Assessment and Management of Those at Risk for Suicide

VA/DOD Clinical Practice Guidelines (CPG)
2019

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Disclosure Statement

- This presentation is based on work supported, in part, by the Department of Veterans Affairs, but does not necessarily represent the views of the Department of Veterans Affairs or the United States Government.

22 Recommendations

- Strength of the recommendations follows the level of evidence
  - 4 domains used to determine strength and direction of the evidence
    - Relative strength (Strong or Weak)
    - Direction (For or Against)

- In many cases, sufficient research has yet to be conducted; thereby highlighting an opportunity to engage in continued rigorous efforts to evaluate practices to augment the existing evidence-base

Evidence-Based Process

- VA and DoD Experts
  - Multi-disciplinary
- Key Questions
  - 12 Key Questions
    - Example: *"For patients identified as being at risk for suicide, what are the most effective treatment approaches? (Who, Where, and When)"*
    - Followed the PICOTS Framework
- Systematic Review of the Evidence
  - Conducted by independent third party

P	Patients, Population, or Problem	A description of the patients of interest. It includes the condition(s), populations or sub-populations, disease severity or stage, co-occurring conditions, and other patient characteristics or demographics.
I	Intervention or Exposure	Refers to the specific treatments or approaches used with the patient or population. It includes doses, frequency, methods of administering treatments, etc.
C	Comparison	Describes the interventions or care that is being compared with the intervention(s) of interest described above. It includes alternatives such as placebo, drugs, surgery, lifestyle changes, standard of care, etc.
O	Outcome	Describes the specific results of interest. Outcomes can include short, intermediate, and long-term outcomes, or specific results such as quality of life, complications, mortality, morbidity, etc.
(T)	Timing, if applicable	Describes the duration of time that is of interest for the particular patient intervention and outcome, benefit, or harm to occur (or not occur).
(S)	Setting, if applicable	Describes the setting or context of interest. Setting can be a location (such as primary, specialty, or inpatient care).

Organization of the Recommendations

- Screening and Evaluation - 5
- Risk Management and Treatment - 12
  - Non-Pharmacologic - 4
  - Pharmacologic – 3
  - Post-Acute Care – 3
  - Technology-Based Modalities - 2
- Other Management Modalities – 5
  - Population & Community-Based Interventions

Example of Recommendation Table

		#	Recommendation	Strength*	Category†
Screening and Evaluation	*a. Screening*	1.	With regard to universal screening, we suggest the use of a validated screening tool to identify individuals at risk for suicide-related behavior.	Weak for	Reviewed, New-added
		2.	With regard to selecting a universal screening tool, we suggest the use of the Patient Health Questionnaire-9 item 9, to identify suicide risk.	Weak for	Reviewed, New-added
	b. Evaluation	3.	We recommend an assessment of risk factors as part of a comprehensive evaluation of suicide risk, including but not limited to: current suicidal ideation, prior suicide attempt(s), current psychiatric conditions (e.g., mood disorders, substance use disorders) or symptoms (e.g., hopelessness, insomnia, agitation), prior psychiatric hospitalization, recent bio-psychosocial stressors, and the availability of firearms.	Strong for	Reviewed, New-replaced
		4.	When evaluating suicide risk, we suggest against the use of a single instrument or method (e.g., structured clinical interview, self-report measures, or predictive analytic models).	Weak against	Reviewed, Amended
		5.	While it is an expected standard of care, there is insufficient evidence to recommend for or against the use of risk stratification to determine the level of suicide risk.	Neither for nor against	Reviewed, New-replaced

Exemplar Recommendations by Area

Screening and Evaluation

- We recommend an assessment of risk factors as part of a comprehensive evaluation of suicide risk, including but not limited to: current suicidal ideation, prior suicide attempt(s), current psychiatric conditions (e.g., mood disorders, substance use disorders) or symptoms (e.g., hopelessness, insomnia, agitation), prior psychiatric hospitalization, recent bio-psychosocial stressors, and the availability of firearms.

  - Strong For

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  - Strong For

R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

Issue 18, Nov. 27, 2018

Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

National Patient Safety Goal for suicide prevention

Effective July 1, 2019, seven new and revised elements of performance (EPs) will be applicable to all Joint Commission-accredited hospitals and behavioral health care organizations. These new requirements are at National Patient Safety Goal (NPSG) 15.01.01 and are designed to improve the quality and safety of care for those who are being treated for behavioral health conditions and those who are identified as high risk for suicide. Because there has been no improvement in suicide rates in the U.S., and since suicide is the 10th leading cause of death in the country, The Joint Commission re-evaluated the NPSG in light of current practices relative to suicide prevention.

The Joint Commission

Risk Management and Treatment Non-Pharmacologic

- We recommend using cognitive behavioral therapy-based interventions focused on suicide prevention for patients with a recent history of self-directed violence to reduce incidents of future self-directed violence.
  - Strong For

- We suggest offering Dialectical Behavioral Therapy to individuals with borderline personality disorder and recent self-directed violence.
  - Weak For

Risk Management and Treatment Non-Pharmacologic

- We suggest offering problem-solving based psychotherapies to:
  - Patients with a history of more than one incident of self-directed violence to reduce repeat incidents of such behaviors
  - Patients with a history of recent self-directed violence to reduce suicidal ideation
  - Patients with hopelessness and a history of moderate to severe traumatic brain injury

- Weak For

Risk Management and Treatment Non-Pharmacologic

- We suggest completing a crisis response plan for individuals with suicidal ideation and/or a lifetime history of suicide attempts.

  - Weak For

Crisis Response Planning vs. Safety Planning

CRP	SPI
• Semi-structured interview of recent suicidal ideation and chronic history of suicide attempts • Unstructured conversation about recent stressors and current complaints using supportive listening techniques • Collaborative identification of clear signs of crisis (behavioral, cognitive, affective or physical) • Self-management skill identification including things that can be done on the patient's own to distract or feel less stressed • Collaborative identification of social support including friends, caregivers, and family members who have helped in the past and who they would feel comfortable contacting in crisis • Review of crisis resources including medical providers, other professionals and the suicide prevention lifeline (1-800-273-8255) • Referral to treatment including follow up appointments and other referrals as needed	• Semi-structured interview of a recent suicidal crisis • Recognizing warning signs of an impending suicidal crisis • Recognizing how an increase and decrease in suicidal risk provides an opportunity to engaging in coping strategies • Employing internal coping strategies without contacting another person for distraction from suicidal thoughts • Utilizing social contacts and social settings as a means of distraction from suicidal thoughts • Utilizing family members, caregivers or friends to help resolve the crisis • Contacting mental health professionals or agencies, including crisis intervention services (e.g., the Veteran/Military Crisis Line: 1-800-273-8255) • Limiting access to lethal means ○ Consider prescribing naloxone for patients at risk for opioid overdose (see VA/DoD Opioid Therapy CPG[12])

Abbreviations: CPG: clinical practice guideline; CRP: Crisis Response Planning; DoD: Department of Defense; SPI: Safety Planning Intervention

Developing a Safety Plan

Overview for VHA Clinicians

The Veterans Health Administration (VHA) has updated the Safety Planning Intervention Manual, a guide for VHA clinicians that defines the best practices for developing safety plans with Veteran patients.

Safety planning should be used with Veterans who meet one or more of the following criteria:

- Attempted suicide or engaged in suicidal behavior
- Reported suicidal ideation
- Have psychiatric disorders that increase suicide risk
- Are otherwise determined to be at risk for suicide (e.g., patient record flags identifying Veterans at high risk for suicide)

The outcome of safety planning intervention is a personalized safety plan: a prioritized list of coping strategies and sources of support that the Veteran can use before or during a suicidal crisis. The best safety plans are brief, easy to read, and written in the Veteran's own words.

Well-developed safety plans can help Veterans recognize when they are experiencing a crisis and guide them in following specific steps to prevent them from acting on suicidal thoughts and urges. The safety plans are an essential part of emergency preparedness, as problem-solving abilities often diminish during a crisis.

The safety plan is not just a form — it's an important clinical intervention that should be developed thoughtfully and collaboratively by the clinician and Veteran.

See the other side of this handout for the six steps of developing a safety plan.

Access the updated Safety Planning Intervention Manual and training materials from the **Mental Health Services SharePoint**. The safety plan template is available in the VA Computerized Patient Record System.

If you or someone you know is in crisis, call the Veterans Crisis Line at **1-800-273-8255 and Press 1**, chat online at **VeteransCrisisLine.net**, or text **838255**.

U.S. Department of Veterans Affairs

Developing a Safety Plan

Steps at a Glance

Step 1: Recognize Warning Signs

What are the specific thoughts, emotions, behaviors, or sensations that indicate a crisis is occurring or escalating?

Step 2: Plan Internal Coping Strategies

What are some coping strategies that can distract from suicidal thinking? Examples include going for a walk, exercising, or listening to inspirational music.

Step 3: Identify Social Contacts and Environments That May Distract From the Crisis

What social contacts or environments can provide a distraction if the coping strategies in Step 2 do not resolve the crisis? Example contacts include a friend, faith leader, or support group.

Step 4: Identify Family Members or Friends Who Can Help

What family members or friends can be contacted if the strategies in Step 3 do not resolve the crisis? If the Veteran discloses having no family or friend support, consider other interventions to address social isolation, like social skills training, peer support, and group therapy.

Step 5: Determine Professionals and Agencies to Contact for Help

What professionals or professional services, such as mental health and primary care providers, can be contacted for help?

Step 6: Create a Safe Environment

Has the Veteran thought of a suicide method or developed a specific suicide plan? For any method that has been identified, determine the Veteran's access to the lethal means and make a plan to reduce that access.

If you or someone you know is in crisis, call the Veterans Crisis Line at **1-800-273-8255 and Press 1**, chat online at **VeteransCrisisLine.net**, or text **838255**.

U.S. Department of Veterans Affairs

Risk Management and Treatment
Pharmacologic Treatments

- In patients with the presence of suicidal ideation and major depressive disorder, we suggest offering ketamine infusion as an adjunctive treatment for short-term reduction in suicidal ideation.
  - Work For

- We suggest offering lithium alone (among patients with bipolar disorder) or in combination with another psychotropic agent (among patients with unipolar depression or bipolar disorder) to decrease the risk of death by suicide in patients with mood disorders.
  - Weak For

- We suggest offering clozapine to decrease the risk of death by suicide in patients with schizophrenia or schizoaffective disorder and either suicidal ideation or a history of suicide attempt(s).
  - Weak For

Risk Management and Treatment
Post-Acute Care

- We suggest sending periodic caring communications (e.g., postcards) for 12-24 months in addition to usual care after psychiatric hospitalization for suicidal ideation or a suicide attempt.
  - Weak For

- We suggest offering a home visit to support reengagement in outpatient care among patients not presenting for outpatient care following hospitalization for a suicide attempt.
  - Weak For

- We suggest offering the World Health Organization Brief Intervention and Contact treatment modality following presentation to the emergency department for suicide attempt, in addition to standard care.
  - Weak For

Technology-Based Modalities

- Behavioral health treatment modalities for suicidal ideation
  - Insufficient Evidence
    - Neither for nor against
- Technology-based adjuncts
  - Insufficient Evidence
    - Neither for nor against

- ***Lower cost:*** *Some apps are free or cost less than traditional care.*
- ***Service to more people:*** *Technology can help mental health providers offer treatment to people in remote areas or to many people in times of sudden need (e.g., following a natural disaster or terror attack)*

NIH National Institute of Mental Health

CPG for SUICIDE PREVENTION Webinar Series

https://www.mirecc.va.gov/visn19/cpg/index.asp

SUICIDE RISK MANAGEMENT
Consultation Program
FOR PROVIDERS WHO SERVE VETERANS

Why worry alone?

The Suicide Risk Management Consultation Program provides free consultation for any provider, community or VA, who serves Veterans at risk for suicide.

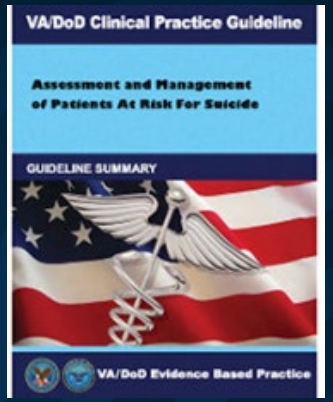
Common consultation topics include:

- Risk Assessment
- Conceptualization of Suicide Risk
- Lethal Means Safety Counseling
- Strategies for How to Engage Veterans at High Risk
- Best Practices for Documentation
- Provider Support after a Suicide Loss (Postvention)

#NeverWorryAlone

To initiate a consult email:
SRMconsult@va.gov

www.mirecc.va.gov/visn19/consult



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