

Recommendation Focus Areas

Identification of Increased Risk of Violence	<ul style="list-style-type: none"> • Verbal or written expression of homicidal ideation • Other red flags <ul style="list-style-type: none"> ○ Texting ○ Stalking • Clinical discretion <p>Record keeping</p>
Further Assessment of Violence Risk	<p>Screen all patients who may be at risk for violence for behavioral health conditions (i.e., mental health, substance use), associated with increased violence risk using a validated instrument(s), including:</p> <ul style="list-style-type: none"> • Depression • Suicidality (i.e., suicidal ideation, past attempts) • Alcohol misuse • Anxiety • Drug use <p>Further identify risk of violence with a validated instrument and identify additional risk factors including:</p> <ul style="list-style-type: none"> • Mental illness diagnosis • Substance use disorder(s) • Stressful life event • Other relevant psychiatric symptoms or warning signs (at clinician’s discretion) <p>Validated instrument</p> <p>Record keeping</p>
Violence Risk Treatment	<ul style="list-style-type: none"> • Address lethal means safety (e.g., gun storage). • Ensure individuals at risk of violent actions have a pathway to timely and adequate care (e.g. follow-up contact same day or later as indicated by suicide risk assessment). • Keep patients in an acute crisis in an observed, safe environment. • Engage patients in collaborative safety planning. • If possible, involve family members or other key support people in risk management. • Ensure the patient is connected to evidence-based follow-up treatment. • Provide contact and support during transition from inpatient to outpatient sites, and from out-patient to no behavioral health treatment. • Ensure supported pathway to adequate and timely care, as outlined above (e.g., collaborative safety planning, onsite or referral to offsite behavioral health) <p>Record keeping</p>
Discharging patients (by treatment setting)	<p><i>The mental health professional or organization may give special consideration to those alternatives which, consistent with public safety, would least abridge the rights of the mental health client or patient established under the Revised Code, including the rights specified in sections 5122.27 to 5122.31 of the Revised Code.</i></p> <p>From Ohio’s 2305.51 Mental health professional or organization not liable for violent behavior by client or patient.</p>

- Exercise any authority the professional or organization possesses to hospitalize the client or patient on an emergency basis pursuant to section 5122.10 of the Revised Code;
- Exercise any authority the professional or organization possesses to have the client or patient involuntarily or voluntarily hospitalized under Chapter 5122. of the Revised Code;
- Establish and undertake a documented treatment plan that is reasonably calculated, according to appropriate standards of professional practice, to eliminate the possibility that the client or patient will carry out the threat, and, concurrent with establishing and undertaking the treatment plan, initiate arrangements for a second opinion risk assessment through a management consultation about the treatment plan with, in the case of a mental health organization, the clinical director of the organization, or, in the case of a mental health professional who is not acting as part of a mental health organization, any mental health professional who is licensed to engage in independent practice;
- Communicate to a law enforcement agency with jurisdiction in the area where each potential victim resides, where a structure threatened by a mental health client or patient is located, or where the mental health client or patient resides, and if feasible, communicate to each potential victim or a potential victim's parent or guardian if the potential victim is a minor or has been adjudicated incompetent, all of the following information:
 - The nature of the threat;
 - The identity of the mental health client or patient making the threat;
 - The identity of each potential victim of the threat.

Record keeping

2017 Designated Mental Health Protocols
Available [here](#)

Recommendations for Stakeholder Actions and Quality Improvement Strategies

Do not use these recommendations in lieu of medical advice.

Patients and Family Members

- Talk to your primary care provider or other care team members about a wish to be dead, thoughts of suicide, or thoughts of harming yourself or others.
- Also talk to your primary care provider or other care team members about any mental health concerns, including feeling low or depressed, feeling anxious, concerns about drinking or drug use, or any other concerns about behavioral or physical health.

Primary Care Providers and Behavioral Health Care Providers

- Complete the Washington-state required training on suicide-prevention as part of continuing education requirements. More information from the Washington State Department of Health on the required training is [here](#).
- **Identification of Violence Risk**
 - TBD
- **Assessment of Violence Risk**
 - Explain to patients the purpose of screening for depression, suicidality, alcohol misuse, anxiety, and drug use including the safety and security of the information.
 - Screen patients who may be at risk for violence for mental health and substance use conditions including:
 - Depression (e.g. PHQ-2, PHQ-3 and/or PHQ-9)
 - Suicidality (e.g. ninth question of the PHQ-9, first and second questions of the Columbia Suicide Severity Rating Scale (C-SSRS), the Ask Suicide-Screening Questions (ASQ) as well as current plans and any past attempts).
 - Alcohol misuse (e.g., AUDIT-C)
 - Anxiety (e.g., GAD-2)
 - Drug use (e.g., ASSIST, DAST-10, single item cannabis and other drug use questions)
 - Assess additional risk factors such as:
 - Presence of mental illness diagnosis (e.g. bipolar disorder, schizophrenia) as identified in the medical record.
 - Severe substance use disorder(s) (e.g., opioid use disorder, severe alcohol use disorder) as identified in the medical record.
 - Asking about any recent experience of a stressful life event (e.g., family or marital conflict, unemployment, social isolation)
 - Other relevant psychiatric symptoms or warning signs (at clinician's discretion)
- **Violence Risk Treatment**
 - *Do not use a no-suicide contract. This is not supported by evidence.*
 - *Track "suicide risk" as a separate item in a patient's problem list when risk factors are present even when suicidal ideation has not been explicitly expressed.*
 - *Keep patients in an acute suicidal crisis in an observed, safe environment.*
 - *Ensure individuals at risk of suicide have a pathway to timely and adequate care (e.g. follow-up contact same day or later as indicated by suicide risk assessment).*

- *Address lethal means safety such as asking about safe firearm and medication (e.g. opioids, anxiety, or sleeping medications) storage in the house.*
- *Engage patients in collaborative safety planning if risk factors are present even if suicidal ideation has not been expressed, including:*
 - *Warning signs of suicidal crisis.*
 - *Internal coping strategies (i.e., activities that can be done alone).*
 - *Socialization strategies for distraction and support.*
 - *Contact numbers for friends and family members to ask for help.*
 - *Providing professionals or agencies to contact during crisis, including Suicide Prevention Lifeline 1-800-273-TALK (8255), the Veteran’s Crisis Line 1-800-273-8255, the Crisis Text Line text HOME to 741741, as well as local crisis resources.*
 - *Treatment strategies may be involved in the safety plan.*
- *If possible, involve family members or other support people in suicidal risk management.*
- *Refer to onsite behavioral health or conduct a supported warm handoff to offsite behavioral health for effective evidence-based treatments that directly target suicidal thoughts and behaviors rather than focusing on specific diagnoses (e.g., depression, anxiety). The interventions with the most robust evidence include:*
 - *Following-up with a patient by initiating non-demanding caring contacts.*
 - *Dialectical behavior therapy.*
 - *Suicide-specific cognitive behavioral therapy.*
 - *Collaborative assessment and management of suicidality (CAMS).*
- *Offer case management services as needed to support suicidal patients in treatment.*
- *Document patient information related to suicide care and referrals.*
 - *The Joint Commission recommends the provider(s) to “Document why the patient is at risk for suicide and the care provided to patients with suicide risk in as much detail as possible, including the content of the safety plan and the patient’s reaction to and use of it; discussions and approaches to means reduction; and any follow-up activities taken for missed appointments, including texts, postcards, and calls from crisis centers.”*
- **Discharging Patients**
 - *Ensure the patient is connected to evidence-based follow-up treatment.*
 - *Provide contact and support during transition from an inpatient to outpatient setting.*
 - *Refer to peer support specialists after inpatient care, if available.*
 - *Assess suicide risk at every visit within the same organization or between organizations as care is transitioned.*
 - *Ensure supported pathway to adequate and timely care, as outlined above using:*
 - *Collaborative safety planning*
 - *Onsite or referral to evidence-based treatments.*
 - *Case management.*
 - *Documentation.*

Care Settings (including Primary Care Practices, Hospitals, Health Systems)

- **Integrating Behavioral Health**
 - *Ideally behavioral health concerns will be addressed in primary care through integrated behavioral health diagnoses for whom accessing services through primary care would be appropriate as outlined in the 2017 Bree Collaborative [Behavioral Health Integration Report and Recommendations](#).*

- *Review and follow the recommendations above including those to primary care practices (e.g., Clearly define roles for integrated care team members, including primary care and behavioral health clinicians and staff, At a minimum, ensure that for each patient with an identified behavioral health need, a plan is developed on the same day that includes continuous patient engagement in ways that are convenient for patients, in person or by phone or videoconferencing.)*
- **Identification and Assessment of Violence Risk**
 - *Display crisis line information and suicide prevention materials. Give them to patients and their supporters at appointments or interventions relevant to suicide, including discharge after a suicide attempt.*
 - *Clarify clinical roles and workflow related to suicide care (e.g., which staff members will participate in suicide risk identification, assessment, management, and treatment and how this care will be coordinated).*
 - *Train clinicians and staff how to identify and respond to patients who exhibit suicidal ideation. Use resources such as the Suicide Prevention and the Clinical Workforce: Guidelines for Training from the Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention, available [here](#).*
 - *Build screening for depression, suicidality, alcohol misuse, drug use, and anxiety into the clinical pathway using a validated instrument.*
 - *Track a patient's scores on the above within the electronic health record.*
 - *Track "suicide risk" as a separate problem on a patient's problem list in the electronic health record.*
 - *Display preventive messaging around safe storage of firearms and medication.*
- **Violence Risk Treatment**
 - *Develop a care protocol for patients who present in an acute suicidal crisis keeping the patient in a safe environment under observation.*
 - *Train staff on how to conduct a collaborative safety plan.*
 - *If not available onsite, facilitate access to psychiatric consultation services in a systematic manner to assist the care team in offering effective evidence-based suicide care the same day as much as possible.*
 - *For emergency departments:*
 - *Keep patient in a safe environment under observation assuring absence of lethal means.*
 - *Evaluate patient for acute risk (e.g., using the C-SSRS, or Patient Safety Screener (PSS-3)).*
 - *Complete a collaborative safety plan as outlined previously.*
 - *Contact primary care for follow-up and behavioral health care provider(s) (if known).*
- **Discharging Patients**

Health Plans

Partially adapted from SAMHSA's ACAP Fact Sheet Safety Net Health Plan Efforts to Integrate Physical and Behavioral Health at Community Health Centers¹

- *Reimburse for Medicare primary care providers participating in a collaborative care program or receiving other integrated behavioral health services as outlined in CMS Federal Register Final Rule for Docket Number CMS-1654-F (e.g., G0502, G0503, G0504).*
- *Work with health care purchasers to identify and provide data on outcome measurements relevant to their population to better ensure treatment efficacy and patient access (e.g., NCAQ behavioral health treatment within 14 days, NCAQ anti-depressant medication management).*
- *Develop and maintain strong, respectful relationships with practices including sharing information, decision-making, costs, and savings as appropriate.*
- *Review reimbursement structures for clinical services involved in suicide care that currently have no or low levels of reimbursement.*

Employers

- *When designing benefits, work to eliminate inadvertent barriers to behavioral health care services and integrating care for employees including equalizing benefit structures for behavioral health and physical health care.*
- *If an employee assistance program is offered, promote employee understanding of behavioral health benefits including suicidality.*
- *Include behavioral health-related components in employee wellness programs (e.g., stress and anxiety reduction, interventions around alcohol consumption).*

Washington State Health Care Authority

- *Certify patient decision aids around treatment options for common behavioral health conditions (e.g., depression, anxiety, alcohol use, substance abuse).*

Table 1: Implementing Suicide Care Recommendations		
Focus Area	Patient Perspective	Pathway to Implementation
Identification of Violence Risk	<i>I am asked about depression, any thoughts I may have of harming myself, alcohol and drug use, and anxiety at my first visit and at least annually thereafter. I understand why I am being asked these questions and feel comfortable talking to my doctor about my feelings.</i>	<p>Usual Care: The patient’s risk of suicide is not assessed or is occasionally assessed. There is no information available that shows if a patient has ever made a suicide attempt or been asked behavioral health questions that may be related to a suicide attempt even if this has occurred from a visit with another provider.</p> <p>Steps Toward Implementation: Screening for suicide risk is incorporated as a pilot for selected group(s) of patients. Patients may only be identified through an explicit question or questions about suicidal ideation or through being identified as having depression.</p> <p>Optimal Care: All patients are screened for suicidality using validated tools (e.g., question 9 of the PHQ-9, the first two questions of the Columbia Suicide Severity Rating Scale (C-SSRS)) and being asked about any previous suicide attempts as well as for depression, anxiety, alcohol misuse, and drug use. Patients are actively involved in their own care.</p>
Assessment of Violence Risk	<i>I understand that if I do have thoughts about harming myself, my care team will ask me questions to help them better understand the risk that I will hurt myself.</i>	<p>Usual Care: Further assessment of suicide risk may be lacking and/or providers may be unsure how best to address the risk factors identified in the initial identification. There may be a lack of training or a lack of a clinical pathway that includes behavioral health.</p> <p>Steps Toward Implementation: Patients who are identified at a higher suicide risk may only receive screening with a tool directly asking about suicide risk rather than a more comprehensive assessment looking at additional risk factors.</p> <p>Optimal Care: If a patient does exhibit risk for suicide, either through screening positive for suicidal ideation or showing higher risk in another area such as high anxiety or depression, the patient is asked additional questions about suicide risk such as the complete six question C-SSRS or another validated instrument. In addition, the provider checks the patient record for a diagnosis of a mental health disorder and/or a severe substance abuse disorder and asks the patient about any stressful life events. Other warning signs as identified by the provider may also lead to next steps of managing suicide risk through a collaborative safety plan.</p>

<p>Violence Risk Treatment</p>	<p><i>If my screening results suggest that I may be at a higher risk for suicide I am assessed that same visit for acute risk, I am engaged in collaborative safety planning.</i></p>	<p>Usual Care: Staff may be uncertain as to next steps after a patient risk for suicide has been identified. Referrals to offsite behavioral health may be made but not in such a way that supports the patient who may fall out of care.</p> <p>Steps Toward Implementation: Providers and staff receive training on how to conduct a collaborative safety plan. The role of staff members is clearly defined, understood by all, and effectively communicated to the patient.</p> <p>Optimal Care: After suicide risk has been identified and assessed, providers or other staff focus on mitigating imminent risk. Providers or staff have a conversation about addressing lethal means safety such as asking about safe firearm and medication storage in the house. Patients receive collaborative safety planning in the clinical visit or through a same-day conversation with another staff such as a social worker in which the patient and staff discuss the warning signs of a suicidal crisis, developing internal coping strategies, socialization strategies for distraction and support, contact numbers for friends and family members to ask for help, and information about professionals or agencies to contact during a crisis. Treatment strategies may be involved in the safety plan.</p>
<p>Discharging Patients</p>	<p><i>After a suicide attempt I am connected with my primary care provider(s) and/or behavioral health. I receive evidence-based treatment.</i></p>	<p>Usual Care: After a suicide attempt, the patient may not receive any follow-up. Risk of a subsequent suicide attempt is high.</p> <p>Steps Toward Implementation: Protocols are in place to support patients after a suicide attempt, but may be inconsistently applied. Patients may be connected with primary care and with treatment in some cases.</p> <p>Optimal Care: Patients are fully supported after a suicide attempt. They are directly connected with primary care and with behavioral health care provider(s) (if known). Primary care provides contact and support through the transition from inpatient to an outpatient setting and from out-patient to no behavioral health treatment. Patients may be referred to peer support specialists and suicide risk is assessed at every visit. Patients receive collaborative safety planning, evidence-based treatment, and case management. Providers document the care given to patients and feel comfortable at all steps along the pathway.</p>

Measurement

Healthcare Effectiveness Data and Information Set

The Centers for Medicare and Medicaid Services adopted behavioral health measures for Accountable Care Organizations in 2016 focused on depression readmission or response at 12 months.² The National Committee for Quality Assurance recently developed Healthcare Effectiveness Data and Information Set (HEDIS) measures for 2017 that include expectation of depression remission and/or response within five to seven months. Studies have supported this shorter time to readmission using evidence-based collaborative care interventions. The Collaborative supports an expectation of depression remission and/or response within five to seven months.

HEDIS

[Healthy People 2020](#) includes metrics on the suicide rate for the population at large and for adolescents, on major depressive episodes, on integrated behavioral health, and on access to mental health care.³

- **MHMD-1: Reduce the suicide rate**
 - Baseline: 11.3 suicides per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population)
 - Target: 10.2 suicides per 100,000 population
 - Target-Setting Method: 10 percent improvement
- **MHMD-2: Reduce suicide attempts by adolescents**
 - Baseline: 1.9 suicide attempts per 100 population occurred in 2009
 - Target: 1.7 suicide attempts per 100 population
 - Target-Setting Method: 10 percent improvement
- **MHMD-4: Reduce the proportion of persons who experience major depressive episodes (MDEs)**
 - MHMD-4.1: Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs)
 - Baseline: 8.3 percent of adolescents aged 12 to 17 years experienced a major depressive episode in 2008
 - Target: 7.5 percent
 - Target-Setting Method: 10 percent improvement
 - MHMD-4.2: Reduce the proportion of adults aged 18 years and older who experience major depressive episodes (MDEs)
 - Baseline: 6.5 percent of adults aged 18 years and over experienced a major depressive episode in 2008
 - Target: 5.8 percent
 - Target-Setting Method: 10 percent improvement
- **MHMD-5: Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral**
 - Baseline: 79.0 percent of primary care facilities provided mental health treatment onsite or by paid referral in 2006
 - Target: 87.0 percent
 - Target-Setting Method: 10 percent improvement
- **MHMD-6: Increase the proportion of children with mental health problems who receive treatment**
 - Baseline: 68.9 percent of children with mental health problems received treatment in 2008
 - Target: 75.8 percent

- Target-Setting Method: 10 percent improvement

Appendix C: Guideline and Systematic Review Search Results

Keywords: homicide, homicidal ideation, violence. Excluding intimate partner violence interventions directed at the recipient.

Augment existing suicide care search

Source	Guidelines or Systematic Reviews
AHRQ: Research Findings and Reports	<p>(2017) Anxiety in Children</p> <p>(2016) Disparities Within Serious Mental Illness</p> <p>(2015) Nonpharmacological Versus Pharmacological Treatments for Adult Patients With Major Depressive Disorder</p> <p>(2015) Management Strategies to Reduce Psychiatric Readmissions</p> <p>(2014) Pharmacotherapy for Adults with Alcohol-Use Disorders in Outpatient Settings</p> <p>(2012) Interventions for the Prevention of Post-traumatic Stress Disorder in Adults After Exposure to Psychological Trauma</p>
Cochrane Collection	<p>(2018) De-escalation techniques for managing non-psychosis induced aggression in adults</p> <p>(2017) Benzodiazepines for psychosis-induced aggression or agitation</p> <p>(2015) Behavioral and cognitive-behavioral interventions for outwardly-directed aggressive behavior in people with intellectual disabilities</p> <p>(2013) User-held personalized information for routine care of people with severe mental illness</p> <p>(2012) Collaborative care for people with depression and anxiety</p> <p>(2012) Zuclopenthixol acetate for acute schizophrenia and similar serious mental illness</p> <p>(2010) Psychological interventions for antisocial personality disorder</p> <p>(2007) Cognitive behavioral therapy for men who physically abuse their female partner</p> <p>(2006) Containment strategies for people with serious mental illness</p> <p>(2006) School-based secondary prevention programmes for preventing violence</p> <p>(2005) Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17</p>
2018 Specialty Society Guidelines (via Guideline Clearinghouse including Choosing Wisely)	<p>(2016) U.S. Preventive Services Task Force Screening for depression in children and adolescents: U.S. Preventive Services Task Force recommendation statement.</p> <p>(2016) Eastern Association for the Surgery of Trauma Prevention of firearm-related injuries with restrictive licensing and concealed carry laws: an Eastern Association for the Surgery of Trauma systematic review.</p> <p>(2016) Department of Defense, Department of Veterans Affairs, Veterans Health Administration VA/DoD clinical practice guideline for the management of major depressive disorder.</p> <p>(2015 Revised) American Psychiatric Association Practice guideline for the treatment of patients with major depressive disorder, third edition.</p> <p>(2015 Revised) National Guideline Alliance, National Guideline Alliance Depression in children and young people: identification and management in primary, community and secondary care.</p> <p>(2014) U.S. Preventive Services Task Force Screening for suicide risk in adolescents, adults, and older adults in primary care: U.S. Preventive Services Task Force recommendation statement.</p> <p>(2013) Department of Defense, Department of Veterans Affairs, Veterans Health Administration VA/DoD clinical practice guideline for assessment and management of patients at risk for suicide.</p>

Health Technology Assessment Program	n/a
Centers for Disease Control and Prevention	Webpage: Assult or Homicide Webpage: Suicide Prevention (2017) Preventing Suicide: A Technical Package of Policy, Programs, and Practices
Institute for Clinical and Economic Review	n/a
Veterans Administration Evidence-based Synthesis Program	(2015) Systematic Review of Suicide Prevention in Veterans (2013) Intimate Partner Violence: Prevalence Among U.S. Military Veterans and Active Duty Servicemembers and a Review of Intervention Approaches (2013) Complications of Mild Traumatic Brain Injury in Veterans and Military Personnel: A Systematic Review (2012) Suicide Risk Factors and Risk Assessment Tools: A Systematic Review (2012) Suicide Prevention Interventions and Referral/Follow-up Services: A Systematic Review (2012) Family Involved Psychosocial Treatments for Adult Mental Health Conditions: A Review of the Evidence (2009) Strategies for Suicide Prevention in Veterans
U.S. Surgeon General	(2012) National Strategy for Suicide Prevention
National Action Alliance for Suicide Prevention	(2018) Recommended standard care for people with suicide risk: Making health care suicide safe

References

¹ Association for Community Affiliated Plans. ACAP Fact Sheet Safety Net Health Plan Efforts to Integrate Physical and Behavioral Health at Community Health Centers. September 2014. Accessed: December 2016.

[www.integration.samhsa.gov/integrated-care-models/Integrated Health Fact Sheet ACAP.pdf](http://www.integration.samhsa.gov/integrated-care-models/Integrated_Health_Fact_Sheet_ACAP.pdf)

² Centers for Medicare and Medicaid Services. Consensus Core Set: ACO and PCMH / Primary Care Measures. March 2, 2016.

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient->

³ Healthy People. Mental Health and Mental Disorders. Accessed: April 2018. Available: www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders/objectives.