ASAP 8th Annual Veterans Summit

- Anchors of Hope
- Universal Suicide Screening – RISK ID
- Safety Planning in Urgent Care – SPED
- Safety Planning and Lethal Means Safety
- High Risk for Suicide Category 1 Flag
- Recovery Engagement And Coordination for Health - Veterans Enhanced Treatment – REACH VET
- Suicide Risk Management Consultation Program

Anchors of Hope

Anchor 1:

399 fewer Veterans died from suicide in 2019 than in 2018.

Anchor 2:

From 2005 to 2018, identified Veteran suicides increased on average by 48 deaths per year.

A reversal totaling 399 lives within one year is unprecedented, dating back to 2001.

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Anchors of Hope

Anchor 3: Decrease in the adjusted suicide rate for Veterans from 2018 to 2019 (7.2%) was larger than any observed for Veterans 2001 through 2018.

Veteran rate of decrease (7.2%) exceeded by four times the non-Veteran population decrease (1.8%)

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Anchor 4:

There was a nearly 13% one-year (unadjusted) rate **decrease** for female Veterans, which represents the largest rate **decrease** for Women Veterans in 17 years.

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Universal Suicide Screening:

Making Suicide Prevention Everyone's Business

Universal Suicide Screening Requirement

On 11/13/20, a memorandum was released to update the field on Risk ID requirements:

- Screen **ALL** Veterans at least annually
- Widen breadth of providers and staff who can conduct suicide risk screening

Requirements: Screening will consist of the Columbia Suicide Severity Rating Scale (C-SSRS) Screener and is required annually for every Veteran accessing VHA for health care (annual Universal Screening Requirement), as well as with new behavioral health presentations and during certain Setting Specific Requirements. A positive C-SSRS screen will require a Comprehensive Suicide Risk Evaluation (CSRE).

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.

Service Area	Service Area N Pts.	Service Area N Encs.
Primary Care	1,253,321	2,237,608
Mental Health	123,814	609,153
Caregiver Support	75,820	142,217
Audiology	73,731	114,848
Ophthalmology/Optometry	67,552	104,407
Medicine Specialty Care	64,172	136,767
Homeless Program	28,358	167,197
Telephone Triage/Ancillary/Care/Case Management	22,047	32,679
Surgical Specialty Care	16,400	29,831
Rehabilitation and Prosthetic Services	16,129	39,353
Womens Health Services	15,811	23,656
Social Work Service	12,569	18,315
HBPC	10,144	137,776
Other	5,434	7,025
PCMHI	2,867	6,404
Palliative & Hospice	1,648	2,868
CIH/Move/Whole Health	1,524	4,695
Home Specialty Care	587	1,196
Chaplain	203	254

These counts represent the number of Veterans seen **only in the service area named**

If you don't ask, who will?

Veterans Seen in One Service Area

N= 1,792,131

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Recent Veteran VHA User Suicide Decedents, 2018 and 2019, Receipt of VHA Mental Health Diagnoses and Encounters

	2018		2019		Change from 2018 to 2019	
	Recent Veteran VHA Users Who Died From Suicide	% With Mental Health Diagnosis	Recent Veteran VHA Users Who Died From Suicide	% With Mental Health Diagnosis	Recent Veteran VHA Users Who Died From Suicide	% With Mental Health Diagnosis
National	**2,384**	**59.7%**	**2,468**	**59.5%**	**+84**	**-0.2%**
VISN 1	75	62.7%	82	68.3%	+7	5.6%
VISN 2	71	56.3%	69	59.4%	-2	3.1%
VISN 4	94	67.0%	108	61.1%	+14	-5.9%
VISN 5	[illegible]	56.8%	54	59.3%	-20	2.5%
VISN 6	[illegible]	69.0%	138	67.4%	+9	-1.6%
VISN 7	[illegible]	59.7%	140	61.4%	+1	1.7%
VISN 8	[illegible]	52.6%	238	58.0%	+10	5.4%
VISN 9	[illegible]	60.7%	118	56.8%	+6	-3.9%
VISN 10	[illegible]	58.8%	205	59.0%	+23	0.2%
VISN 12	[illegible]	[illegible]3%	88	60.2%	-3	0.9%
VISN 15	[illegible]	[illegible]%	113	57.5%	+5	-5.5%
VISN 16	[illegible]	59.9%	165	57.0%	+8	-2.9%
VISN 17	[illegible]	58.5%	145	56.6%	-14	-1.9%
VISN 19	[illegible]	68.3%	167	54.5%	+6	-13.8%
VISN 20	124	55.6%	153	65.4%	+29	9.8%
VISN 21	141	53.2%	134	55.2%	-7	2.0%
VISN 22	225	57.8%	232	58.6%	+7	0.8%
VISN 23	114	62.3%	119	61.3%	+5	-1.0%

In some VISNs, 30-40% of Veterans who die from suicide have NO MH diagnosis

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RESEARCH ARTICLE

WILEY

Association of vision impairment with suicide ideation, plans, and attempts among adults in the United States

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Abstract

Objective: This study aims to investigate the relative strength of association between vision impairment (VI) and suicidal ideation, plans, and attempts among adults in the United States.

Method: The study sample consisted of 214,505 adults, aged 18 years and older. Researchers used data from the 2015–2019 National Survey on Drug Use and Health, in which respondents were asked whether they had any suicidal thoughts, plans, and attempts, in the past 12 months.

Results: Approximately, 4.4% of respondents reported experiencing VI, being blind, or having serious difficulty seeing. Compared to their sighted peers, a relatively high proportion of adults with VI had serious thoughts about suicide (9.0%), suicidal plans (3.0%), or suicidal attempts (1.6%) in the past year. The findings showed that individuals with VI may disproportionately experience suicidal ideation, plans, and attempts, after controlling potentially confounding variables (adjusted odds ratio [AOR] = 1.36; AOR = 1.27; AOR = 1.40, respectively).

Conclusion: With findings demonstrating such a strong association between VI and suicide, this study suggests the

Support for Screening in Ophthalmology:

- N = 214, 505 adults from 2015-2019 National Survey on Drug Use and Health
- Respondents asked about SI, plan and attempts in previous 12 months
- Compared to sighted peers, respondents reporting visual impairment, being blind or having serious difficulty seeing disproportionately experienced suicidal thoughts and behavior (after controlling for controlling for potentially confounding factors, including sociodemographic variables, health status and behaviors, and mental health challenges).
- Conclusion: "*With findings demonstrating such a strong association between VI and suicide, this study suggests the importance of screening for suicidal ideation, plans, and attempts among adults with VI, and the strong need for developing behavioral health services which keep this correlation in mind.*"

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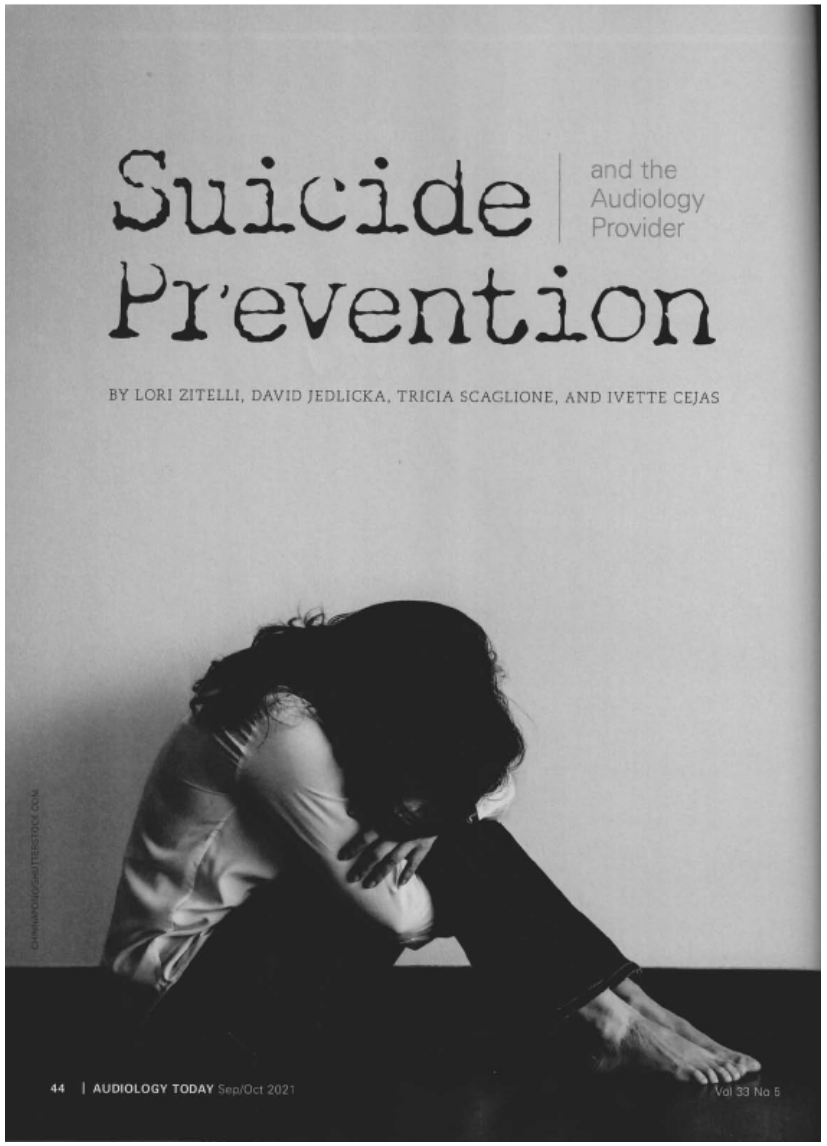

Support for Screening in Audiology:

- Educational article describing the role of audiologists in suicide prevention.
- Notes various studies describing associations between audiologists' patient populations and various mental health diagnoses associated with increased risk for suicide.
- Recognizes need to use validated screening tools
- Provides a review of warning signs, helpful strategies for engaging in discussion of suicide and case studies.
- Conclusion: *"Audiologists bear the shared responsibility of identifying and mitigating suicide risk. In a situation where a patient is suffering from a hearing or balance disorder, an audiologist may be the first and only person with whom an individual shares thoughts of suicide. These experiences should be viewed as opportunities for audiology to help bridge the mental-health gap by reducing stigma, breaking down barriers that prevent the open discussion of difficult topics, connecting with patients who are emotionally struggling and ultimately saving lives."*

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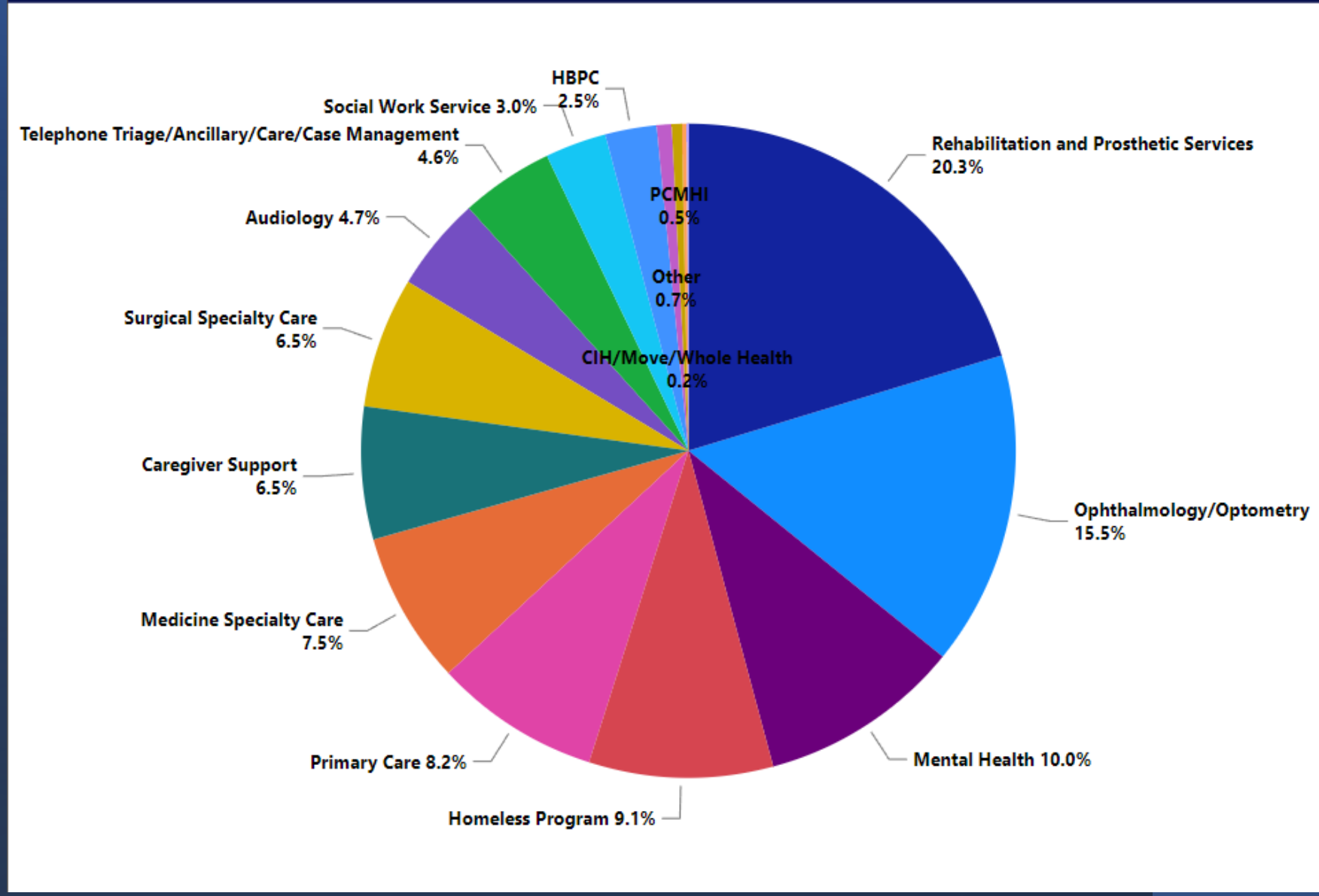
% of Overall Missed C-SSRS Screens



What happens if someone screens positive?

Stay calm & thank the Veteran for sharing

Alert Mental Health

MH Clinician completes **same day** risk evaluation to determine appropriate level of care

1. **On Unit Mental Health**
2. **Mental Health Triage Line Pager (914-321-0755)**
3. **Mental Health Care Line (x20-2330)**

Enter FULL extension

* Night/Weekend staff- Check on call schedule or with MAA/NOD/MOD

Check out our resources on Sharepoint

SUICIDE PREVENTION SCREENING GUIDES

Safety Planning in the Emergency Department (SPED)

- Evidence-based intervention required in VA after research (Stanley et al., 2018) demonstrated that safety planning and structured outreach was associated with a reduction in suicidal behavior in the six months following the ED visit.
- Ahmedani et al. (2019) highlight risk after ED visit
- Those who died by suicide were more likely to have health care visits of any variety compared to matched controls:
  - 7% with ED visit within 7 days
  - >14% within 30 days and
  - 43.8% within 365 day
  - Compared to controls where only .6% and 21% of visited with ED within the 7 days and year prior, respectively

Take away:

ED is an ideal place for intervention given the higher likelihood of a visit for the at-risk group

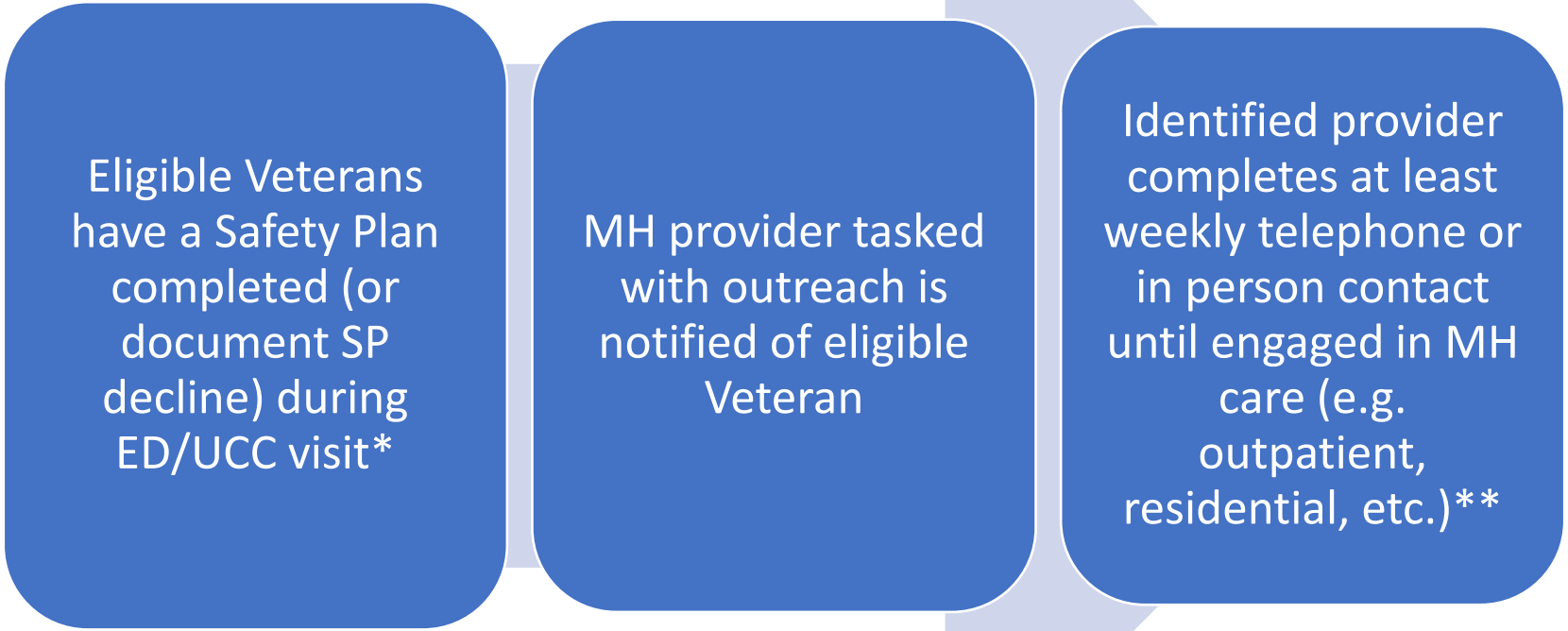
Why SPED?

- Goldman-Mellor et al. (2019) looked at longitudinal outcomes of those presenting to ED with deliberate self-harm, SI without self-harm
- In the year following ED presentation:
  - Rates of suicide mortality were highest among those with self-harm, followed by those with SI as compared to the reference group
  - **Even ED patients without self-harm or SI were 2x more likely to die by suicide than matched demographic controls**

Take away:

Presentation to the ED is a risk factor. Screening is essential and discharge is a critical time to intervene (safety planning, linkages to outpatient MH, etc.)

SPED Requirements



*Documentation can occur within 24 hours of the positive C-SSRS

**It is recommended that the first call occur within 72 hours of the ED visit

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Suicide Prevention Safety Plan

MY SAFETY PLAN

Please follow the steps described below on your safety plan.
If you are experiencing a medical or mental health emergency, please call 911 at any time.
If you are unable to reach your safety contacts or you are in crisis, call the Veterans Crisis Line at **988 (press 1)** or **1-800-273-8255 (press 1).**

Step 1: Triggers, Risk Factors, and Warning Signs

Signs that I am in crisis and that my safety plan should be used:

1. _____
2. _____
3. _____
4. _____
5. _____

Step 2: Internal Coping Strategies

Things I can do on my own to distract myself and keep myself safe:

1. _____
2. _____
3. _____
4. _____
5. _____

Step 3: People and Social Settings that Provide Distraction

Who I can contact to take my mind off my problems/help me feel better:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____
4. Name: _____ Phone: _____
5. Name: _____ Phone: _____

Public places, groups, or social events that help me feel better:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Step 4: Family Members or Friends Who May Offer Help

Who I can tell that I am in crisis and need support:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____
4. Name: _____ Phone: _____
5. Name: _____ Phone: _____
6. Name: _____ Phone: _____

Step 5: Professionals and Agencies to Contact for Help

Mental Health professionals or services I can contact for help:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____
4. Name: _____ Phone: _____

Veterans Crisis Line: 988, press 1
or 1-800-273-8255, press 1

VCL Text Messaging Service: Text to 838255

VCL Chat:
https://www.VeteransCrisisLine.net/Chat

Dial 911 in an emergency

If I need to go to an emergency room or urgent care, I will go to: _____

ER Address: _____

ER Phone: _____

Step 6: Making the Environment Safe

These are the ways I will make my environment safer and barriers I will use to protect myself from potentially lethal means:

_____

_____

These are the people who will help me protect myself from having access to dangerous items:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____

Other Resources:

Virtual Hope Box Smartphone App	www.MakeTheConnection.net
Safety Plan in PTSD Coach Smartphone App	www.KeepItSecure.net

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What is Lethal Means Safety?

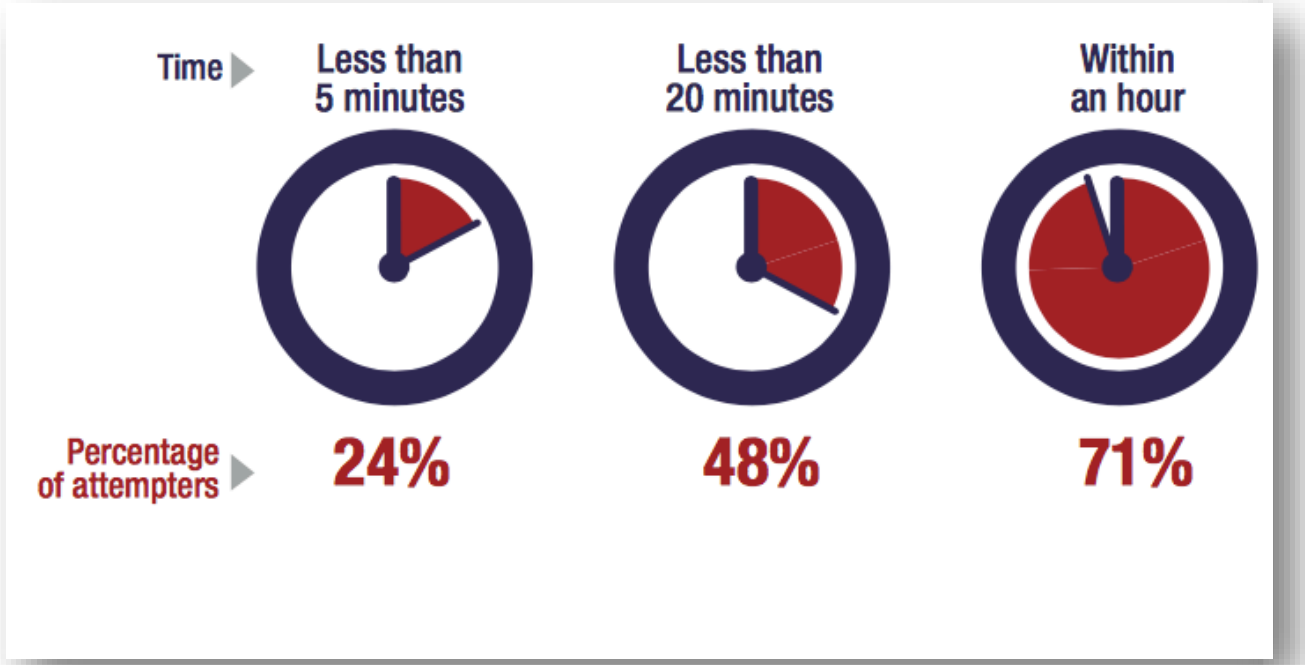
- In the context of suicide prevention, safe storage of lethal means is any action that builds in time and space between a suicidal impulse and the ability to harm oneself.

- Effective lethal means safety education and counseling is collaborative and Veteran-centered. It respects the important role that firearms and medications may play in Veterans' lives and is consistent with their values and priorities.

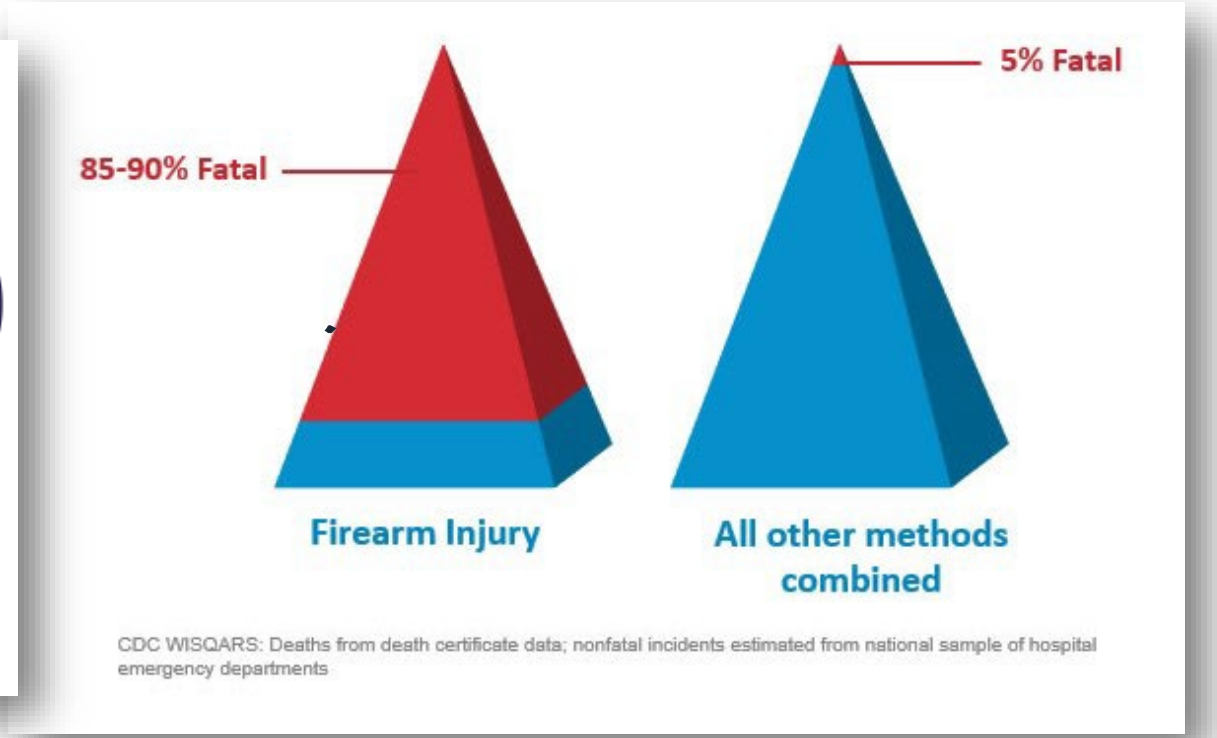
Lethal Means Safety Works

- Reducing access to lethal suicide methods is one of the few population level interventions that has been shown to decrease suicide rates.
- About **90 percent** of people who survive a suicide attempt do not go on to die by suicide.
- If we can collaborate with Veterans **ahead of time** to help them survive a suicidal crisis, we have likely prevented suicide for the **rest of their lives**.

Most Suicidal Crises are Brief
Time from Decision to Action < 1 hour



Source: Simon, T.R., Swann, A.C., Powell, K.E., Potter, L.B., Kresnow, M., and O'Carroll, P.W. Characteristics of Impulsive Suicide Attempts and Attempters. SLTB. 2001; 32(supp):49-59.



Source: CDC WISQARS and US Dept. of Veterans Affairs
https://www.mirecc.va.gov/lethalmeanssafety/facts/

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Category 1 High Risk for Suicide Flag

- HRF1: Percent of Veterans with a newly assigned or reactivated HRF with a **Safety Plan documented within 7 days before or after** flag initiation, or on or before inpatient discharge
- HRF2: Percent of Veterans with a newly assigned or reactivated HRF who received **at least 4 mental health visits within 30 days** of flag initiation
- HRF3: Percent of Veterans with a newly assigned or reactivated HRF who received **at least 1 mental health visits within 31-60 days** of flag initiation
- HRF4: Percent of Veterans with a newly assigned or reactivated HRF who received **at least 1 mental health visits within 61-90 days** of flag initiation
- HRF5: Percent of Veterans with a newly assigned, reactivated, or continued HRF who received a **case review between 80-100 days** after flag initiation, for new or reactivated flags, or within 7-100 days, for continued flags
- Alert SPC when you have a HRF no-show
- Contact SPC when you want to consult and put in consult for HRF

What is REACH VET?

- REACH VET summarizes information from the Veterans Health Record and uses **predictive modeling to identify Veterans at statistical risk for suicide** and other negative outcomes. This tool supplements clinical strategies used to identify at-risk Veterans and may help providers intervene prior to these negative outcomes occurring.
- The REACH VET program:
  - Helps alert facilities of Veterans at the top 0.1% increased statistical risk at each facility
  - Summarizes past two years of health record data to streamline clinical review
  - Provides an additional data point for conceptualization and treatment
  - Offers an opportunity to engage Veterans in their own healthcare and make enhancements, as indicated

REACH VET Recovery Engagement And Coordination for Health - Veterans Enhanced Treatment

- Releases names monthly to alert facility to Veterans within the top 0.1% of statistical risk

Provider Steps At-a-Glance

- 1 Receive notification about a high-risk Veteran you serve.
- 2 Optional: Access the dashboard.
- 3 Re-evaluate care.
- 4 Consider treatment enhancement strategies.
- 5 Outreach the Veteran.
- 6 **Document in CPRS with REACH VET PROVIDER note**

Supporting Providers Who Serve Veterans

Free consultation and resources for any provider in the community or VA who serves Veterans at risk for suicide.

Request a consult: srmconsult@va.gov

#NeverWorryAlone

- **Provider support after a suicide loss (Postvention)**
- **Risk assessment**
- **Lethal means safety counseling**
- **Conceptualization of suicide risk**
- **Best practices for documentation**
- **Strategies for how to engage Veterans at high risk**