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Special Considerations for Veteran Suicide Prevention: End-of-Life

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OBJECTIVES

- Discuss valuable role of Palliative and Hospice Care in suicide prevention
- Review Home-Based Primary Care (HBPC) Suicide Prevention Tool Kit Special Considerations Training Module on Suicide Prevention and EOL
- Case presentation to illustrate an acceptance-based intervention for managing chronic suicidal ideation at EOL



SULLIVAN (ATS PUBLIC RELEASE 5/21/2018)

- Suicide is a leading cause of death in the U.S. and rates are increasing among Veterans
- Increased rates of suicidal ideation among individuals with advanced/terminal illness facing end-of-life
- Increased rates of completed suicide among VA registered cancer patients, with the highest rates among those with lung cancer
- VA registered lung cancer patients who had at least one palliative care encounter after their diagnosis were 82 percent less likely to die by suicide
- Palliative care was associated with a reduced risk of death by suicide



National Veteran Suicide Data: 2015 Update

- Largest national analysis of Veteran suicide rates:
https://www.mentalhealth.va.gov/suicide_prevention/Suicide-Prevention-Data.asp; report includes:
 - Veteran suicide rates by age, gender, means, and more
 - Suicide rates in the Veteran population compared to the non-Veteran population
 - Suicide rates among Veterans who use VHA health care compared to those that do not
- Highest RATE of suicide among younger Veterans (ages 18-34) but highest BURDEN of suicide among older Veterans



Risk Factors for Suicide and HBPC

- VA Home-Based Primary Care (HBPC) cares for Veterans who often have multiple risk factors for suicide
 - Depression
 - Anxiety
 - Chronic, advanced illness/disability
 - Pain
 - Sleep problems
 - Social isolation, lack of social connectedness
 - Substance abuse
 - Cognitive deficits (e.g., executive dysfunction)



QI PROJECT: SUICIDE PREVENTION IN HBPC

- Purpose
 - To delineate current suicide prevention and crisis management practices across HBPC programs
 - To identify the most common challenges and barriers toward effective suicide prevention and risk management strategies
 - To develop interventions and resources targeting identified needs, to improve suicide prevention activities in HBPC nationally
- Work Group members
 - Michelle Mlinac, PsyD, ABPP, Co-Chair
 - Kevin Siffert, PhD, Co-Chair
 - Luis Richter, PsyD, ABPP
 - Pamela Steadman-Wood, PhD, ABPP
 - Julie Wetherell, PhD, ABPP
 - Advisory: Michele J, Karel, PhD, ABPP
- Project funded by a 2017 VA Innovation Grant

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End-of-Life

Special Considerations for Suicide Prevention in HBPC

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Note: The following slides are based on clinical pearls from the field and relevant literature, and are not official VA guidance



APPROACHING END OF LIFE

- Individuals with advanced, terminal illness experience a range of emotional reactions near the end-of-life (EOL)
- Death contemplation is common
- Goals of care near EOL (i.e., advance directives, life-sustaining treatment orders, requests for assisted suicide, etc.) change as individuals get closer to death



DEATH CONTEMPLATION: TERMINOLOGY

- Little consensus in the literature on how to define suicidal ideation
- Current nomenclature:
 - Passive suicidal ideation (thought of or wishing for death)-- Also known as death ideation
 - Active suicidal ideation (thinking or planning on taking one's own life)



- Other meanings of death contemplation are used in EOL communities of practice (i.e., *Palliative care, Hospice care*)
 - Desire for death
 - Desire for hastened death



SUICIDAL IDEATION AT THE END-OF-LIFE

- Prevalence studies suggest that older adults are more likely to endorse passive ideation than active ideation
- Passive ideation (PI) is common in individuals nearing EOL (point prevalence = 17–45%) and thus most widely studied



- PI and thoughts of death may be distinctly different categories
 - PI = thoughts of wanting life to end
 - Thoughts of death = contemplation of end- of- life and how that might be experienced



PASSIVE SUICIDAL IDEATION VS THOUGHTS OF DEATH (CONT)

- PI among those facing EOL is associated with depressive symptoms, poor social support, and pain and suffering

AND

- PI and/or death ideation may be normative at the end of life



SUICIDAL IDEATION AND PSYCHOLOGICAL DISTRESS

- Distress experienced by people with PI near EOL is not fully explained by depression or other psychiatric illness
- Distress at EOL may reflect a loss of dignity and/or meaning in life
- Assessment must clearly determine the nature of the death contemplation



VALIDATING CONCERNS ABOUT DEATH AND DYING

- Given prevalence rates of death contemplation in this population, it is important to provide a supportive environment to discuss feelings/wishes related to death and dying
- Example conversation starters:
 - “Have you thought about how you want the end of your life to look?”
 - “What is most important to you as approach the end of your life?”
 - “What concerns you the most when you think about death and dying?”
 - “Who else should we include in these conversations?”



BALANCING VALIDATION AND SUICIDE RISK ASSESSMENT

- EOL clinical discussions may differ when focused on suicide risk assessment
- EOL clinical discussions require a careful balance of validation and risk assessment
- While important, interviews that emphasize traditional approaches to suicide prevention (SP) (i.e., suicide risk assessment and safety planning) may be perceived as invalidating



END-OF-LIFE SUICIDE RISK ASSESSMENT CONSIDERATIONS

- Focus on standard suicide risk assessment may:
 - Pose a barrier to facilitating open discussions regarding death contemplation
 - Set a clinician-centered agenda for the conversation, rather than a patient-centered approach that would encourage discussion of other concerns that may not reflect active suicide risk



How best to focus discussion?

- When thoughts of death/suicide are determined to be passive, or even normative, it is important to facilitate open discussions to examine those thoughts and provide individualized intervention
- When thoughts of death/suicide are considered to be active suicidal ideation (with or without plan/intent/means), traditional suicide risk assessment and safety planning are important
- Both approaches may be important



POSSIBLE INTERVENTIONS AT END-OF-LIFE

- Treatments designed to enhance dignity and meaning and end-of-life care planning can result in decreased thoughts of death/suicide in individuals facing EOL
- Discussions about values and acceptance can help individuals connect with what is important to them and reduce suffering as they contemplate EOL



EOL suicide prevention should also include discussions related to:

- Fears related to death
- Minimizing pain and suffering (existential and physical)
- Planning for death (comfort care/hospice care, advance directives, life sustaining treatment discussions, etc.)
- Dignity preservation
- Relational work



BARRIERS TO END-OF-LIFE DISCUSSIONS

- Discomfort initiating discussions about death can be experienced by:
 - Veterans
 - HBPC staff
 - Other treatment providers
 - Informal caregivers
 - Family/friends
- Discomfort can be a barrier to engaging in EOL discussions



Important to be aware of reasons for avoiding end-of-life discussions

- Examples for patients include:
 - Inequitable access to health care and providers
 - Health beliefs about death and dying
- Examples for providers include:
 - Training background in discussing sensitive topics
 - Cultural competence with elderly
 - Personal beliefs about death and dying can bias provider



ADDRESSING BARRIERS TO END-OF-LIFE DISCUSSIONS

- Consulting with palliative care/hospice services and spiritual experts can be helpful in increasing comfort initiating EOL discussions
- Team/family meetings can be useful to ensure everyone has a mutual understanding of values, priorities, and treatment goals



END-OF-LIFE SUICIDE PREVENTION ASSESSMENT

- Motivating factors for desire for death at EOL:
 - Insomnia
 - Physical pain
 - Psychiatric conditions (e.g., depression, anxiety, hopelessness)
 - Existential suffering (e.g., loss of autonomy, loss of dignity, desire to have control over death, responsibility toward loved ones, unresolved relational issues)
- All should be evaluated



END-OF-LIFE SUICIDE PREVENTION ASSESSMENT MEASURES

Tools:

- Depression measures
- Anxiety measures
- Beck Hopelessness Scale
- Patient Dignity Inventory (PDI)
- Decision-Making Capacity Assessments



END-OF-LIFE INTERVENTION CONSIDERATIONS

- Advance directives may need updated
- Life-Sustaining Treatment Decision discussions
 - Goals of Care (GOC) conversations
 - LST orders (e.g., MOLST or POLST)
- Palliative care/Hospice referrals



END-OF-LIFE INTERVENTIONS (CONT)

- Decision-making capacity assessments, if concerns about abilities, may be indicated in context of:
 - Treatment refusal
 - Changes to advance directives
 - Completing life sustaining treatment orders
 - Requests for assisted suicide
- Be sure all parties involved are informed of Veteran's care preferences



END-OF-LIFE PSYCHOTHERAPY RESOURCES

- Dignity Therapy & Patient Dignity Inventory (PDI)

<http://www.dignityincare.ca/en/toolkit.html>

- Acceptance & Commitment Therapy (ACT)

[VA ACT MINI LECTURE SERIES: The Nature of Suffering in Advanced Disease: The Role of ACT](#)

[VA ACT MINI LECTURE SERIES: The ACT of Letting Go](#)



END-OF-LIFE RESOURCES

- APA End-of-Life Issues and Care:

<http://www.apa.org/topics/death/end-of-life.aspx>

- VA Palliative Care:

https://www.va.gov/GERIATRICS/Guide/LongTermCare/Palliative_Care.asp

- VA National Center for Ethics in Health Care Life Sustaining Treatment Decisions Initiative (LSTDI)

<https://www.ethics.va.gov/LST.asp>

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National Center for Ethics in Health Care
Life-Sustaining Treatment Decisions Initiative

Goals of Care Conversations, Depression, and
Suicidal Ideation (*TMS #36240*)



Suicide Risk Screening & Assessment

On 5/23/2018, an informational memo was released to VISN Directors, CMOs and Mental Health Leads describing plans to implement standardized methods for screening and assessing for suicide risk in VA

These are considered to be minimum requirements for the field

Department of Veterans Affairs **Memorandum**

Date: **MAY 23 2018**

From: Deputy Under Secretary for Health for Operations and Management (10N)

Re: Suicide Risk Screening and Assessment Requirements

To: Veterans Integrated Service Network (VISN) Directors (10N1-23)
VISN Chief Medical Officers (10N1-23)
VISN Mental Health Leads (10N1-23)

1. As part of its focus on suicide prevention, the Veterans Health Administration (VHA) has developed a strategy for standardized, evidence-based screening for the risk of suicide, and structured methods for the subsequent evaluation of those who screen positive for suicide risk.
2. This memorandum is informational. Its purpose is to alert and prepare the field for this enhancement to suicide risk evaluation procedures and provide general guidance, so facilities may start preparing for full implementation. It is expected that new templates will be sent to sites for installation by June 30, 2018. Sites will have 30 days to install templates and 90 days to begin full implementation of new screening and risk assessment procedures. By the end of Fiscal Year (FY) 2018, every VHA facility will be required to implement suicide risk screening and assessment procedures outlined in this memorandum. In FY 2019, performance metrics will be amended to reflect these new requirements.
3. VHA is adopting a staged process for suicide risk screening and assessment with three phases: a primary screen; a secondary screen; and a comprehensive assessment. A positive primary screen for suicide risk will lead to a secondary screen, and a positive secondary screen will lead to a comprehensive suicide risk assessment. All stages of the screening and assessment procedure should be conducted during the same day.
 - a. The primary screen is highly sensitive, and consists of a single question, item 9 from the Patient Health Questionnaire-9 (PHQ-9). See Attachment A.
 - b. Secondary screening, aimed at improving specificity, consists of the Columbia-Suicide Severity Rating Scale (C-SSRS) Screener. See Attachment A.
 - c. The Department of Veterans Affairs Comprehensive Suicide Risk Assessment is in the final stages of field testing. This is a standardized template designed to assist providers in conducting a comprehensive evaluation of a patient's level of suicide risk in order to inform risk management.
4. The initial phase of screening is focused on identifying suicide risk among patients whose risk may not already be identified (e.g., those without a diagnosis of serious mental illness, depression, bi-polar or posttraumatic stress disorder).



Rationale

- Historically, VA has not had a national standard for screening, assessment, or documentation of suicide risk
- The Veterans Health Administration (VHA) Office of Mental Health and Suicide Prevention (OMHSP) has launched an effort to develop and implement a national, standardized process for suicide risk screening and assessment, using high-quality, evidence-based tools and practices in all services medical-center wide
- Three stage process currently being rolled out
 - Webinars, CPRS Templates, Clinical Reminders, Staff Trainings

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Case Example



- 78 year old, widowed, Caucasian, male 100% SC (bronchitis) Korean War veteran referred to HBPC for advanced cardiopulmonary disease, O2 dependent and largely homebound
- Admitted for *routine care*
- Referred to me by his psychiatrist for psychotherapy for “refractory depression” (i.e., severe MDD w/chronic suicidal ideation) in the context of prolonged grief



RELEVANT MEDICAL & PSYCHIATRIC HISTORY

Medical Diagnoses:

- Atrial Fibrillation
- Coronary Artery Disease
- Congestive Heart Failure
- COPD (O2 dependent)
- Hypertension
- Hyperlipidemia
- DM Type II, w/o comp
- Cataract, Nuclear Sclerosis
- Age Macular Degeneration, Dry
- Bronchiectasis
- Iron deficiency anemia
- Raynaud's Syndrome
- Osteoarthritis
- Idiopathic Periph Neuropathy

Psychiatric Diagnoses:

- Major Depressive Disorder, Recurrent, Severe
- Prolonged Grief Disorder
- Mild Neurocognitive Disorder



Relevant Psychosocial Hx

- ❖ Unremarkable childhood— youngest of 12, urban upbringing, impoverished, but “good”
- ❖ Army 1954-1956 (non-combat)
- ❖ Worked for a cable company— retired in 1970’s due to back injury
- ❖ Married for 47 years-- two children--2 grandchildren
- ❖ Resides in two-family home; dtr and her family live downstairs
- ❖ Good support system
- ❖ Wife committed suicide 2003 while Vet was hospitalized in ICU for a cardiac event w/ poor prognosis
- ❖ Difficulty ambulating due to poor endurance r/t advanced COPD, CHF
- ❖ Requires assistance with ADLs
- ❖ Limited social interactions—due to poor endurance
- ❖ + Trauma history (wife’s suicide; several life threatening medical crises & surgeries w/complicated recovery)



Treatment History

- Onset of severe depression in 2003 after his wife committed suicide—No prior psychiatric hx.
- Tx for Depression 2003-2011—combined psychopharm & individual and group therapy focused on grief work and stress management w/benefit—though continued to have intrusive memories of wife, particularly at night affecting sleep. Progressing illness prevented him from coming into outpatient appointments.
- 2003-2011-several medical admissions for various medical crises with progressive functional decline.



Treatment History

- 2006 hospitalization—started experiencing extreme guilt for feeling like being in the hospital drove his wife to suicide. Began having suicidal ideation—very severe at night—pacing all night long.
- 2006-2011 Several psychiatric admissions for depression w/suicidality w/plan to jump off bridge, hang himself—anniversary reactions (50th anniversary, birthdays, anniversary of wife's death)



Our work—Part I

- 1) Suicide Prevention and Safety Planning
- 2) Increase pleasurable activities
- 3) Improve sleep
- 4) Grief work
 - learn to have a different relationship with painful thoughts/emotions (vs. trying to get rid of them) which we believed was his driving suicidal ideation

Not making much progress-- ongoing si, low mood, isolation, anxiety, poor sleep



Our Work Part II: *The ACT of Letting Go*





Our work-Part II

- Values: What is important in the time left
- Acceptance vs. Suffering (physical and emotional)
- Self-as-Context: leaving a legacy, life review
- Willingness to be present with uncomfortable experiences *and...*
- Take Committed Actions: preparing self and others for death



Our work-Part II

- Completed 8/10 weekly sessions-- then hospitalized for complications r/t defibrillator replacement and suicidal ideation-- discharged to a SNF for rehab
- Readmitted to HBPC for Palliative Care
- Severe symptoms of anxiety and panic
- Resumed psychotherapy and re-reviewed treatment plan/goals = Values Clarification



Case Conceptualization

1. What valued directions does the vet want to move in (what is important to him)?
 - Prepare for a dignified and peaceful death
2. What stands in the vet's way?
 - Family and medical team's unwillingness to let him go— focused on treatment and suicide prevention
3. What thoughts/rules is the vet fused with?
 - My family isn't ready for me to die so I have to keep fighting for them
4. What private experiences (feelings) is the vet avoiding?
 - Guilt for wanting to die; fear of hurting his family
5. What unworkable action is the vet taking?
 - Unwilling to share his wishes with his family, agreeing to be hospitalized and undergo treatments against his wishes



Treatment Plan

- Mindfulness and Experiential exercises helped manage overwhelming symptoms of anxiety and panic, guilt
- Identified that continuing to focus on Suicide Prevention was contributing to his anxiety –feeling unheard
- Explored his value of wanting to plan for a dignified and peaceful death while respecting his love and devotion to his family
- Agreed to a team/family meeting to discuss his care plan to make it more consistent with his values and wishes:
 - Acceptance of readiness to die



Integrated Care Approach

- Treatment plan transitioned from Suicide Prevention to planning for end-of-life
- Goals of care based on Vet's values and wishes
 - Comfort care only (i.e., no life sustaining treatments)
 - No hospitalization
- Referred to Hospice
- Integrated team approach HBPC team members (i.e., psychologist, social worker, RN, PCP), VA outpatient psychiatrist, family and Hospice



The ACT of Letting Go

- Veteran received Hospice care for 3 weeks with resolution of suicidal ideation, and passed away peacefully, in the supportive presence of his family
- Family was able to have a corrective death and dying experience



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Thank you

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