



Evidence-Based Management of Suicide Prevention

2012 VA/DoD Suicide Prevention Clinical Practice Guideline

Janet Kemp, PhD, RN

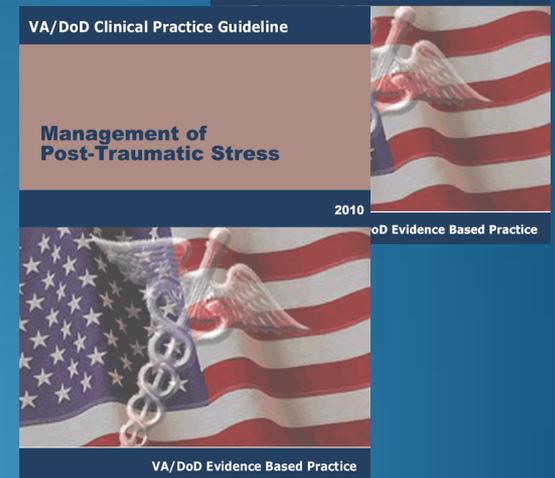
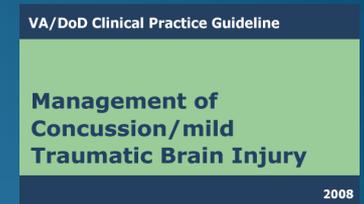
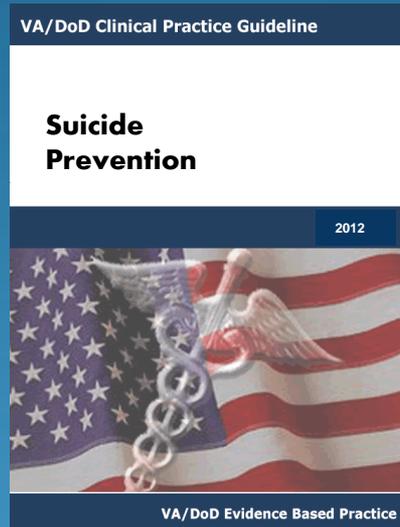
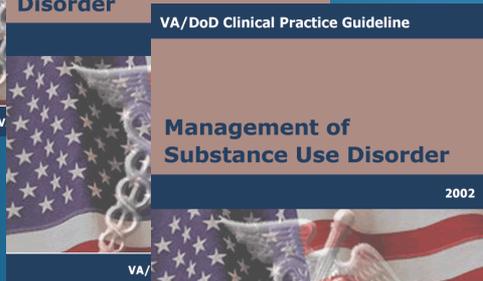
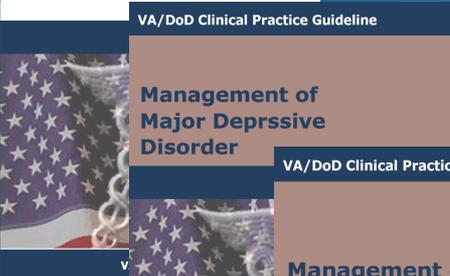
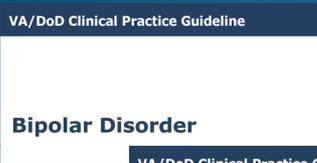
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VA/DoD Clinical Practice Guideline for Prevention of Suicide



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Learning Objectives

- Describe the CPG Development Process
- Discuss the Evidence Review to date
- Provide an overview of the CPG Content & Framework



Goals of the CPG

- To promote efficient and effective assessment of patients at risk for suicidal behavior
- To identify the critical decision points in management of patients with at risk for suicidal behavior
- To promote evidence-based management of patients at risk for suicide to minimize risk of:
 - Re-attempt
 - Death by Suicide



Goals of the CPG (cont'd)

- To promote evidence-based management of individuals with suicidal behavior across the deployment cycle.
- To inform local policies or procedures, such as those regarding referrals to or consultation with specialists and the systems of care.
- To facilitate and encourage innovative plans to break down barriers that may prevent patients from having prompt access to appropriate assessment and care.



The CPG Working Group

VHA	DoD
<p>Jan Kemp Ira Katz</p>	<p>Brett Schneider John Bradley</p>
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Guideline Facilitator: Oded Susskind, MPH

OVERVIEW

VA/DoD Clinical Practice Guideline

Process - Building Consensus

Concept – Evidence-based Practice Guidelines

Format – Decision based on Clinical Logic

Content – What's in the Guideline so far?



Definitions

Suicide: Death caused by self-inflicted behavior with evidence (explicit or implicit) that the act was intentional

Suicide attempt : Self-injurious behavior with a non-fatal outcome accompanied by evidence (explicit or implicit) that the person attempted to die

Suicidal intent : Subjective expectation and a desire for a self-destructive act that would end in death

Suicidal ideation or thoughts : Thoughts of engaging in suicide-related behavior. Suicidal ideation may vary in seriousness depending on the specificity of suicide plans and degree of suicidal intent

Deliberate self-harm : Willful self-inflicting of, at times, painful, destructive or injurious acts without intent to die



Clinical Practice Guideline

- Systematically developed statements to assist practitioner and patient in choosing appropriate healthcare for specific clinical conditions. (IOM 2009)
- Clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.



PROCESS

Process - Building consensus

Concept – Evidence-based Practice Guidelines

Format – Decision based on clinical logic

Content – What's in the Guideline so far?



Principles of CPG Development

- a) Guidelines are developed by multidisciplinary groups;
- b) They are based on a systematic review of the scientific evidence; and
- c) Recommendations are explicitly linked to the supporting evidence and graded according to the strength of that evidence.



Systematically Developed

- Determination of criteria to **predict outcome** (benefit, harm)
- Systematic search of the literature to **identify available evidence**
- **Appraisal** of the evidence using the pre-determined criteria
- Assessment of the methodological **quality, quantity, consistency,** and **applicability** of the evidence base
- Link between the **strength** of the available evidence and the **grade** of the recommendations
- Construct a clear and unambiguous **presentation** that would allow the users to understand the link between the strength of the evidence and the grade of recommendations



Development Process

1. Determine **Scope** – Started in January 2011
2. Develop **Key Questions**
3. Literature **Search** – Summer 2011
4. **Appraisal** of evidence – March 2012
5. Construct **Evidence Tables** – March 2012
6. Formulate **Recommendations** - Ongoing
7. **Grade** the Evidence – May 2012
8. Produce **Final Draft** – Expected July 2012
9. **Review** (Outside experts, organization)
10. **Approval** – December 2012



Development Process

Determine Scope:

- Define framework and conceptual model for the CPG
- Define Target Population
 - Adult patients (18 years or older) with Suicidal behavior or Suicide related thoughts (identified at risk for suicide) and managed in the VA/DoD health care clinical setting
- Define Audience
 - all healthcare professionals providing or directing treatment services to patients in any VA/DoD healthcare setting, including both primary and specialty care
- Identify content areas and models of treatment
- Review SEED documents from DoD Services and VA manual



Identify content areas

1. Definitions, classification of etiology, risk factors, and severity
2. Assessment and determination of risk
3. Management of urgent/emergent - Indications for Referral
4. Treatment Interventions (modalities) based on risk level
5. Safety (action) plan for patient at risk
6. Monitoring and re-assessment of low-risk patients
7. Follow-up – Continuity of care



Development Process

- Develop **Key Questions** to guide the literature search in the following :
 1. Assessment
 - Risk factors for suicide
 - Assessment instruments for Suicide Risk
 2. Treatment
 - Psychotherapy
 - Pharmacotherapy
 - Referral & Follow-up



OUTCOMES

1. Death by suicide
2. Suicide Re-attempts
3. Suicide behaviors (attempts)
4. Ideation
5. Re-hospitalization
6. Compliance with Treatment Plan
7. Functionality



Key Questions

Treatment of Suicidality?

1. Psychotherapy techniques?

Cognitive Behavioral Therapy (CBT)

Dialectical Behavior Therapy (DBT)

Problem Solving Therapy (PST)

Interpersonal Psychotherapy (IPT)

ACT or Mindfulness-Based Therapy (MBT)

Psychoeducation

Other



Key Questions

Treatment of Suicidality?

2. Pharmacotherapy?

Lithium

Clozapine

Antidepressants

Conventional antipsychotics

Atypical antipsychotics

Anticonvulsants

Anxiolytic (Benzodiazepine)

Omega-3 fatty acids



Key Questions

What intervention are effective in management of co-occurring conditions with Suicide Risk?

MDD

BD

BPD

SUD

mTBI

PTSD

Pain



Key Questions

Other questions:

1. Is **individual** therapy more effective than **group** therapy?
2. Is **inpatient** therapy more effective than **outpatient** therapy?
3. Is **single provider** more effective than **collaborative care**?
4. Is **follow-up intervention early after SA** more effective than **later intervention**?
5. Is **technology-based delivery** more effective than **provider-based delivery**?
6. Is **Safety Planning** more effective than **no-suicide contracts**?
7. Is **Means Restriction** effective in reducing suicide?



CONCEPT

Process - Building consensus

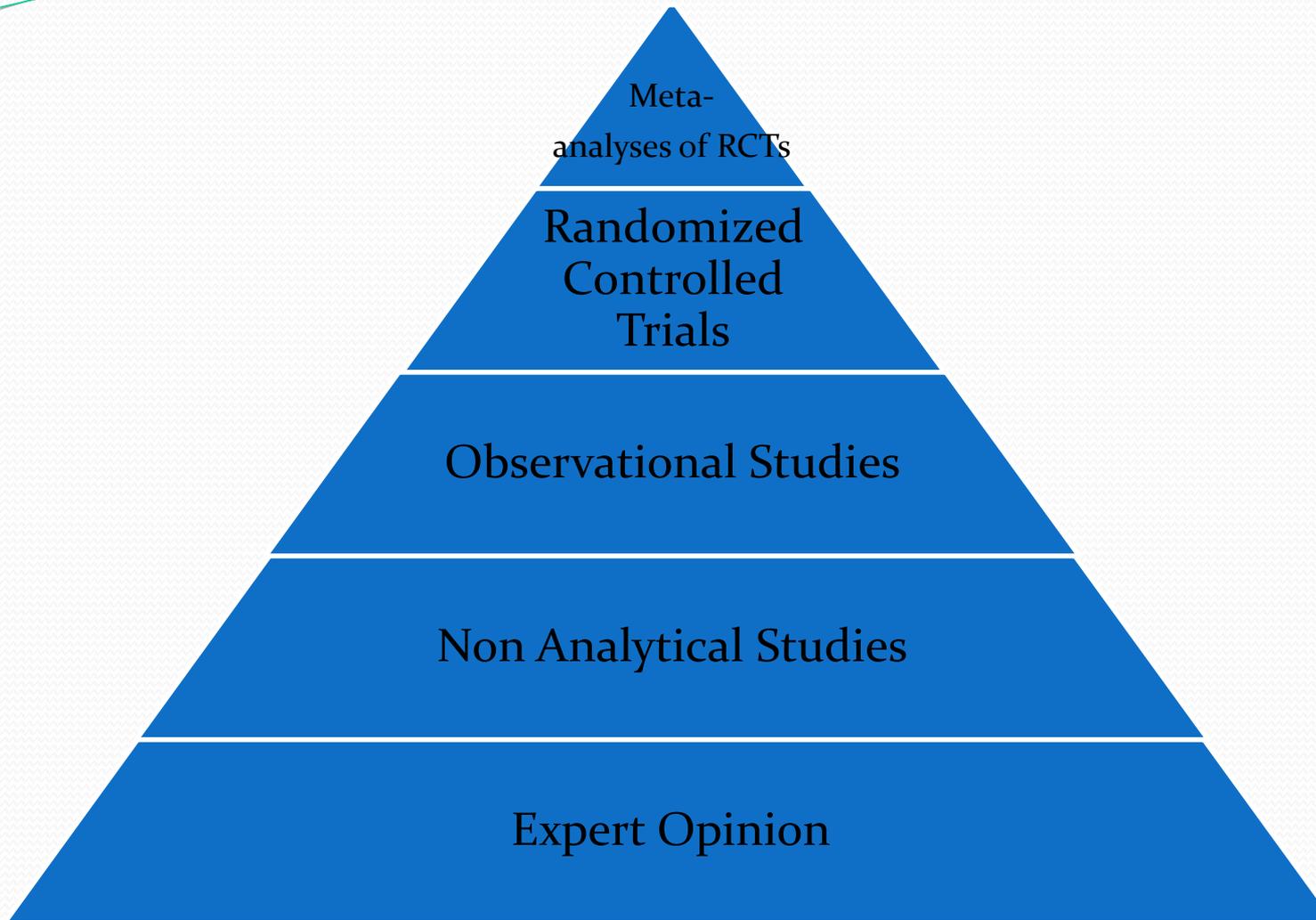
Concept – Evidence-based Practice Guidelines

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Content - What's in the Guideline so far?



LEVEL OF THE EVIDENCE



EVIDENCE HIERARCHY



Hierarchy of Evidence

I	Evidence obtained from at least one properly randomized controlled trial. Or Evidence from systematic reviews or meta-analysis of randomized controlled trials
II-1	Evidence obtained from well-designed controlled trials without randomization.
II-2	Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.
II-3	Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin in the 1940s) could also be regarded as this type of evidence.
III	Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

* Canadian Task Force on the Periodic Health Examination: The periodic health examination: 2. 1987 update. *Can Med Assoc J* 1988;138:618-26.



STRENGTH of RECOMMENDATIONS

Meta Analysis
Systematic
Reviews

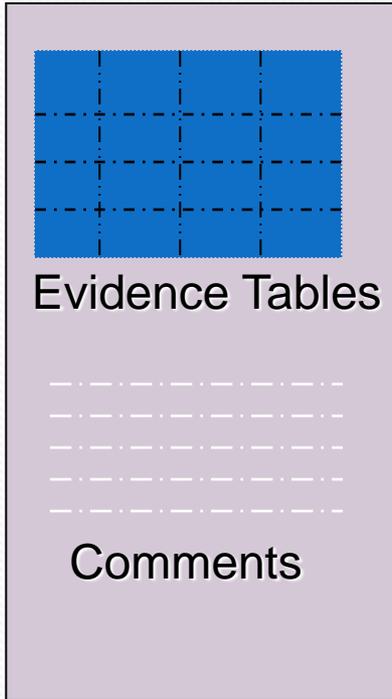
Randomized
Controlled
Trials

Observational
Studies

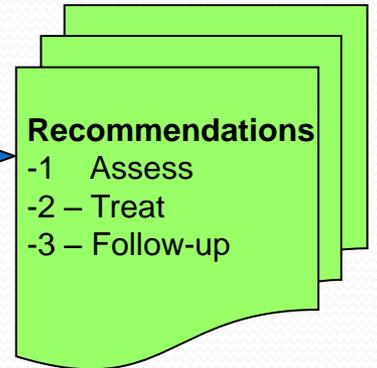
Non Analytical
Studies

Expert Opinion

Rating
Quality



Grading
Strength



EVIDENCE → Evaluation → *Synthesis* → Judgment →

RECOMMENDATIONS



Quality of the Evidence

- High** Further research is unlikely to change confidence in the estimate of effect.
- Moderate** Further research is likely to have important impact on our confidence in the estimate of effect and may change the estimate.
- Low** Confidence in the estimate of effect and is likely to change with further research
Any estimate of effect is very uncertain.
- Insufficient** No-Data to make prediction of effect



Balance = Benefit - Harm

SUBSTANTIAL: *The intervention substantially improves important health outcomes; benefits substantially outweigh harm*

MODERATE: *The intervention improves health outcomes for some and the benefits outweigh harm*

SMALL: *The intervention can improve health outcomes –small benefit may involve potential harm*

ZERO- Negative: *The intervention provides no benefit and/or may cause harm*



Strength of Recommendations

A Strongly Recommend to offer or provide ...

*There is **good** evidence that the intervention improves important health outcomes -- **benefits substantially outweigh harm***

B Recommend to offer or provide ...

*There is **fair** evidence that the intervention improves health outcomes -- **that benefits outweigh harm.***

C Consider offering or providing

*There is **poor** evidence that the intervention can improve health outcomes -- **balance of benefit and harm is too close to justify a general recommendation.***

I Insufficient Evidence is to recommend for or against ...

*Evidence that the intervention is effective is lacking or of poor quality, or conflicting, - **balance of benefits and harms cannot be determined.***



Strength of Recommendations

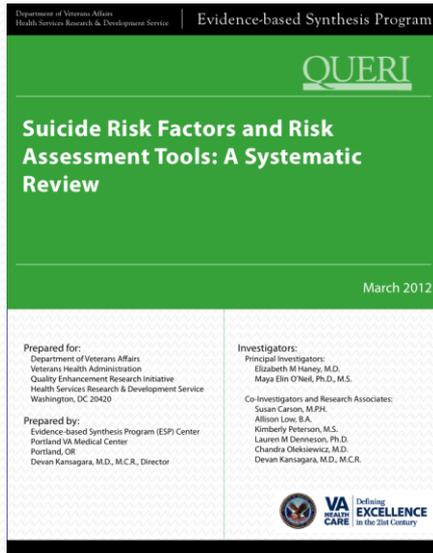
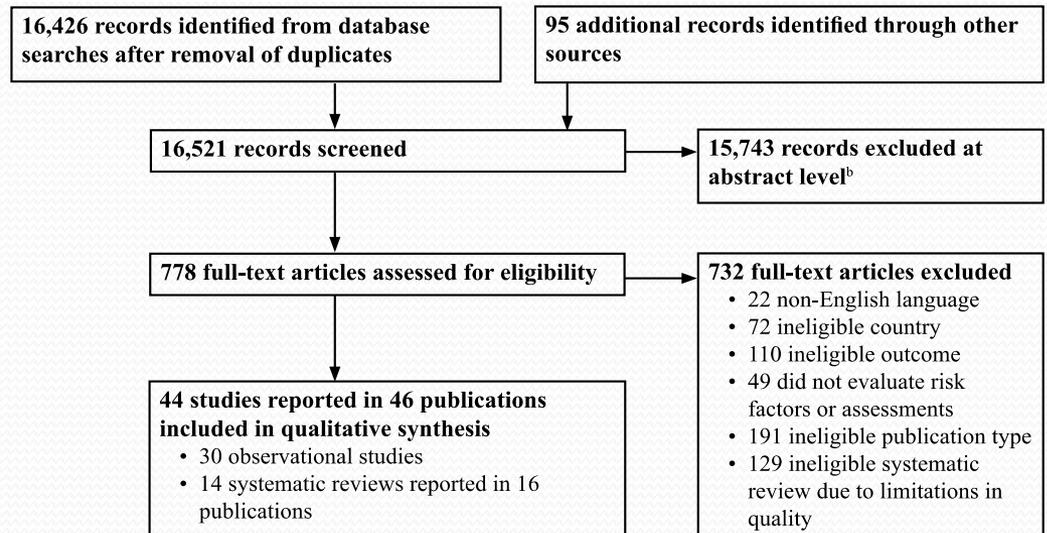
	<i>The net benefit of the intervention</i>			
<i>Quality</i>	Substantial	Moderate	Small	Zero / Negative
Good <i>I II-1</i>	A	B	C	D
Fair <i>I II-1-2-3</i>	B	B	C	D
Poor <i>III</i>	I	I	I	I

USPSTF 2007



Evidence-Based Synthesis Program

Figure 2. Literature Flow Chart^a



CONCLUSIONS

KQ#	Key Question	Type of Evidence	Quality of Evidence	Comments
1	What assessment tools are effective for assessing risk of engaging in suicidal self-directed violence in Veteran and military populations?	5 studies testing validated measures in Veteran or military populations	2 studies had unclear risk of bias; 3 studies had high risk of bias	Insufficient evidence overall to recommend screening with these risk assessment tools based on this evidence. Future research is warranted, particularly for risk assessment instruments that are already in use within the VA system.
2	In addition to the risk factors included by current assessment tools, what other risk factors predict suicidal self-directed violence in Veteran and military populations?	25 studies of risk factors for suicide attempts and suicides among Veteran and military populations	21 studies with unclear risk of bias and 4 studies with high risk of bias	Insufficient evidence overall. Strongest evidence exists for risk factors that have been previously identified (white race, male gender, psychiatric disorders, substance use disorders, and trauma). More research is warranted to understand emerging risk factors in younger Veteran and military populations.



FORMAT

Process - Building consensus

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Format – Decision based on clinical logic

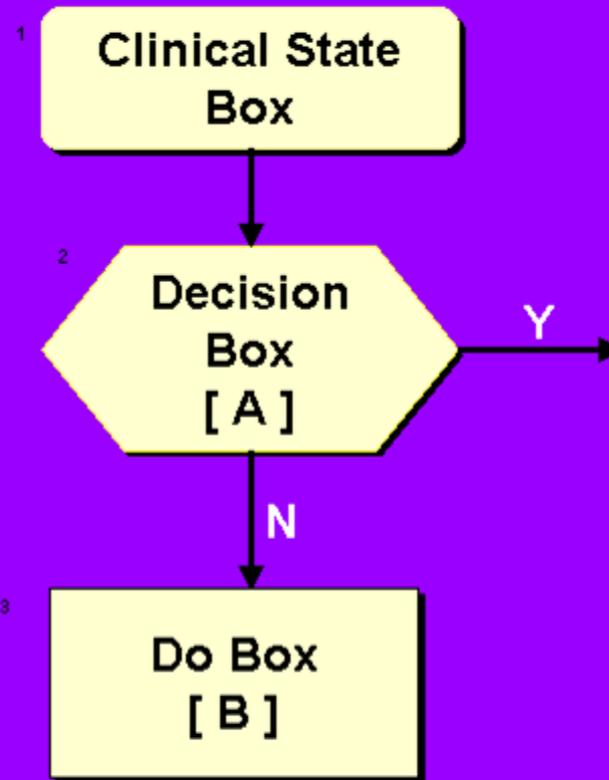
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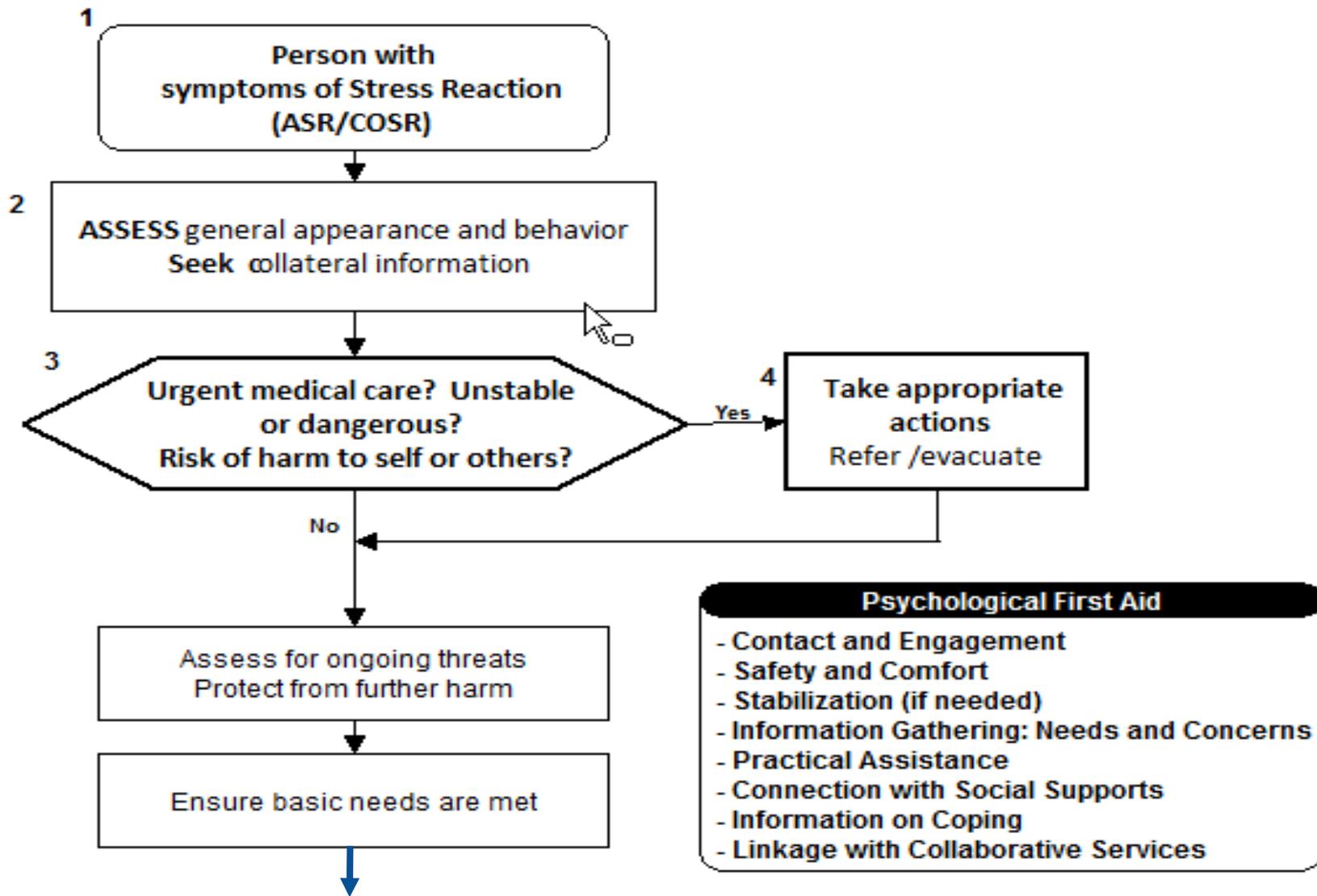
VA/DoD Guidelines are driven by Clinical Algorithms

Annotation

Discussion
Evidence
Bibliography



Example: Stress Reaction 0-4 days



Annotation - Example

RECOMMENDATIONS

1. Risks and benefits of long term pharmacotherapy should be discussed prior to starting medication and continued during treatment. [I]
2. Monotherapy therapeutic trial should be optimized before proceeding to subsequent strategies by allowing sufficient response time. (For at least 8 weeks). [C]
3. Strongly recommend selective serotonin reuptake inhibitors (SSRIs), for which fluoxetine, [paroxetine](#) or sertraline have the strongest support, or serotonin norepinephrine reuptake inhibitors (SNRIs), for which venlafaxine has the strongest support, for the treatment of PTSD. [A]



Evidence Table - Example



EVIDENCE TABLE

	Recommendations	Sources of Evidence	Level of Evidence	Quality of Evidence	Net benefit	Strength of Recommendation
1	Paroxetine effective in reducing PTSD symptoms in civilians and Veterans	Marshall 2001, 2007 Tucker 2001	I	Good	Substantial	A

LE – Type of research (RCTs)

QE – Large RCTs, good methodology,

BENEFIT - Significant improvement, CAPS-2 & CGI. Tolerable side effects

SR – How confident are we in recommending it to our patients?



CONTENT

Process - Building consensus

Concept – Evidence-based Practice Guidelines

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Content - What's in the Guideline so far?



Target Population

- DoD
 - Active duty (deployed/not deployed),
 - Combat (in theater)
 - Reserve / Guard
- VHA veterans
 - Elderly,
 - Young,
 - Specific cohorts {Vietnam, OEF/OIF, etc.}



Audience

- The role and expectation of the professional care and coordination of the behavioral health team and the primary care team addressing prevention of suicide
 - Primary care
 - Other medical specialists and support staff
 - BH Specialty Care
 - Suicide Prevention Specialists
 - Leaders
 - Policy Makers



Outcomes

- Prevention (reduction in rate) of:
 - Death by Suicide
 - Suicide Re-attempt
 - Suicide Attempt
 - Recurrence of Ideation or thoughts
- Admissible Evidence
 - Direct health outcomes {Suicide (re-attempt); Attempt; Self-harm; Ideation}
 - Assessment: Observational, Retrospective studies; Qualitative; Surveys
 - Prevention: RCTs/Prospective Trials

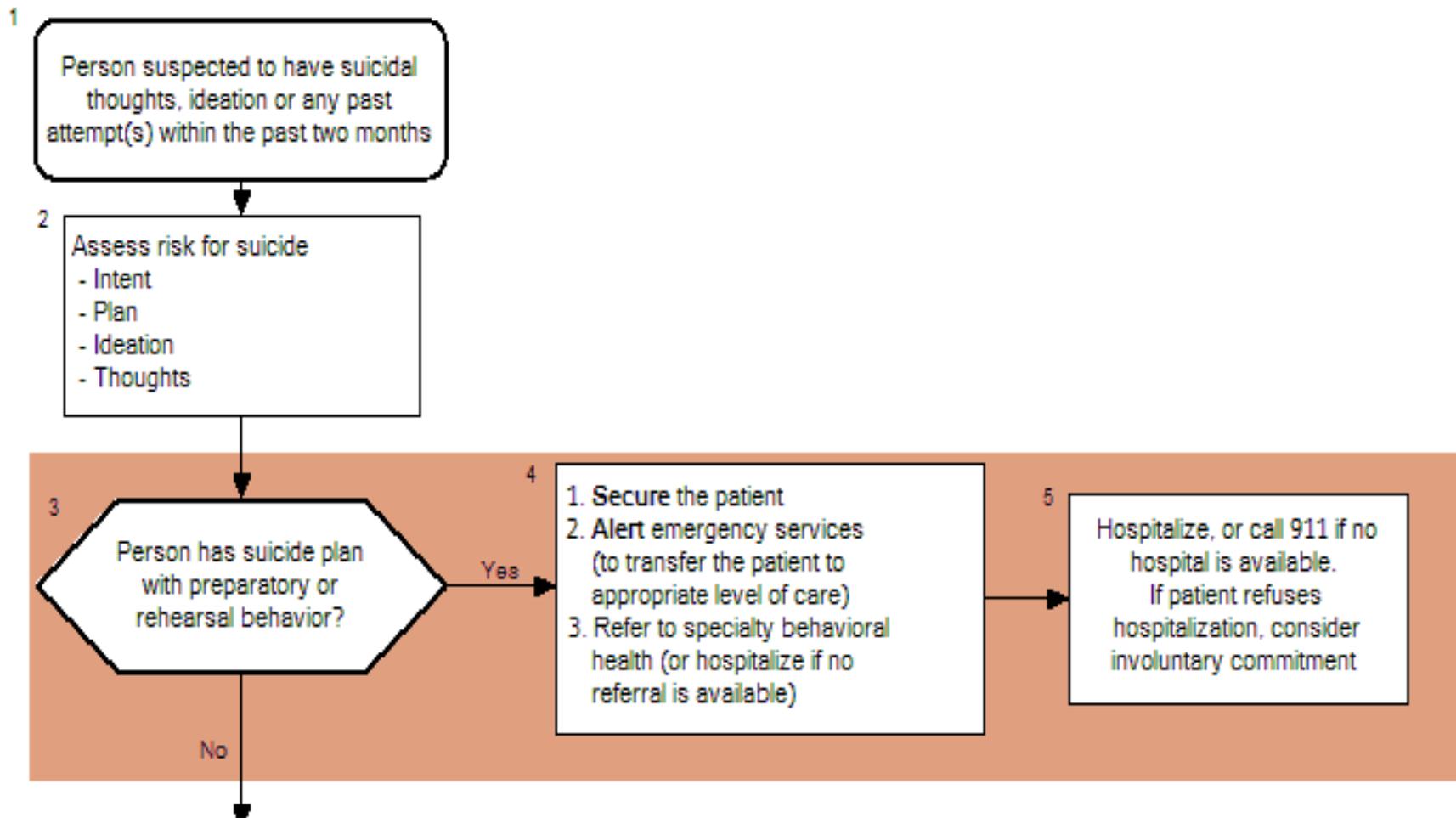


Content

- A – Assessment of Suicide Risk
 - Suicide Behavior
 - Risk/Protective Factors
 - Determine Risk /Severity Level
- B – Treatment Interventions
 - Management of acute/imminent risk [Hospitalization, Specialty care]
 - Manage the underlying cause [VA/DoD CPGs] (Depression, Psychosis, SUD, etc.)
 - Adjust, optimize treatment to address suicidality (e.g., Lithium, DBT, AD)
 - Treat Suicidality (Problem Solving, Psychoeducation)
- C – Safety Planning
- D – Follow-up / Referral
- E – Special Populations



ASSESSMENT



ASSESSMENT

- Assessment of risk for suicide should not be based on any assessment instrument alone.
 - Risk factor checklists are not complete assessments in themselves but they may provide a structure for systematic inquiry about risk factors and can help inform a management plan.
- Risk factors precede suicidal behavior and distinguish a higher risk group from a lower risk group.
 - Risk factors may be modifiable and non-modifiable.
 - Both non-modifiable and modifiable risk factors inform risk formulation and modifiable risk factors may also be targets of intervention.



ASSESSMENT

Suicide risk assessment includes three steps:

1. Obtaining information related to the patient's suicidal ideation, intent, plan, & behaviors.
2. Gathering information (direct and collateral) related to risk factors, protective factors, and warning signs of suicide.
3. Determining a clinical formulation of the risk for suicide based on the above.



LEVELS of RISK

Patients at **High and Acute Risk** include those with current intense and persistent suicidal ideation, OR strong direct or indirect evidence of intent to die, OR recent attempt or preparatory behaviors

Patients at **Moderate Risk** include those with chronic, intermittent, or resistible suicidal ideation AND/OR some direct or indirect evidence of intent to die but with NO recent attempt or behavior indicating preparation

Patients at **Low or Chronic Risk** may include those with fleeting or passive suicidal ideation, or thoughts of death only, and absence of direct or indirect evidence of intent to die or recent attempt or preparatory behavior



ACTION BASED ON RISK LEVEL

- Patients at **HIGH** risk should be immediately referred for a specialty evaluation.
- Patients at **MODERATE** risk should be urgently managed in consultation with a Behavioral Health consultant.
- Patients at **LOW** risk should be considered for consultation with or referral to a Behavioral Health practitioner.

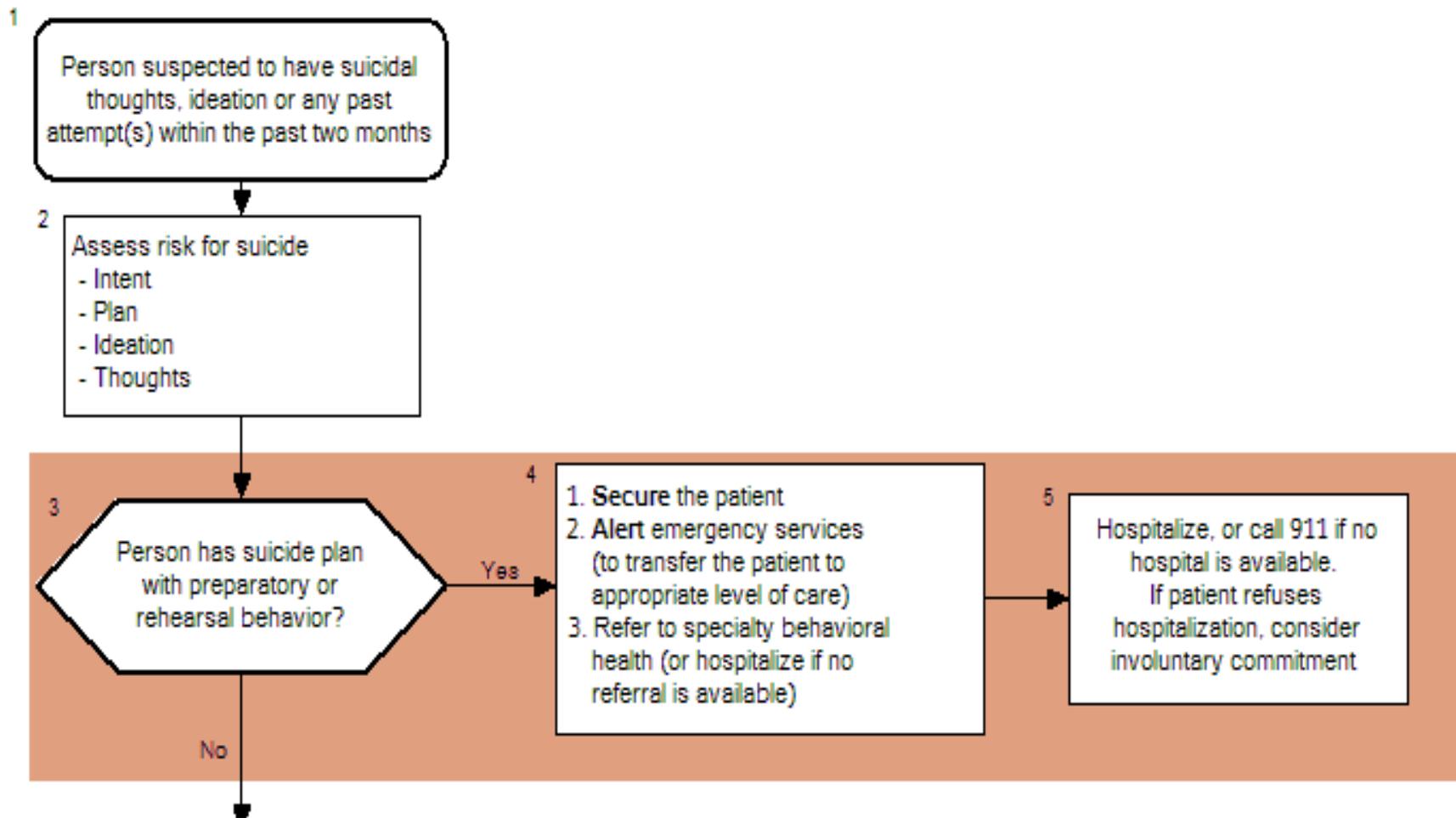


Assessment & Referral Guidelines

- Detection, Recognition and Referral (in Primary Care)
 - 5.1 Role of primary care team members
 - 5.2 Assessment in Emergency Department
 - 5.2 Tools to structure assessment and referrals in primary care
- Comprehensive Evaluation of level of Risk & Needs (in Specialty care)
 - 6.1 Behavioral Health
 - 6.2 The psychiatric interview (evaluation)
 - 6.3 Tools to structure evaluation in specialty care
 - 6.5 Documentation



ASSESSMENT

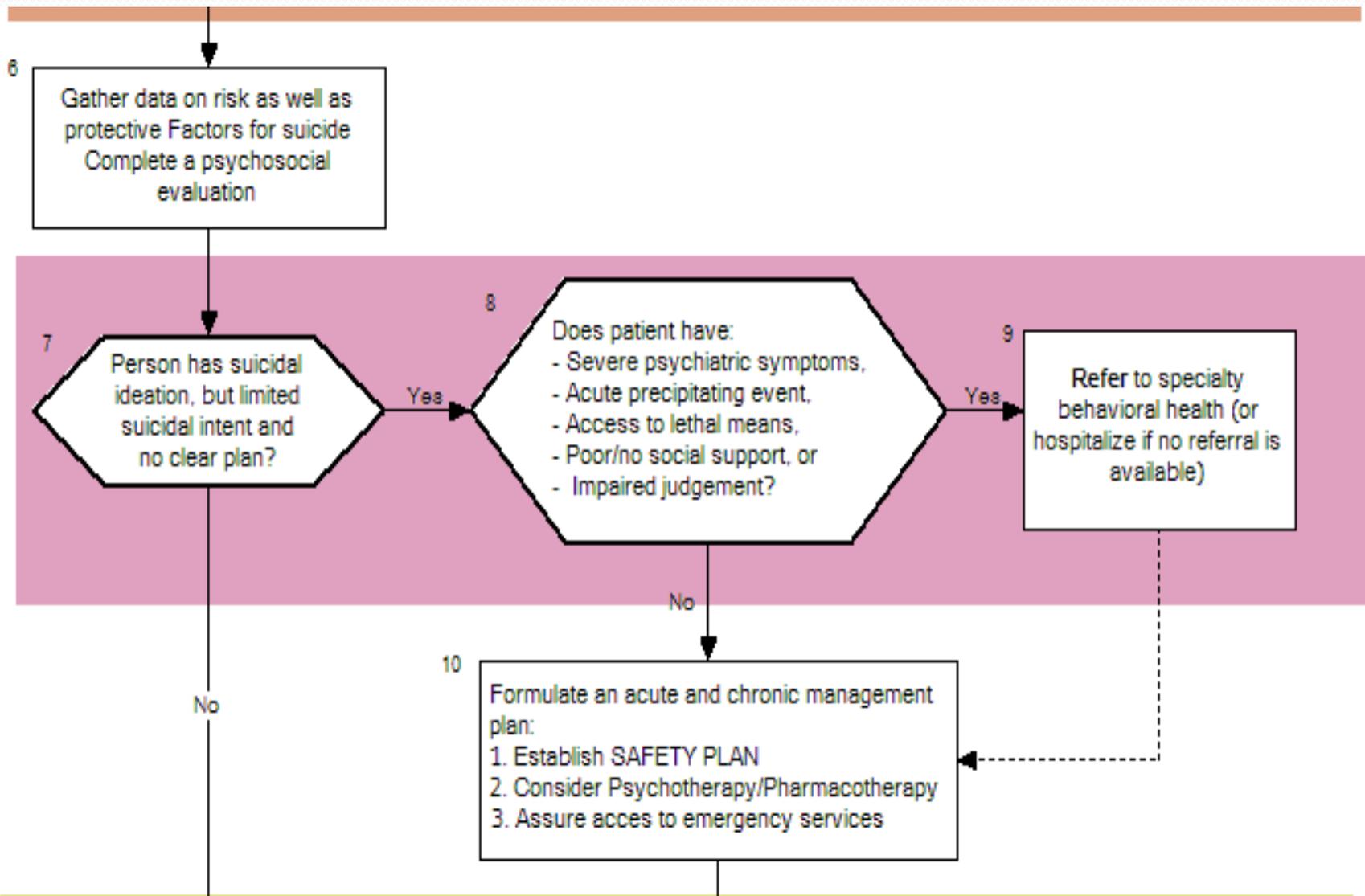


Management of Suicidal Patient

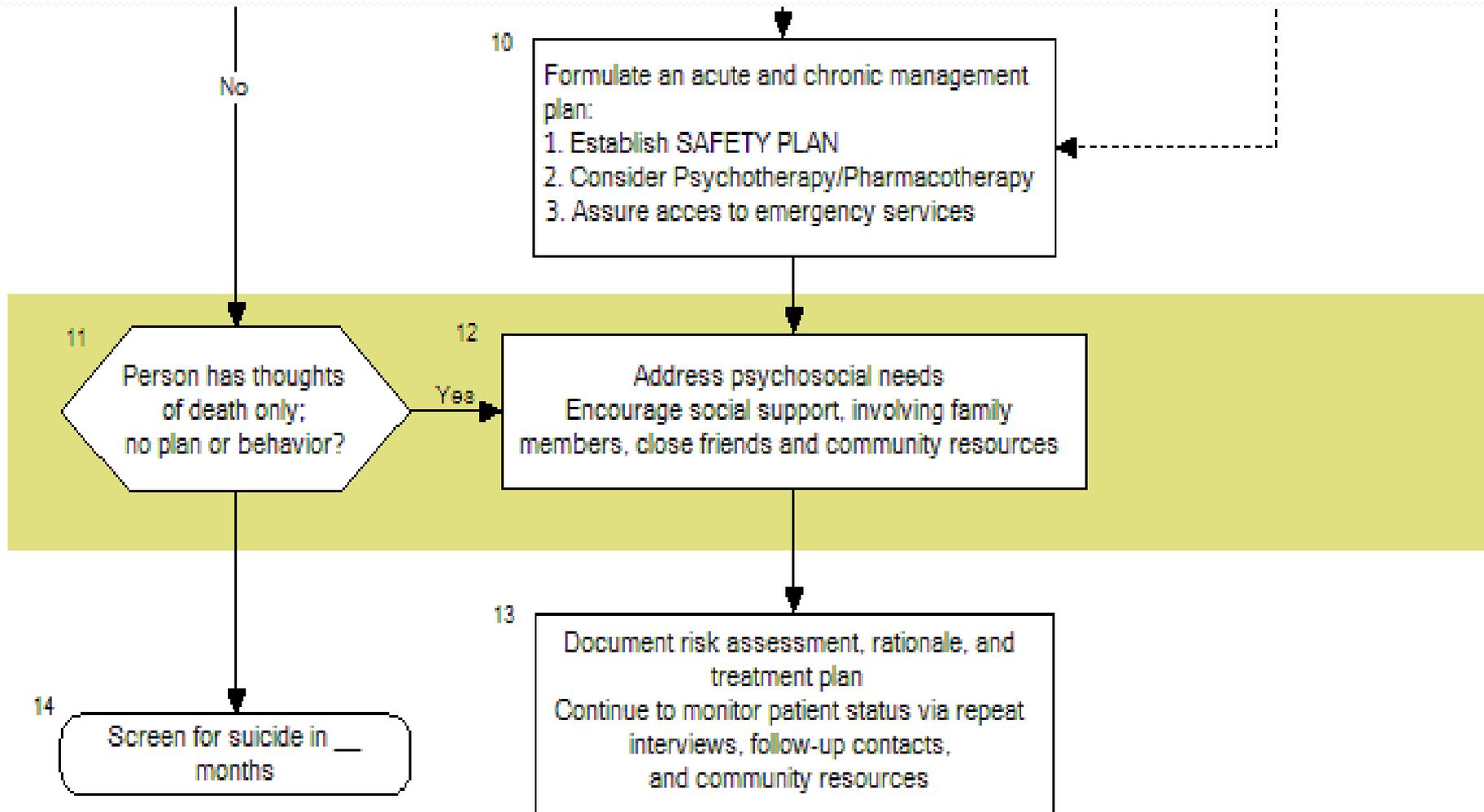
- Management of Urgent Risk (Imminent risk)
 - 7.1 Indications for Referral
 - 7.2 Hospital admission
- Developing an integrated care and risk management plan
 - 8.1 Clinical Engagement
 - 8.3 Addressing Needs
 - 8.4 Treating the Co-occurring mental health condition (see other CPGs)
 - 8.5 Optimize treatment of Underling Cause to prevent suicide
 - 8.6 Interventions for Preventing Suicide:
 - 8.6.1 Psychotherapy (CBT, PS, IPT, PA)
 - 8.6.2 Pharmacotherapy (AD, Omega 3, methadone, naloxone nasal)
 - 8.6.3 Other (ECT, TMS, Exercise, Group therapy)
 - 8.6.3 Restriction of Means (Firearms, Drugs, Alcohol, other)



ASSESSMENT



ASSESSMENT



Risk Level		Suicidality (Intensity & Duration)	ACTION
High (Acute)	Thought	<p><u>Any of the following:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Current intense suicidal ideation <input type="checkbox"/> Strong direct or indirect evidence of intent to die <input type="checkbox"/> Recent attempt or preparatory behaviors <input type="checkbox"/> Undetermined 	<p>Immediate transfer for specialty evaluation and consideration for Hospital Admission or Transfer safely to Emergency Setting (with escort) if not in hospital setting</p>
	Intent		
	Behavior		

Risk Level	Suicidality (Intensity & Duration)		ACTION
Moderate	Thought	<input type="checkbox"/> Chronic, intermittent, or resistible suicidal ideation	<p>Same Day (urgent) Consultation with Behavioral Health to determine acuity and preferred setting for further evaluation and care.</p> <p>Decision for referral is based on clinical judgment and availability of resources in conjunction with weighing factors that modify risk</p>
	Intent	<p>AND/OR</p> <input type="checkbox"/> Some direct or indirect evidence of intent to die	
	Behavior	<p>BUT</p> <input type="checkbox"/> NO recent attempt or behavior indicating preparation	

Risk Level		Suicidality (Intensity & Duration)	ACTION
<p style="text-align: center; color: green; font-weight: bold;">Low (Chronic)</p>	Thought	<ul style="list-style-type: none"> <input type="checkbox"/> Fleeting or Passive suicidal ideation, or thoughts of death <p>BUT:</p>	<p>Consider Routine Referral to or Consultation with Behavioral Health</p>
	Intent	<ul style="list-style-type: none"> <input type="checkbox"/> NO direct or indirect evidence of intent to die 	
	Behavior	<ul style="list-style-type: none"> <input type="checkbox"/> NO recent attempt or behavior indicating preparation 	

Risk Level		
Moderate to High	Thought	<p>Increased Risk if:</p> <ul style="list-style-type: none"> • History of Suicide Attempt or Self-Directed Violence • Acute psych symptoms (e.g. anxiety, depression, psychosis, SUD) • Existence of acute stressors • Multiple chronic risk factors
	Intent	<ul style="list-style-type: none"> • Exhibits warning signs • Impaired judgment • Intoxication • Recent (3m) change in level of care (e.g., d/c from hospital, treatment program)
	Behavior	<ul style="list-style-type: none"> • Recent initiation or increase in antidepressant therapy • Treatment non-compliance • Lack of Social Support • Access to lethal means

Treating the Underlying Cause

- For those who have more fundamental disorders of personality or who have a formal diagnosed psychiatric illness, the management or treatment approach may or may not require CBT and/or its elements but will most likely require biopsychosocial interventions – medication, other psychotherapies, assistance with arrangements for living, containment and protection from harm, etc.



Co-occurring Disorders

www.healthquality.va.gov

- **Bipolar Disorder** (VA/DoD CPG for Bipolar)

Refer to specialty , Mood stabilizer

- **SUD** (VA/DoD CPG for SUD)

Treat concurrently not sequential

- **MDD** (VA/DoD CPG for MDD)

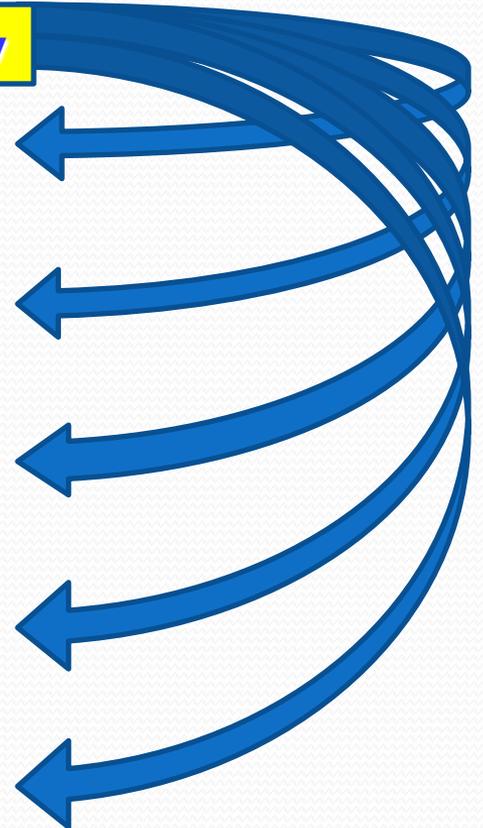
Treat MDD

- **mTBI** (VA/DoD CPG for mTBI)

Consider CBT for mTBI

- **PTSD** (VA/DoD CPG for PTSD)

Treat PTSD



EVIDENCE (In Progress)

	SUBSTANTIAL	SOMEWHAT	UNKNOWN	ZERO or HARM
High				
Moderate		Psychotherapy (DBT, CBT, PST)		
Low	Means restriction	Psychoeducation Training providers to assess risk Caring letters or other outreach		Inpatient No-suicide contracts
None			Safety Planning CAMS	



Psychotherapy

- Patients who are at high risk for suicide should be offered one of evidence-based suicide-focused psychotherapeutic interventions that are based on evidence, patient preference, available resources, and severity of symptoms (suicidality)
- Evidence-based therapies, including problem-solving therapy and cognitive-behavioral therapy (CBT), have been proved beneficial for some people who harm themselves.
- A structured problem solving approach should be considered in the treatment for persons with acts of self-harm in the last year.



PHARMACOTHERAPY

1. Recommend against the use of drug treatment as a specific intervention for prevention self-harm or suicide
2. Where self-harm is attributable to a psychiatric illness, pharmacological intervention may be helpful in managing the underlying problem and therefore the danger of repeated or more dangerous self-harm. However, the evidence for the usefulness of pharmacological interventions specifically to address self-harming behavior beyond definite psychiatric illness is limited.
3. When a patient expresses thoughts of self-harm or has demonstrated self-harm, the patient's medication regimen should be reviewed for medications associated with suicidal thoughts or behavior. The continuation of such medications should be re-evaluated.



PHARMACOTHERAPY

4. Patients at risk for suicide with co-occurring disorders who are treated with medication for the conditions should be reviewed to ensure effective treatment
5. When prescribing or dispensing any drugs (including for associated mental health conditions) to people who self-harm, consider the toxicity of drugs in overdose and the need for follow-up and monitoring for adverse events.
6. Some medications have been shown to reduce suicide risk in patients with specific conditions.



Safety Planning

- A Safety Plan that is designed to empower the patient, manage the suicidal crisis, and engage other resources to assist in the process should be institute for all persons who are moderate to high risk for suicide, regardless of inpatient or outpatient status. It should be included as part of discharge planning. Providers should discuss safety with patients at low risk or consider offering a copy of a Safety Plan handout.
- Safety plan should be:
 - Collaborative between the provider team and the patient
 - Proactive, i.e. explicitly anticipates a future suicidal crisis
 - Individually tailored
 - Oriented towards a no-harm decision
 - Capitalize on existing social support



Means Restriction

- Consider ways to restrict access to lethal means that service members/veterans could use to take their own lives. This includes the restriction of access to firearms and ammunition, use of blister packs for lethal medications to prevent intentional overdoses, bridge safeguards to prevent fatal falls, and constructing shower-curtain rods so as to prevent fatal hangings.



Follow Up

- Patients at elevated risk of suicide should be followed regularly and reassessed frequently, particularly if the patient's situation changes.
- Frequency of contact should be determined on an individual basis, and increased when there are increases in risk factors or indicators of suicide risk.
- Support should include reinforcement of the safety plan at regular intervals, including practice and, if needed, revisions.
- Contact and support may be helpful even when it is provided by telephone, letters, home visit or brief intervention.



Continuity

- Care for patients with risk for suicide must pay attention to maintain continuity across the health care system and assure smooth and safe transition between care settings.
- Mechanisms for bridging across transitions and for providing information to new providers must be developed on a system by system basis and emphasize coordination and collaboration of care, adequate clinical documentation, and promoting of treatment adherence.



Special Populations

- Elderly
- Women's issues
- Substance Use
- Neuropsychiatric Conditions (TBI)
- Post-Deployment (OEF/OIF)
- DoD in transition



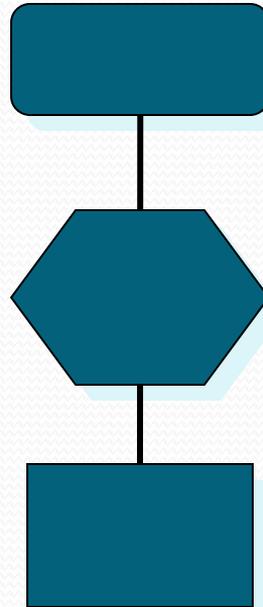
Caveat

- This is a work in progress
- Your questions & comments are welcomed
- Stay tuned...
- Guideline will be posted for public review before final approval.



? Questions

???



VA/DoD Clinical Practice Guideline

Suicide Prevention

2012



VA/DoD Evidence Based Practice

