of depressive symptoms</td>
<td>Beck Depression Inventory–II⁴</td>
<td>Medical record</td>
</tr>
<tr>
<td>Thoughts about the future</td>
<td>Beck Hopelessness Scale⁵</td>
<td>Collateral data</td>
</tr>
<tr>
<td>History of suicide-related behaviors/suicidal ideation</td>
<td>Beck Scale for Suicide Ideation⁶</td>
<td>Medical record</td>
</tr>
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<td></td>
<td>Self-Harm Behavior Questionnaire⁷</td>
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<tr>
<td>Suicide protective factors</td>
<td>Reasons for Living Inventory⁹</td>
<td>Clinical interview</td>
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<tr>
<td>Anger expression and anger control</td>
<td>State Trait Anger Expression Inventory¹⁰</td>
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<tr>
<td>Effortful performance</td>
<td>Computerized Assessment of Response Bias¹¹</td>
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<tr>
<td>Impulsivity/distractibility</td>
<td>Conners’ Continuous Performance Test¹²</td>
<td>Medical record</td>
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<tr>
<td></td>
<td>Wisconsin Card Sorting Test¹⁴</td>
<td>Neuropsychological testing</td>
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<tr>
<td>Executive functioning</td>
<td>Iowa Gambling Task¹³</td>
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<tr>
<td></td>
<td>Wisconsin Card Sorting Test¹⁴</td>
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</tbody>
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*Note.* M.I.N.I. = Mini-International Neuropsychiatric Interview; MMPI = Minnesota Multiphasic Personality Inventory.

clinician, and other members of the treatment team. This meeting allows the consultant to share impressions of the nature and extent of the client’s suicide risk, to answer questions about the process and conclusions drawn, to attend to concerns the client articulated at the onset of the consultation, and to discuss potential treatment plan modifications. We often discuss with the client our conceptualization of their psychological functioning on whole. This allows us to further model the process of providing feedback in an empathic and constructive manner. Moreover, to highlight the nature of the primary therapeutic relationship, which is between the patient and the consultee, we do not provide ongoing follow up regarding these cases. It is our belief that the client’s overall safety can best be improved by the client and clinician working together to decide how or if to implement the provided recommendations. We are available for informal consultation or formal discussion regarding past consultations upon request.

The service described here was started in 2005 when 12 referrals were received. Since then our numbers have almost doubled each year, with 42 referrals having been accepted in 2008. Because this service is clinically based and relative young, our current focus has been on revising and improving the consultation process. Exploring means of assessing short and long-term outcomes are a future goal.

Process Issues for Clients

Although evaluating client suicidality can be difficult and anxiety-provoking, it is the standard of care to assess suicidal ideation, communication, and behaviors with all clients potentially at risk for suicide (Coombs et al., 1992; O’Carroll & Potter, 1994). This assessment can be activating to the client, particularly when he/she is recollecting painful histories and providing suicidally-specific clinical information. Recognizing these concerns, research has, however, shown that clients are generally receptive to the assessment of suicide and past suicide attempts (Hahn & Marks, 1996).

A number of validated techniques can be used to diffuse distress (Carkhuff & Berenson, 1967; Corsini & Wedding 1989; Truax & Carkhuff, 1967). Use of empathy, respect, and genuineness during the course of our evaluation helps to foster improved psychological adjustment, greater tolerance for frustration, decreased defensiveness, and accelerated learning. Clients who are involved in a psychological assessment of some kind may be looking for confirmation or verification about what they believe or know about themselves and about the world around them (Finn & Tonsager, 1997). A technique commonly used in the evaluation process is to reframe the consultation as one in which the client can learn something about him/herself. The concept of self-discovery and the ability to organize and understand one’s life experiences can be quite powerful. Through a collaborative approach, we address the anxieties that our clients have as they discuss their histories, as well as help to clarify and create new meanings of the emotional and cognitive schemas they have developed about themselves (Youlom, 1980).

In addition, we attempt to normalize clients’ experiences with distress and discomfort by talking openly, candidly, and nonjudgmentally about suicidality. Finn and Tonsager (1997) discussed the notion that one universal human motive is to think of oneself highly, and be thought of by others with positive regard. Through the process of assessment and evaluation, we show respect and positive regard for our clients, evidenced by the invitation we extend to them to collaboratively engage in the consultation process. This process is intended to preserve or bolster the client’s sense of relevance and value (Rogers, 1961, 1986) as an integral participant in the consultation and to acknowledge the subjective experiences that drive or accompany their suicidality.

Because of the duration and intensity of the consultation process, we are mindful of clients’ sense of being “left” or abandoned once the consultation has been completed. This phenomenon parallels the concept of termination in therapy (Clemens, 2006). Acknowledging that the consultation can foster an intense and psychologically intimate relationship between consultant and client, it is no wonder that the alliances formed may be difficult to end. Termination is not seen just as a passive process of finalizing the consultation, but as a potentially empowering one that can help clients from “slipping back.” Termination is addressed early in our consultations, revisited throughout the process, and entails a transfer of responsibility back to the consultee (Brown et al., 2001). Efforts are made at all times to alleviate the potential negative effects of counterproductive termination. Thus, both the client and referring clinician are a part of the termination and feedback processes.

Although we apply this comprehensive approach to assessment and feedback to all referrals received, there are times when circumstances lead to other courses of action. For example, the client may prematurely terminate the consultation by refusing to participate in the evaluation. This behavior is a useful data point and is articulated in the conceptualization of the case and in the feedback to the referring clinician (and the client, if possible). There are also occasions when the referring clinician’s request is a comprehensive record review to ensure that they have not overlooked any important historical elements in their conceptualization. In these situations the consultant provides this service to the clinician without meeting the client directly.

Common Issues for Referring Clinicians

Each consultation is its own unique case; however, there are a number of common themes that recur throughout the process. First, it has been important to determine the extent to which the client is able to maintain a strong therapeutic alliance with the suicidal client. Research has consistently shown that the therapeutic alliance is critical in the assessment and treatment of suicidal clients (Chiles & Strossahl, 1995; Ellis, 2004; Hawton et al., 1998; Meichenbaum, 2005). Working with high-risk clients can be emotionally and cognitively taxing, with the resulting risk of the relationship between the clinician and client being strained during times of increased suicide risk.

We find it especially important to provide feedback to clinicians in the aim of helping them maintain supportive, collaborative, and nonjudgmental therapeutic relationships with challenging high-risk clients (Horvath & Greenberg, 1989, 1994; Martin, Garske, & Davis, 2000; Rogers, 1942, 1961). For example, a suicidal patient may interpret a clinician’s suggestion regarding involuntary hospitalization as an infringement of autonomy. In effect, such a suggestion might actually (albeit, unintentionally) result not only in the client surrendering responsibility to stay alive but also in the demise of the therapeutic alliance (Meichenbaum, 2005). There-
fore, a clinician using this approach might be encouraged to share their concerns regarding safety with the client and then together collaboratively determine whether hospitalization is the best treatment option (Jobes, 2006).

Although damage to the working alliance can occur via many channels, a significant amount of attention is placed on a loss of objectivity (Caplan, 1970) often secondary to countertransference. Freud (1959) coined the term and used it to refer to the psycho-analyst’s “neurotic transference reaction” to the analysand. However, countertransference has been redefined to broadly encompass any of the therapist’s internal reactions, feelings, or attitudes toward clients (Fromm-Reichmann, 1950; Gabbard, 2001; Kiesler, 2001; Peabody & Gelso, 1982). Today these responses are recognized as common, and it has been acknowledged that working with such material can positively contribute to the therapy (Peabody & Gelso, 1982).

From this framework, it has been helpful for consultants to discuss with referring clinicians the potential effects of therapists’ countertransference on the assessment and treatment of highly suicidal clients. Countertransference is examined and understood by two themes adapted from Cutler (1958): the under- or overemphasis of client material that is emotionally threatening; and/or the extent to which the clinician withdraws personal involvement in the work, and thus also withdraws empathy thereby jeopardizing the therapeutic alliance. In the first case, it is common for clinicians to under- or overemphasize the client’s suicidal communications or behaviors. In the latter case, clinicians might become overwhelmed to the point of desiring to “protect” themselves by avoidance of, or withdrawal from, the therapeutic relationship. In such cases, encouraging consultees to address this avoidance is a likely recommendation.

Specific Risk-Reduction Recommendations

We also offer a variety of practical recommendations for reducing client suicide risk. Exploring restricting clients’ access to means for harm is vital. Such restriction could include removing firearms or weapons from the home, prescribing a short-term supply of medications, and/or dispensing medication in blister packs. Research indicates that in most cases restricting a client’s access to their first choice means of self-harm does not result in substitution of another means (Hawton, 2007; Leenaars, 2007). Military veterans may be reluctant to remove weapons. Thus, creative approaches that involve collaboration between the client and consultant/consultee and support persons to limit access (e.g., gun locks, separate storage of guns and ammunition) may be necessary. To address suicidal crises, we commonly recommend increasing the frequency of appointments and clinician availability, encouraging veterans to access emergency resources including the VA national suicide prevention hotline (1-800-273-TALK), and engaging in safety planning (Stanley et al., 2008).

We may also provide suggestions regarding specific psychotherapeutic interventions (e.g., cognitive-behavioral therapy), with continued emphasis on collaboration and the therapeutic relationship. A relational and interpersonal emphasis may be recommended for clients with chronic suicidality and interpersonal challenges (e.g., social isolation). In essence, we reiterate Linehan’s (1999) remarks, “Therapy must be more than a suicide prevention program. It must be a life improvement program” (p. 166).

Lessons Learned

We have found that maintaining good collaborative relationships with the mental health staff facilitates the maintenance of the service. One way to foster collaboration is through consultation team members’ active involvement with mental health team meetings, complex case reviews, and morbidity and mortality conferences. When working with referring clinicians individually, the ability of the consultant to engage, reflect, respect, and provide recognition of the clinicians’ skills and efforts is also vital, and furthers the goal of maintaining a nonhierarchical relationship between the consultant and consultee (Caplan, 1970, 1995). Consultants who are approachable, trustworthy, helpful, and skilled at understanding the therapist/client relationship are much more likely to accurately assess the client and treatment process. As such, they are in a position to offer relevant insights and recommendations.

The “consultant-consultee” dyad embodies its own dynamics that influence the process of a consultation. The intensity of affect associated with suicide may add to the hesitance of inviting an opinion from someone not directly involved in the client’s care. Again, the consultant’s ability to recognize and respond to the complexities of these relationships is a significant factor in effectively working with the clinician and client. Systemic challenges can also arise. We therefore strive to offer constructive and beneficial solutions for the client, while minimizing recommendations that would unrealistically stretch available resources in the clinic. Accomplishing this goal requires an understanding of systemic resources and constraints (Brown et al., 2001; Caplan, 1995). Similarly, the length and duration of the consultation process is communicated explicitly, along with a realistic time frame in which the consultee can expect final feedback. It is the consultant’s responsibility to convey and manage the boundaries in the triad. Such boundaries include the following: managing the relationship among parties, providing coherent plans for the parties to follow, and encouraging clear communication of treatment recommendations for clinicians and clients. The consultation process employed in this service strives to use and model for consultees appropriate informed consent, thorough assessment of risk, and treatment recommendations based in the current empirical literature. In so doing, not only is the level of care provided increased, but the malpractice liability for all involved clinicians is reduced (Jobes et al., 2008). Frequent use of consultation also reduces liability risk for the referring clinician. As Jobes (2006) states “there is a need to routinely seek professional consultation on difficult cases because it demonstrates good clinical judgment and the appropriate use of one’s resources” (p. 122).

Conclusions

Several issues must be considered before starting a suicide consultation service. Strategic formation of the interdisciplinary team to suit the organization’s needs and available resources is recommended. It is also important to remember that any group of experienced mental health professionals will develop and expand their expertise in suicide consultation through the process of conducting such a service, so it is not always necessary to staff the team with “suicide experts.”

Providing high-quality care to suicidal clients is an extremely important endeavor. Significant resources in terms of staff time
may be required to keep a client safe and to maintain them in the least restrictive environment feasible. Helping clinicians and clients tease apart the complex interactions leading to suicide, and developing treatment plans to target those factors is time well spent. A suicide consultation service such as the one described here may not be necessary or practical in all institutions. However, it is worth carefully assessing the need for such a service, the resources that could be accessed to form one, and the potential benefits to the staff and clients. The outlined model is flexible enough to be adapted to a wide range of settings.

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