Assessment and Management of Patients at Risk for Suicide

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THE SCOPE OF SUICIDE

In U.S. Adult Population:
Suicide is one of the top ten causes of death among US residents. Among those aged 10-34 suicide is the second most common cause of death.

In Department of Defense (DoD):
- ❑ Rates of suicide in the military increased dramatically in the first decade of the 21st century (*Anglemyer et al 2016*).
- ❑ Beginning in 2011, this increase slowed and the rate of suicide eventually plateaued (*DoDSER*).
- ❑ Despite substantial efforts have been devoted to suicide prevention, the trajectory of military suicide has neither reversed nor worsened (*Anglemyer et al 2016*).

In Department of Veterans Affairs (VA):
- ❑ The 2016 Veteran rate was 1.5 times higher than the rate associated with non-Veteran adults *(VA National Suicide Data Report).*
- ❑ Adjusting for age, the suicide rate for female Veterans was 1.8 times greater than the suicide rate for non-Veteran women *(VA National Suicide Data Report).*

VA/DOD ASSESSMENT AND MANAGEMENT OF PATIENTS AT RISK FOR SUICIDE CLINICAL PRACTICE GUIDELINE (CPG)

- ❑ System-wide goal of developing evidence-based guidelines is to improve the patient's health and well-being by guiding health providers who are taking care of patients who are at risk for Suicide providing assessment and management guidance that is supported by evidence
- ❑ Current Assessment and Management of Patients At Risk for Suicide CPG updated in 2019 by a VA/DoD Work Group based on evidence and best practice

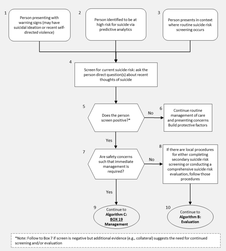
- ❑ Includes objective, evidence-based information on assessment and management of patients at risk for suicide and related conditions to assist healthcare providers in all aspects of patient care, including diagnosis, treatment, and follow-up
- ❑ Intended for VA and DoD healthcare practitioners including primary care physicians, nurse practitioners, physician assistants, psychiatrists, psychologists, social workers, nurses, pharmacists, chaplains, addiction counselors, and others involved in the care of service members or veterans who are at risk for suicide

CPGs are not standard of care and use of guidelines must be considered within the context of a provider's clinical judgment and patient values and preferences, for the care of an individual patient

One in four people has a mental illness.
You can be the one that helps.

GENERAL GUIDELINES AND PREVENTION

Algorithm A Identification of Risk for Suicide



*Note: Follow to Box 7 if screen is negative but additional evidence (e.g., collateral) suggests the need for continued screening and/or evaluation

SCREENING AND EVALUATION

1. Use a validated screening tool
2. PHQ-9, Item 9
3. Insufficient evidence for or against the use of risk stratification to determine level of suicide risk

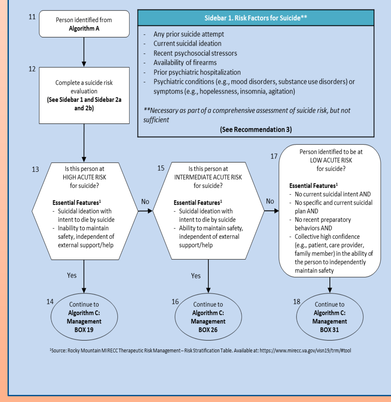
RISK MANAGEMENT AND TREATMENT

- ❑ Non Pharmacologic
- ❑ Pharmacologic
- ❑ Post acute care
- ❑ Technology based

GUIDELINE FEATURE

- ❑ Evidence based
- ❑ Developed by a multidisciplinary team
- ❑ Included patients
- ❑ Conflict free
- ❑ GRADE methodology
- ❑ 3rd party evidence review
- ❑ Synopsis published in Annals of Internal Medicine

Algorithm B Evaluation by a Provider

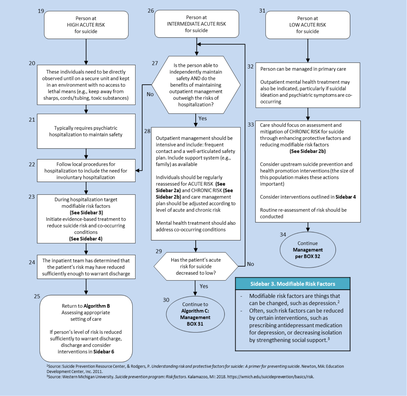


[1]Source: Rocky Mountain MIRECC Therapeutic Risk Management—Risk Stratification Table. Available at: https://www.mirecc.va.gov/visn19/trm/#tool

ASSESSMENT OF SUICIDE

- ❑ **PHQ – 9, Item 9:** Over the past 2 weeks, how over have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way? **A:** Not at all, several days, more than half the days, nearly every day.
- ❑ Assess risk factors: current suicidal ideation, prior suicide attempt(s), current psychiatric conditions (e.g., mood disorders, substance use disorders) or symptoms (hopelessness, insomnia, agitation), prior psychiatric hospitalization, recent bio-psychosocial stressors, and the availability of firearms.

Algorithm C: Management of Patients at Acute Risk for Suicide



[2]Source: Suicide Prevention Resource Center, & Rodgers, P. *Understanding risk and protective factors for suicide: A primer for preventing suicide.* Newton, MA: Education Development Center, Inc. 2011.
[3]Source: Western Michigan University. Suicide prevention program: Risk factors. Kalamazoo, MI: 2018. https://wmich.edu/suicideprevention/basics/risk.

NON PHARMACOLOGIC

- ❑ Cognitive Behavioral Based Interventions
- ❑ Dialectical Behavioral Therapy to individuals with borderline personality disorder and recent self-directed violence
- ❑ Complete a crisis response plan for individuals with suicidal ideation and/or a lifetime history of suicide
- ❑ Problem-solving based psychotherapies for:
  1. Patients with a history of more than one incident of self-directed violence to reduce repeat incidents of such behaviors
  2. Patients with a history of recent self-directed violence to reduce suicidal ideation
  3. Patients with hopelessness and a history of moderate to severe traumatic brain injury

PHARMACOTHERAPY

- ❑ Ketamine infusion as an adjunctive treatment for short-term reduction in suicidal ideation.
- ❑ Lithium alone or in combination with another agent to decrease the risk of death by suicide in patients with mood disorders.
- ❑ 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).

POST ACUTE CARE

- ❑ Periodic caring communications
- ❑ Home visit to support reengagement in outpatient care among patients not presenting for outpatient care following hospitalization for a suicide attempt

TECHNOLOGY BASED

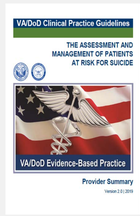
- ❑ Insufficient evidence to recommend for/against technology-based behavioral health treatment modalities for individuals with suicidal ideation. Includes self-directed digital delivery of treatment protocols with minimal or no provider interaction (e.g., compact disc, web-based), and provider-delivered virtual treatment.
- ❑ insufficient evidence to recommend for/against the use of technology-based adjuncts (e.g., web or telephone applications) to routine suicide prevention treatment for individuals with suicidal ideation.

POPULATION AND COMMUNITY BASED

- ❑ Reduce access to lethal means
- ❑ insufficient evidence for/against community-based interventions targeting patients at risk for suicide
- ❑ insufficient evidence for/against community-based interventions to reduce population-level suicide rates
- ❑ insufficient evidence for/against buddy support programs to prevent suicide, suicide attempts, or suicidal ideation.

CLINICAL SUPPORT TOOLS FOR *PROVIDERS*

Provider Summary



A quick reference for providers that summarizes the Suicide CPG

Crisis Response Plan

A collaborative safety planning tool for trained providers and their patients to create a dynamic plan to reduce patient risk for suicidal behavior

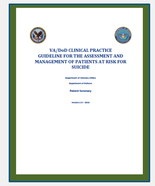
Pocket Guide

Guide to help providers assess and manage suicide as recommended in the 2019 clinical practice guideline

CLINICAL SUPPORT TOOLS FOR *PATIENTS AND FAMILIES*

Patient Summary

A reference for patients on understanding Suicide and treatment recommendations and resources



Tool for Family and Caregivers

A reference document that reviews the risk factors and warning signs for patients at risk for suicide

Family Tool

A reference for family members of patients to help them recognize when someone is at risk for suicide and understand the actions they can take to help

VA/ARMY MEDCOM/PHCOE COLLABORATION

- ❑ The VA, Army Medical Command (MEDCOM) partner with the Psychological Health Center of Excellence to support clinical support tools to accompany the clinical practice guidelines for psychological health conditions.
- ❑ Clinical support tools help health care providers deliver evidenced-based treatment that is consistent with Department of VA and DoD clinical practice guidelines.
- ❑ These tools include educational materials and decision aids for primary and specialty care providers, patients and families.

FOR MORE INFORMATION

- ❑ **DOWNLOAD THE CLINICAL PRACTICE GUIDELINE AND CLINICAL SUPPORT TOOLS**
  https://www.healthquality.va.gov/guidelines/MH/srb/
  https://www.qmo.amedd.army.mil

References:

Anglemyer A, Miller ML, Buttrey S, Whitaker L. Suicide rates and methods in active duty military personnel, 2005 to 2011: A cohort study. Ann Intern Med. Aug 2 2016;165(3):167-174.

Department of Defense suicide event report (DoDSER) calendar year 2016 annual report. Joint Base Lewis-McChord, United States: Psychological Health Center of Excellence;2018. 0-A2345E0.

VA national suicide data report, 2005-2016. 2018. https://www.mentalhealth.va.gov/mentalhealth/suicide_prevention/data.asp. Accessed March, 2019.