U.S. Department of Veterans Affairs

Using Clinical Practice Guidelines to Inform Suicide Prevention Efforts

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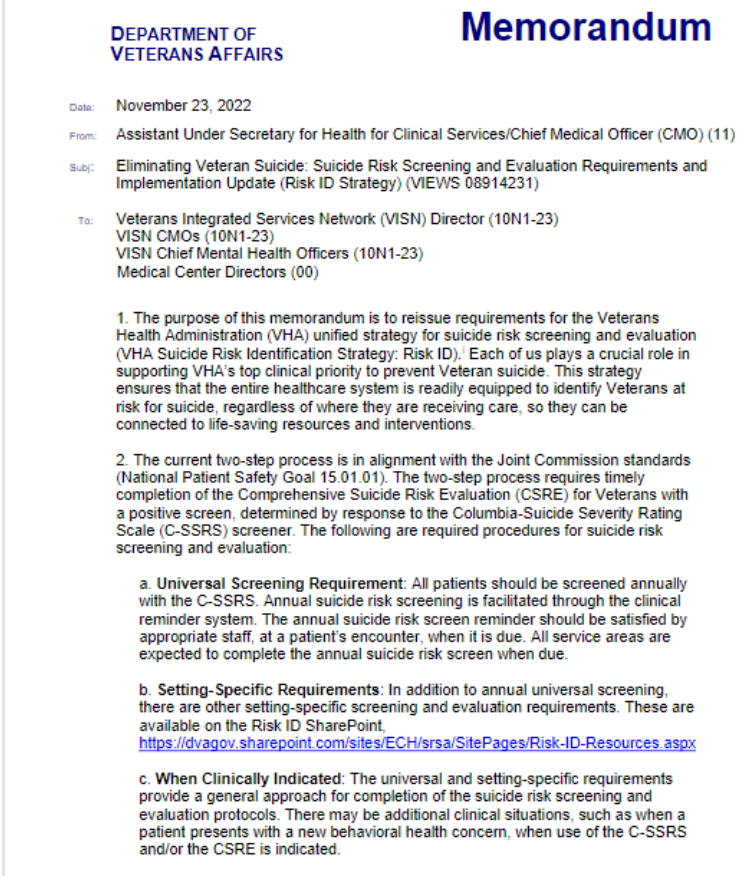
Suicide Risk ID Requirements

On 11/23/22 a memorandum was released to update the field on Risk ID requirements:

- Ensure compliance with Joint Commission Requirements
- Screen **ALL** Veterans at least annually
- Widen the breadth of providers and staff that can conduct suicide risk screening.



DEPARTMENT OF VETERANS AFFAIRS

Memorandum

Date: November 23, 2022

From: Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11)

Subj: Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy) (VIEWS 08914231)

To: Veterans Integrated Services Network (VISN) Director (10N1-23)
VISN CMOs (10N1-23)
VISN Chief Mental Health Officers (10N1-23)
Medical Center Directors (00)

1. The purpose of this memorandum is to reissue requirements for the Veterans Health Administration (VHA) unified strategy for suicide risk screening and evaluation (VHA Suicide Risk Identification Strategy: Risk ID).' Each of us plays a crucial role in supporting VHA's top clinical priority to prevent Veteran suicide. This strategy ensures that the entire healthcare system is readily equipped to identify Veterans at risk for suicide, regardless of where they are receiving care, so they can be connected to life-saving resources and interventions.

2. The current two-step process is in alignment with the Joint Commission standards (National Patient Safety Goal 15.01.01). The two-step process requires timely completion of the Comprehensive Suicide Risk Evaluation (CSRE) for Veterans with a positive screen, determined by response to the Columbia-Suicide Severity Rating Scale (C-SSRS) screener. The following are required procedures for suicide risk screening and evaluation:

a. **Universal Screening Requirement**: All patients should be screened annually with the C-SSRS. Annual suicide risk screening is facilitated through the clinical reminder system. The annual suicide risk screen reminder should be satisfied by appropriate staff, at a patient's encounter, when it is due. All service areas are expected to complete the annual suicide risk screen when due.

b. **Setting-Specific Requirements**: In addition to annual universal screening, there are other setting-specific screening and evaluation requirements. These are available on the Risk ID SharePoint, https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Risk-ID-Resources.aspx

c. **When Clinically Indicated**: The universal and setting-specific requirements provide a general approach for completion of the suicide risk screening and evaluation protocols. There may be additional clinical situations, such as when a patient presents with a new behavioral health concern, when use of the C-SSRS and/or the CSRE is indicated.

U.S. Department of Veterans Affairs

VA Risk ID Suicide Strategy Overview

- VA Risk ID is a national, standardized process for suicide risk screening and evaluation, using high-quality, evidence-based tools and practices.

- Risk ID ensures fidelity to best practices for suicide risk screening and evaluation across the healthcare system.

- **VA Risk ID outlines a clear process for:**
  - **WHO** *should be screened and/or evaluated.*
  - **WHEN** *screening and/or evaluation should occur.*
  - **HOW** *screening and/or evaluation should be conducted and documented.*

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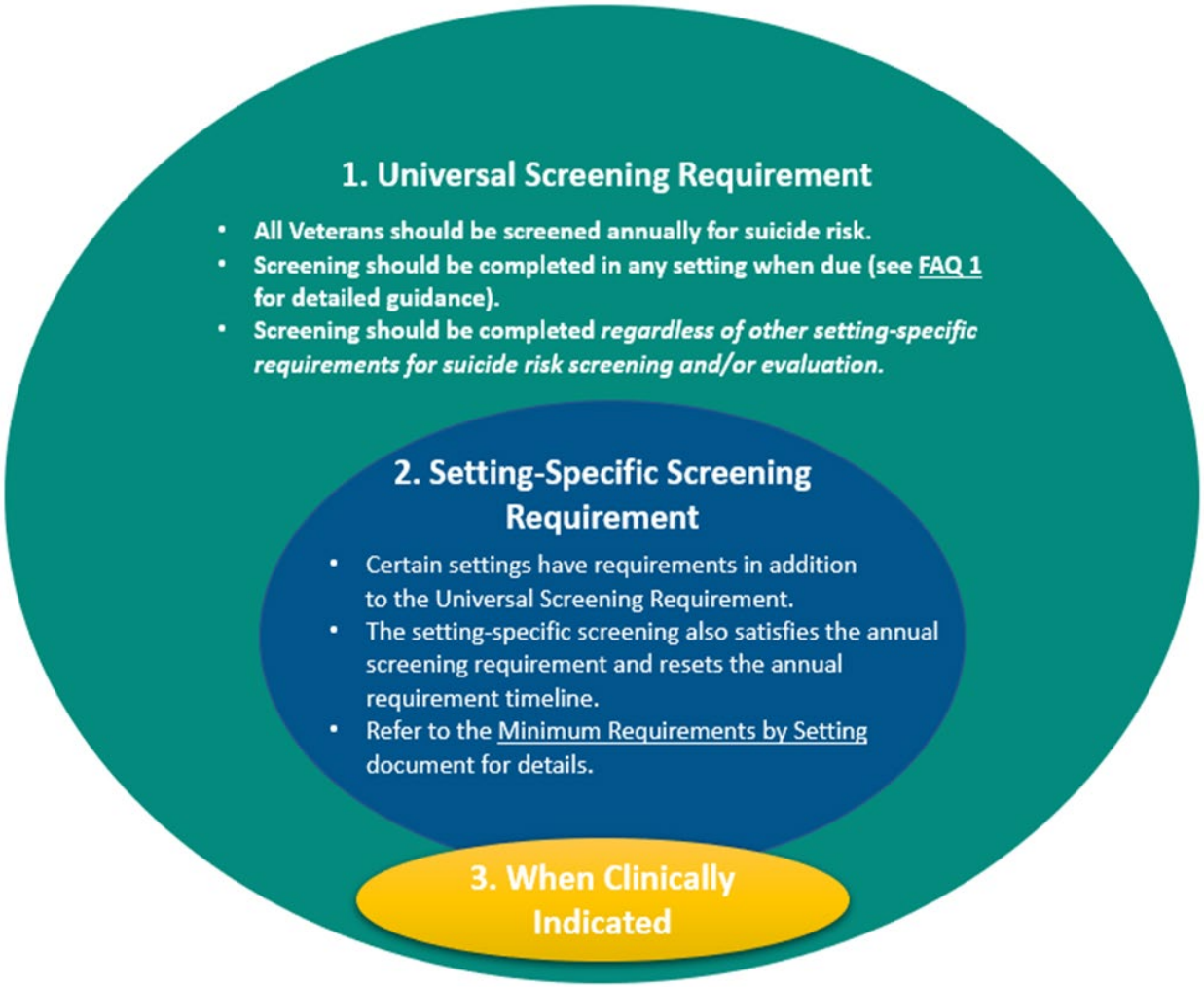
Why Universal Screening?

- Suicide rates are higher among Veterans with recent VHA use than among Veterans without recent VHA use
- From 2018 to 2019 suicide rates increased 8.6% among Veterans with recent VHA encounters *(VHA Veterans; with use in the year or prior year)*
- Suicide rates in 2019 increased among patients who had not received mental health or substance use disorder diagnoses.
- Nearly all individuals who die by suicide make a healthcare visit in the year before their death and half have contact in the month before their death. On average, those who die by suicide have 10 outpatient medicine specialty and 4 primary care visits in the year before death.
- Screening facilitates Veteran connection with Mental Health treatment. For patients without MH treatment in the past year, a positive C-SSRS screen is associated with a greater increase in probability of MH engagement.

Suicide Risk Screening: Requirements



Risk ID Requirements: Two-Stage Process

C-SSRS Screener → VA Comprehensive Suicide Risk Evaluation

SCREEN: To detect who may be at risk for suicide and is need of further evaluation

EVALUATE: To inform clinical impressions about acute and chronic risk and associated disposition

*A positive C-SSRS requires the timely completion of the Comprehensive Suicide Risk Evaluation (CSRE).

In ambulatory care settings, timely = same day as the positive C-SSRS
In inpatient, residential and ED/UCC settings, timely = within 24 hours of the positive C-SSRS

C-SSRS: Columbia Suicide Severity Rating Scale

- Offers structured, standardized and specific method of suicide risk screening.
- Screening questions focus on severity and recency of suicidal ideation, and suicidal behavior, such as:
  - **Wish to die**
  - **Suicidal thoughts without intent**
  - **Suicidal thoughts with specific plan and intent**
  - **Recent preparatory behavior or suicide attempt**
- There is automatic branching in CPRS based on their response in the template that will guide you.
- Link to additional C-SSRS Resources and Training on SharePoint

Columbia Lighthouse Project. Home page. 2016. August 20, 2018. https://www.cssrs.columbia.edu.

Comprehensive Suicide Risk Evaluation (CSRE)

Comprehensive evaluation of factors contributing to suicide risk

- Conduct the CSRE in a therapeutic and collaborative manner
- Allows the Veteran to share their narrative around their suicidal thoughts and any past behavior
- Helps stratify the Veteran's current risk
  - **Acute risk** *(minutes, hours, days… shorter-term)*
  - **Chronic risk** *(weeks, months…longer-term)*
- Identify individually-tailored risk mitigation strategies that map onto these levels of risk.

JAMA Network Open

Original Investigation | Health Policy

Assessment of Rates of Suicide Risk Screening and Prevalence of Positive Screening Results Among US Veterans After Implementation of the Veterans Affairs Suicide Risk Identification Strategy

Nazanin Bahraini, PhD; Lisa A. Brenner, PhD; Catherine Barry, PhD; Trisha Hostetter, MPH; Janelle Keusch, MPH; Edward P. Post, MD, PhD; Chad Kessler, MD; Cliff Smith, PhD; Bridget B. Matarazzo, PsyD

Abstract

IMPORTANCE In 2018, the Veterans Health Administration (VHA) implemented the Veterans Affairs (VA) Suicide Risk Identification Strategy to improve the identification and management of suicide risk among veterans receiving VHA care.

OBJECTIVES To examine the prevalence of positive suicide screening results among veterans in ambulatory care and emergency departments (EDs) or urgent care clinics (UCCs) and to compare acuity of suicide risk among patients screened in these settings.

DESIGN, SETTING, AND PARTICIPANTS This cross-sectional study used data from the VA's Corporate Data Warehouse (CDW) to assess veterans with at least 1 ambulatory care visit (n = 4 101 685) or ED or UCC visit (n = 1 044 056) at 140 VHA medical centers from October 1, 2018, through September 30, 2019.

EXPOSURES Standardized suicide risk screening and evaluation tools.

MAIN OUTCOMES AND MEASURES One-year rate of suicide risk screening and evaluation, prevalence of positive primary and secondary suicide risk screening results, and levels of acute and chronic risk based on the VHA's Comprehensive Suicide Risk Evaluation.

RESULTS A total of 4 101 685 veterans in ambulatory care settings (mean [SD] age, 62.3 [16.4] years; 3 771 379 [91.9%] male; 2 996 974 [73.1%] White) and 1 044 056 veterans in ED or UCC settings (mean [SD] age, 59.2 [16.2] years; 932 319 [89.3%] male; 688 559 [66.0%] White) received the primary suicide screening. The prevalence of positive suicide screening results was 3.5% for primary screening and 0.4% for secondary screening in ambulatory care and 3.6% for primary screening and 2.1% in secondary screening for ED and UCC settings. Compared with veterans screened in ambulatory care, those screened in the ED or UCC were more likely to endorse suicidal ideation with intent (odds ratio [OR], 4.55; 95% CI, 4.37-4.74; $P < .001$), specific plan (OR, 3.16; 95% CI, 3.04-3.29; $P < .001$), and recent suicidal behavior (OR, 1.95; 95% CI, 1.87-2.03; $P < .001$) during secondary screening. Among the patients who received a Comprehensive Suicide Risk Evaluation, those in ED or UCC settings were more likely than those in ambulatory care settings to be at high acute risk (34.1% vs 8.5%; $P < .001$).

CONCLUSIONS AND RELEVANCE In this cross-sectional study, population-based suicide risk screening and evaluation in VHA ambulatory care and ED or UCC settings may help identify risk among patients who may not be receiving mental health treatment. Higher acuity of risk among veterans in ED or UCC settings compared with those in ambulatory care settings highlights the

(continued)

Key Points

Question Are population-level suicide risk screening and evaluation feasible in Veterans Health Administration medical settings and do they identify patients at risk for suicide?

Findings In this cross-sectional study of more than 4 million US veterans screened in ambulatory care and emergency department settings during fiscal year 2019, the prevalence of suicidal ideation was 3.5%. Acuity of suicide risk was greater among patients screened in the emergency department than in ambulatory care.

Meaning Population-based suicide risk screening and evaluation in Veterans Health Administration medical settings may facilitate identification of risk among those who may not be receiving mental health treatment.

+ Editorial

+ Supplemental content and Audio

Author affiliations and article information are listed at the end of this article.

Table 1. Patient Demographics for Patients Who Received the Primary Suicide Risk Screen by Setting, 2018-2019[a]

Demographic	Ambulatory care (n = 4 101 685)	ED or UCC (n = 1 044 056)
Age, mean (SD),	62.3 (16.4)	59.2 (16.2)
Sex		
Male	3 771 379 (91.9)	932 319 (89.3)
Female	330 303 (8.0)	111 736 (10.7)
Race/ethnicity		
White	2 996 974 (73.1)	688 559 (66.0)
Black or African American	695 039 (17.0)	266 708 (25.5)
Native Hawaiian or Other Pacific Islander	34 434 (0.8)	7960 (0.8)
Asian	46 254 (1.1)	8326 (0.8)
American Indian or Alaska Native	30 606 (0.8)	8576 (0.8)
Multirace	35 260 (0.9)	10 436 (1.0)
Missing	263 118 (6.4)	53 491 (5.1)

Abbreviations: ED, emergency department; UCC, urgent care clinic.

[a] Data are presented as number (percentage) of patients unless otherwise indicated.

Table 2. Prevalence of Positive and Negative Screening Results by Setting, 2018-2019

	No. (%) of unique patients with item 9 response	
Result	AC (n = 4 101 685)	ED or UCC[a] (n = 1 044 056)
Negative item 9[b]	3 959 053 (96.5)	1 025 175 (98.2)
Positive item 9[b]	142 632 (3.5)	37 761 (3.6)
No C-SSRS Screener[c]	45 406 (1.1)	6958 (0.7)
Negative C-SSRS Screener[d]	80 226 (2.0)	12 977 (1.2)
Positive C-SSRS Screener[d]	17 000 (0.4)	21 909 (2.1)

Abbreviations: AC, ambulatory care; C-SSRS Screener, Columbia Suicide Severity Rating Scale Screener; ED, emergency department; UCC, urgent care clinic.

[a] In the ED or UCC cohort, categories are not mutually exclusive. For example, because unique individuals in the ED could have multiple encounters, they could have been counted in multiple categories if screening results differed during these encounters. In such cases, they would be counted only once in each category.

[b] A total of 22 569 unique people in the ED or UCC cohort had a positive item 9 response and negative item 9 response on 2 separate encounters.

[c] In the AC cohort, 1691 of those with no C-SSRS Screener result went from a positive item 9 response to a Comprehensive Suicide Risk Evaluation; in the ED or UCC cohort, 2346 of those with no C-SSRS Screener result went from a positive item 9 response to a Comprehensive Suicide Risk Evaluation.

[d] A total of 2110 unique people in the ED or UCC cohort had a positive C-SSRS Screener result and a negative C-SSRS Screener result on 2 separate encounters.

PLOS ONE

RESEARCH ARTICLE

Mental health follow-up and treatment engagement following suicide risk screening in the Veterans Health Administration

Nazanin Bahraini[1,2,3]*, **Daniel J. Reis**[1,2], **Bridget B. Matarazzo**[1,2], **Trisha Hostetter**[1], **Christina Wade**[1], **Lisa A. Brenner**[1,2,3,4]

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OPEN ACCESS

Citation: Bahraini N, Reis DJ, Matarazzo BB, Hostetter T, Wade C, Brenner LA (2022) Mental health follow-up and treatment engagement following suicide risk screening in the Veterans Health Administration. PLoS ONE 17(3): e0265474. https://doi.org/10.1371/journal.pone.0265474

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Data Availability Statement: Data cannot be shared publicly because of VA policies regarding data privacy and security. Data contain potentially identifying and sensitive patient information. All relevant de-identified data are included in the manuscript. For investigators with appropriate authorizations within the Department of Veterans Affairs, requests for data access can be made to VHAECHMIRECCAdmin@va.gov.

Funding: The Veterans Health Administration Suicide Risk Identification Strategy was funded by

Abstract

Importance

Understanding the extent to which population-level suicide risk screening facilities follow-up and engagement in mental health treatment is important as engaging at-risk individuals in treatment is critical to reducing suicidal behaviors.

Objective

To evaluate mental health follow-up and treatment engagement in the Veterans Health Administration (VHA) following administration of the Columbia-Suicide Severity Rating Scale (C-SSRS) screen, a component of the VHA's universal suicide risk screening program.

Design

This cross-sectional study used data from VA's Corporate Data Warehouse.

Settings

140 VHA Medical Centers.

Participants

Patients who completed the C-SSRS screen in ambulatory care between October 1, 2018—September 30, 2020.

Exposure

Standardized suicide risk screening.

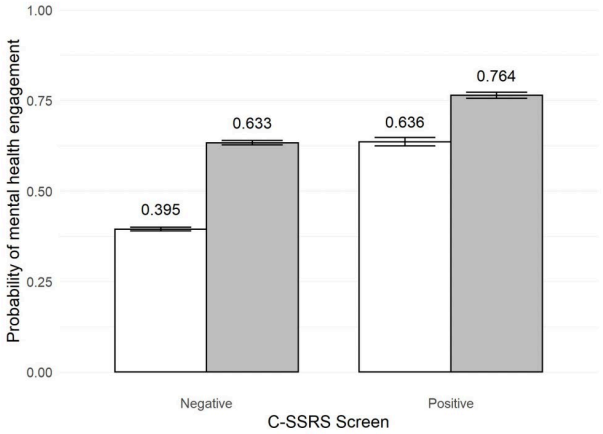
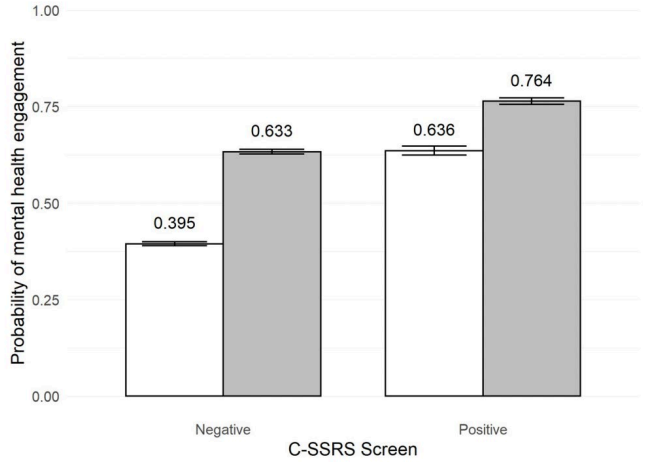


Fig 2. Probability of mental health engagement after C-SSRS screening in fiscal year 2019. The gray bars represent having received mental health treatment in past year. The white bars represent not having received mental health treatment in the past year. Error bars represent standard error. C-SSRS = Columbia-Suicide Severity Rating Scale.

https://doi.org/10.1371/journal.pone.0265474.g002



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https://doi.org/10.1371/journal.pone.0265474.g002

U.S. Department of Veterans Affairs

PLOS ONE

RESEARCH ARTICLE

VA's implementation of universal screening and evaluation for the suicide risk identification program in November 2020 – Implications for Veterans with prior mental health needs

Kritee Gujral[1,2]*, Nazanin Bahraini[3,4,5], Lisa A. Brenner[3,4,5,6], James Van Campen[2,7], Donna M. Zulman[2,7], Samantha Illarmo[1], Todd H. Wagner[1,2,8]

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OPEN ACCESS

Citation: Gujral K, Bahraini N, Brenner LA, Van Campen J, Zulman DM, Illarmo S, et al. (2023) VA's implementation of universal screening and evaluation for the suicide risk identification program in November 2020 –Implications for Veterans with prior mental health needs. PLoS ONE 18(4): e0283633. https://doi.org/10.1371/journal.pone.0283633

Editor: Bettye A. Apenteng, Georgia Southern University, UNITED STATES

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Published: April 11, 2023

Data Availability Statement: Data cannot be shared publicly because of VA policies regarding data privacy and security. Data contain potentially identifying and sensitive patient information. All relevant de-identified data are included in the manuscript. For investigators with appropriate authorizations within the Department of Veterans Affairs, data are available in the VA Corporate Data Warehouse and the suicide screening and evaluation data are available through the Program

Abstract

Importance

United States Veterans are at higher risk for suicide than non-Veterans. Veterans in rural areas are at higher risk than their urban counterparts. The coronavirus pandemic intensified risk factors for suicide, especially in rural areas.

Objective

To examine associations between Veterans Health Administration's (VA's) universal suicide risk screening, implemented November 2020, and likelihood of Veterans being screened, and receiving follow-up evaluations, as well as post-screening suicidal behavior among patients who used VA mental health services in 2019.

Methods

VA's Suicide Risk Identification Strategy (Risk ID), implemented October 2018, is a national, standardized process for suicide risk screening and evaluation. In November 2020, VA expanded Risk ID, requiring annual universal suicide screening. As such, we are evaluating outcomes of interest before and after the start of the policy among Veterans who had ≥1 VA mental health care visit in 2019 (n = 1,654,180; rural n = 485,592, urban n = 1,168,588).

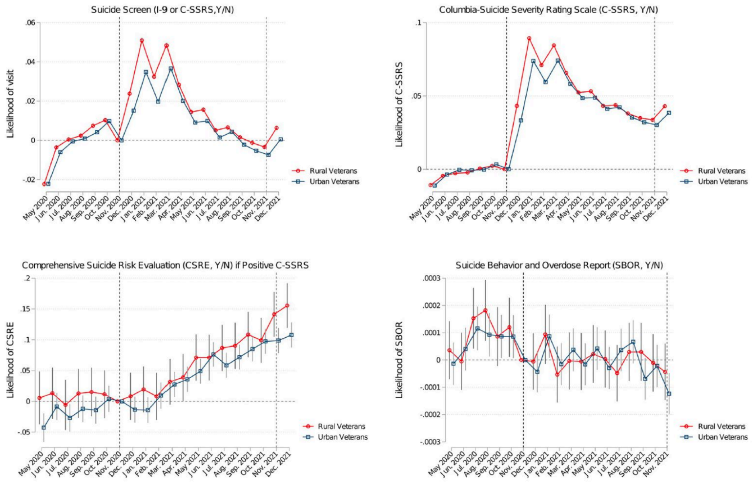

Fig 3. Model-adjusted outcome differences compared to Nov. 2020, for rural and urban Veterans–monthly coefficients from regression analyses. Note: Rural (urban) cohort analyses not conditioned on positive C-SSRSs included 485,592 (1,168,588) Veterans and 9,711,840 (23,371,760) Veteran-monthly observations. Rural (urban) cohort conditioned on positive C-SSRSs included 15,097 (42,576) Veterans and 21,040 (64,197) Veteran-monthly observations. All models adjusted for Veterans' age, sex, race, ethnicity, number of physical and mental health chronic conditions, diagnoses of substance use disorder, post-traumatic stress disorder and depression, nosos score, VA priority-based enrollment, marital status, homelessness indicator, high suicide risk indicator, cumulative monthly COVID-19 cases in the patient's county. All models included indicators for patients' closest facility to control for any time-invariant facility characteristics. In sensitivity analyses, models also adjusted for broadband coverage in patients' residential zip-codes.

https://doi.org/10.1371/journal.pone.0283633.g003

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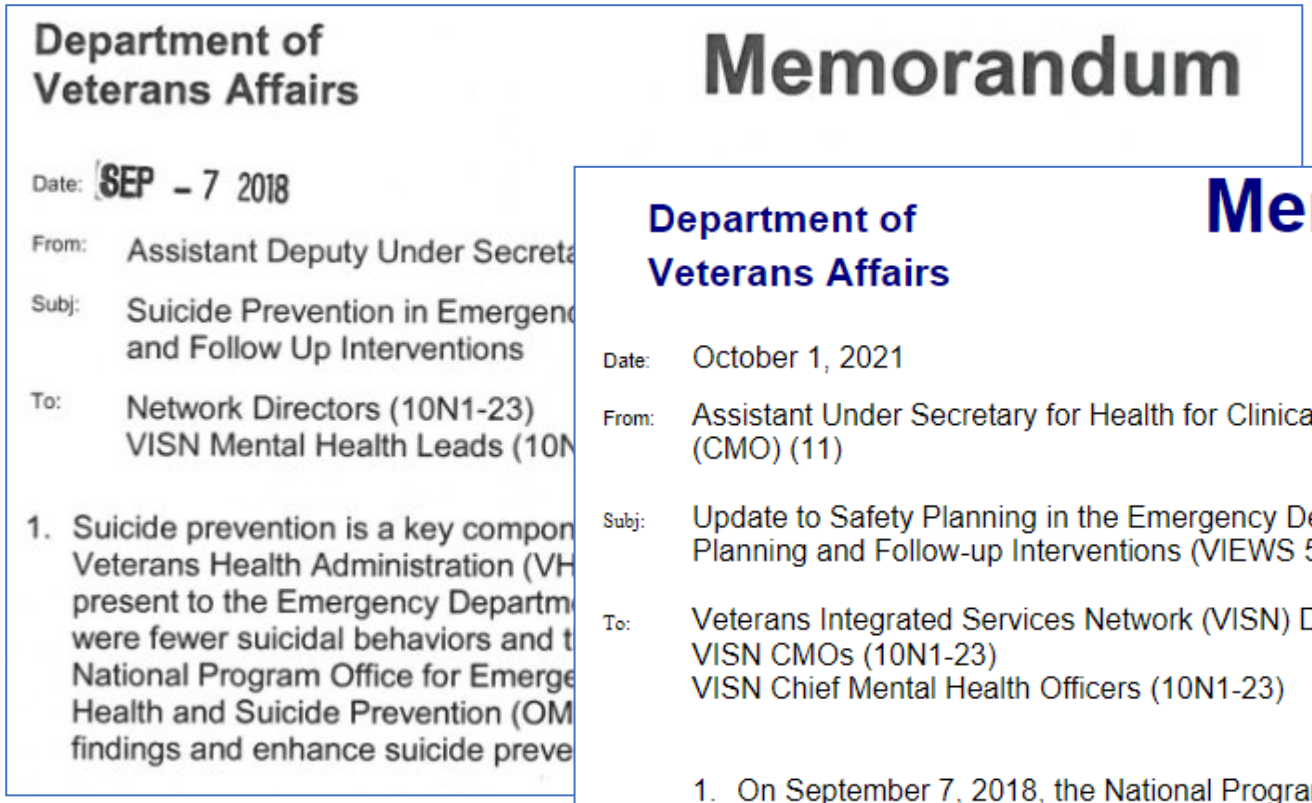
Safety Planning in the Emergency Department (SPED)



Department of Veterans Affairs

Memorandum

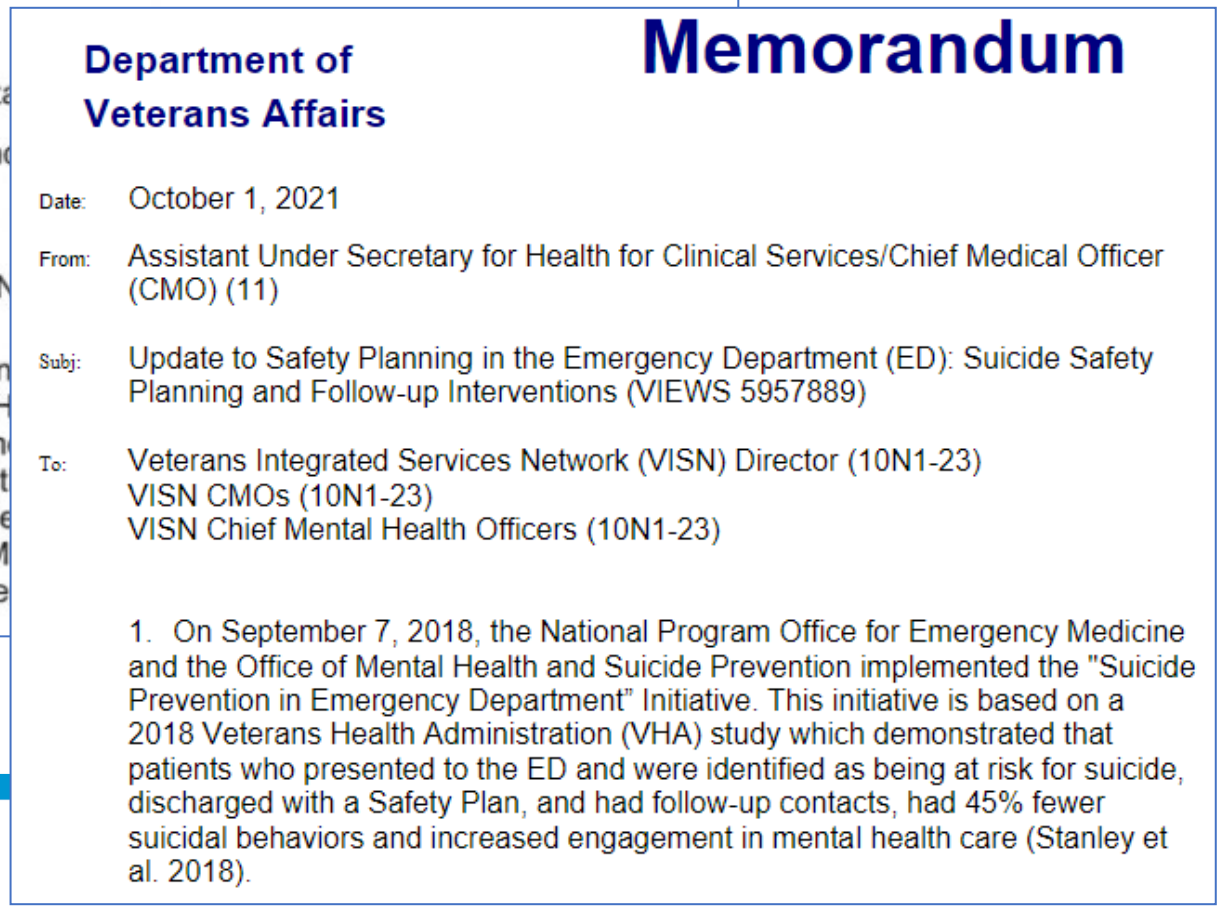
Date: SEP – 7 2018

From: Assistant Deputy Under Secreta

Subj: Suicide Prevention in Emergenc and Follow Up Interventions

To: Network Directors (10N1-23)
VISN Mental Health Leads (10N

1. Suicide prevention is a key compon Veterans Health Administration (VH present to the Emergency Departm were fewer suicidal behaviors and t National Program Office for Emerge Health and Suicide Prevention (OM findings and enhance suicide preve



Department of Veterans Affairs

Memorandum

Date: October 1, 2021

From: Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11)

Subj: Update to Safety Planning in the Emergency Department (ED): Suicide Safety Planning and Follow-up Interventions (VIEWS 5957889)

To: Veterans Integrated Services Network (VISN) Director (10N1-23)
VISN CMOs (10N1-23)
VISN Chief Mental Health Officers (10N1-23)

1. On September 7, 2018, the National Program Office for Emergency Medicine and the Office of Mental Health and Suicide Prevention implemented the "Suicide Prevention in Emergency Department" Initiative. This initiative is based on a 2018 Veterans Health Administration (VHA) study which demonstrated that patients who presented to the ED and were identified as being at risk for suicide, discharged with a Safety Plan, and had follow-up contacts, had 45% fewer suicidal behaviors and increased engagement in mental health care (Stanley et al. 2018).

The Why: Best Available Evidence

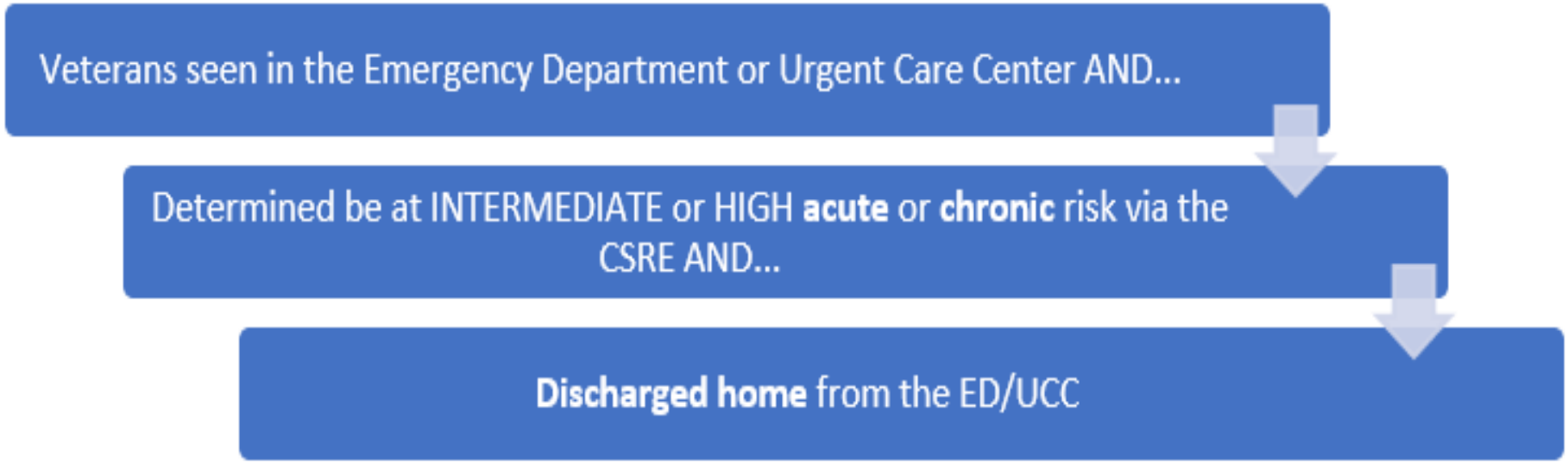
Presentation to the ED is a suicide risk factor.

- ED patients presenting without self-harm or suicidal ideation were 2x more likely to die by suicide than matched controls *(Goldman-Mellor et al., 2019).*
- ED/UCCs can ID risk (via the C-SSRS), support engagement in mental health care and potentially minimize repeat ED/UCC visits.

VA SPED Strategy Overview

Safety Planning in the Emergency Department (SPED) is an evidence-based intervention offered to Veterans whose suicide risk was identified in a VHA Emergency Department or Urgent Care Center (ED/UCC).

- **Veterans at risk are identified and evaluated via Risk ID processes.**



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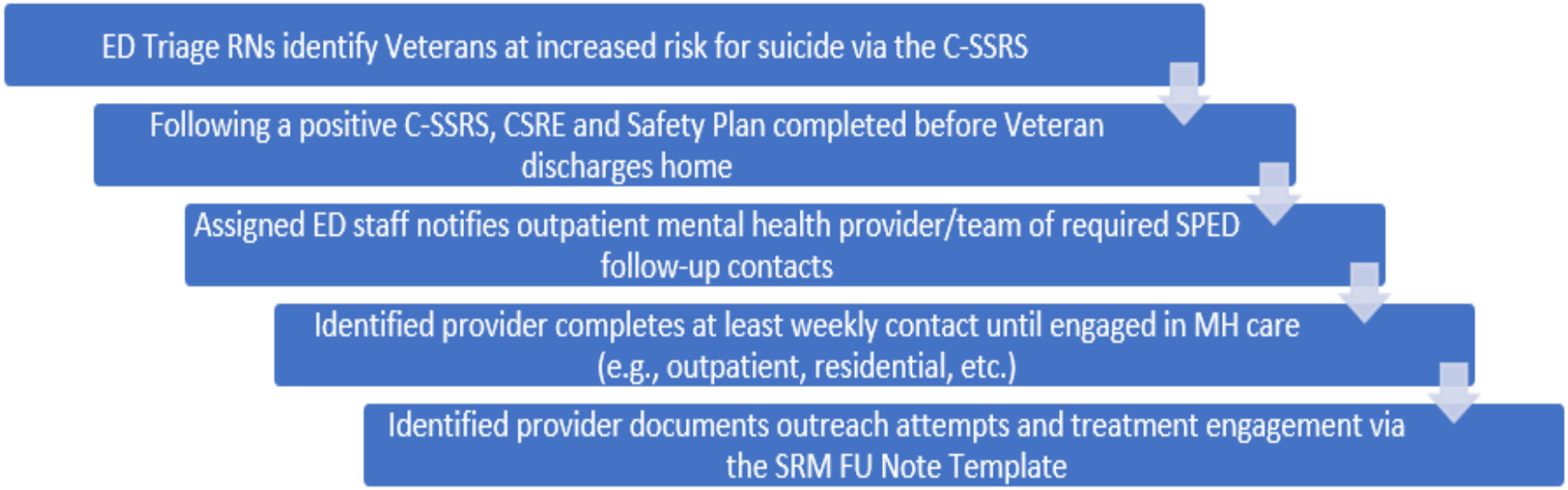
JAMA Psychiatry | Original Investigation

Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department

Barbara Stanley, PhD; Gregory K. Brown, PhD; Lisa A. Brenner, PhD; Hanga C. Galfalvy, PhD; Glenn W. Currier, MD; Kerry L. Knox, PhD; Sadia R. Chaudhury, PhD; Ashley L. Bush, MMA; Kelly L. Green, PhD

- 1640 patients seen in a VA Emergency Department for a suicide-related concern and were not hospitalized (5 intervention and 4 control sites)
  - 454 in comparison group and 1186 in intervention group
- Intervention: Safety Planning Intervention + telephone follow-up
  - Telephone follow-up consisted of at least 2 contacts to monitor suicide risk, review and revise the SPI, and support treatment engagement
- Outcomes (6 mo. follow-up period)
  - Intervention associated with 45% fewer suicidal behaviors
  - Double the odds of attending at least 1 outpatient MH visit

How is SPED Implemented?



- Effective SPED implementation requires collaboration between Emergency Department and Outpatient Mental Health

Monitoring Performance

Annual Suicide Risk Screen Adherence: eCSSRS1

Description: % of Patients with timely completion of the C-SSRS Annual Suicide Risk Screen (i.e., during an encounter in which it is due)

Timely CSRE after Annual Suicide Risk Screen: eCSRE1

Description: % of Patients with timely completion of the CSRE following a positive C-SSRS Annual Suicide Risk Screen (C-SSRS Annual Screen)

Timely CSRE in the ED: EDSR1

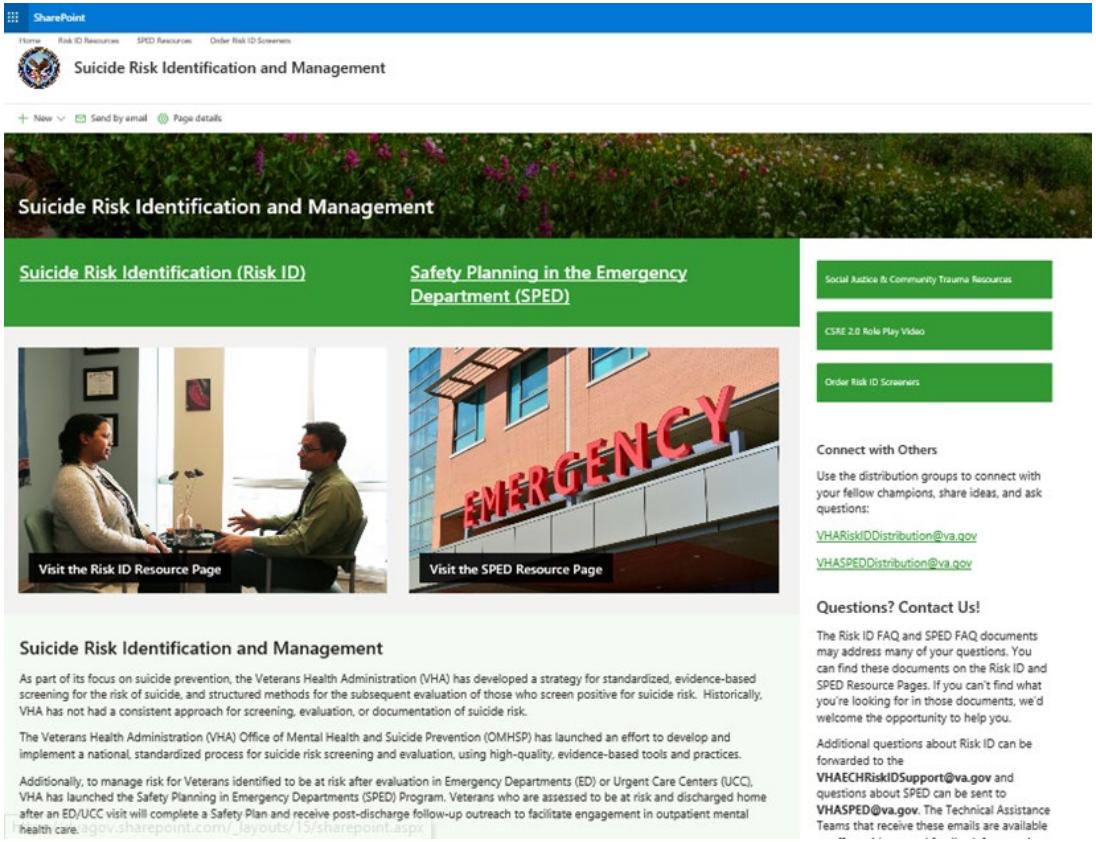
Description: Number of ED/UC visits where a Veteran completed a new CSRE or updated an existing CSRE within 24 hours after a positive C-SSRS.

SPED Safety Plan Attempted: SPED1

Description: Number of visits where a patient attempted (completed a new safety plan, reviewed an existing plan or declined to complete) a Suicide Prevention Safety Plan within +/- 24 hours of the ED/UCC visit time in/time out

Supporting the Field

- **Weekly Community of Practice Calls**
- **National Technical Assistance Team**
- **Regional and Facility Site Visits**
- **External Facilitation – QUERI Grant**
- **SharePoint with training, orientation, and guidance documents**
- **Provide data feedback for performance improvement**
- **Maintain clinical decision support tools**



Until recently, suicide prevention research with Veterans had largely taken a gender-neutral approach, despite the need for tailored intervention.

FORUM

translating research into quality healthcare for Veterans

Suicide Prevention Spring 2018

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Research Highlight

Concerning Trends in Suicide Among Women Veterans Point to Need for More Research on Tailored Interventions

Claire A. Hoffmire, PhD, Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC) for Suicide Prevention, Denver, Colorado, and Lauren M. Denneson, PhD, Center to Improve Veteran Involvement in Care, VA Portland Health Care System, Portland, Oregon

*"The epidemiologic trends in rates, use of firearms, and risk over time observed among women Veterans suggest that **we must incorporate gender into suicide prevention work to rapidly increase our knowledge of** suicide risk and resilience across the life course, as well as **strategies to tailor firearm safety efforts, for women Veterans.***

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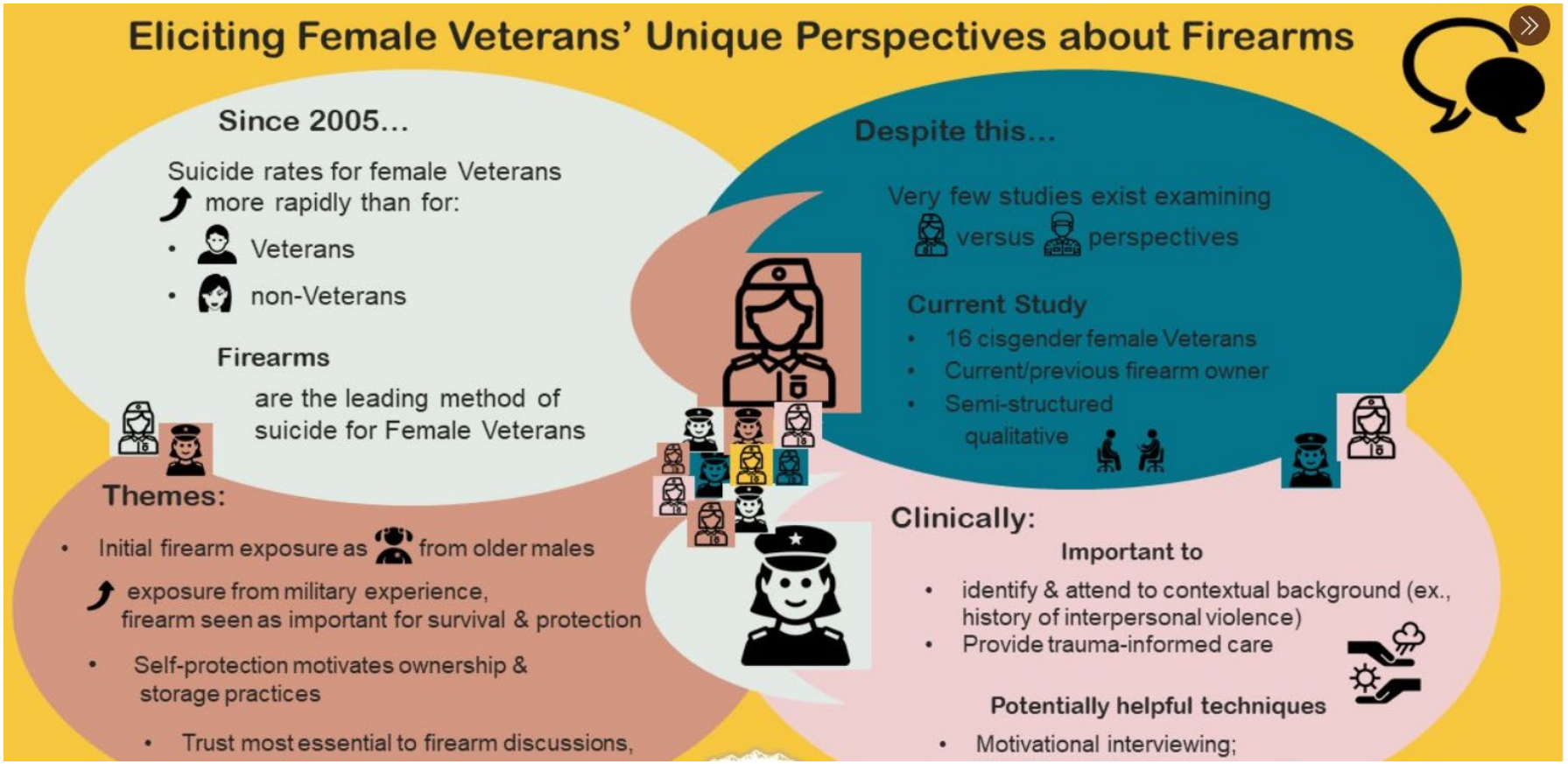
Forum Spring 2018

Qualitative Study of Women Veterans' Firearm-Related Experiences and Perspectives across the Life course



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Monteith, L. L., Holliday, R., Dorsey Holliman, B. A., Brenner, L. A., & Simonetti, J. A. (2020). Understanding female veterans' experiences and perspectives of firearms. *Journal of Clinical Psychology*, *76*(9), 1736-1753. https://doi.org/10.1002/jclp.22952

VA Suicide Risk Clinical Training Tools & Resources

Clinical Practice Guideline (CPG) for Suicide Prevention Resources
https://www.mirecc.va.gov/visn19/cpg/

Lethal Means Safety Website
https://www.mirecc.va.gov/visn19/lethalmeanssafety/

Self Directed Violence (SDV) Classification System, Clinical Toolkit & Nomenclature Website
https://www.mirecc.va.gov/visn19/clinical/nomenclature.asp

Suicide Risk Management Consultation Program Website
https://www.mirecc.va.gov/visn19/consult/

Therapeutic Risk Management (TRM) of the Suicidal Patient Website
https://www.mirecc.va.gov/visn19/trm/

U.S. Department of Veterans Affairs

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