

# VA/DoD Clinical Practice Guideline

## Assessment and Management of Patients at Risk for Suicide

GUIDELINE SUMMARY

2013



VA/DoD Evidence Based Practice





**DEPARTMENT OF VETERANS AFFAIRS**  
**DEPARTMENT OF DEFENSE**



**VA/DoD CLINICAL PRACTICE GUIDELINE**  
**FOR**  
**ASSESSMENT AND MANAGEMENT OF**  
**PATIENTS AT RISK FOR SUICIDE**  
**GUIDELINE SUMMARY**

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*and*

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*Full guideline available at:*

*<http://www.healthquality.va.gov> or <https://www.qmo.amedd.army.mil>*

**QUALIFYING STATEMENTS**

The Department of Veterans Affairs (VA) and The Department of Defense (DoD) guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision-making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

Variations in practice will inevitably and appropriately occur when providers take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every health care professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

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# INTRODUCTION

## BACKGROUND

### US Population

Suicide remains a serious public health problem and reducing suicide is a national imperative (IOM 2002). More than 36,000 people (age-adjusted rate is 11 per 100,000 persons) take their lives every year (CDC – WISQARS 2010). Suicide was the tenth leading cause of death for all ages in 2010 and the third leading cause of death for persons aged 24 and younger. There were 38,364 suicides in 2010 in the United States—an average of 105 each day. Based on data about suicides from National Violent Death Reporting System in 16 states in 2009, 33.3% of suicide decedents tested positive for alcohol, 23% for antidepressants, and 20.8% for opiates, including heroin and prescription pain killers (MMWR Summary 2012).

### Veterans

Suicide and other forms of suicidal self-directed violence are a persistent and growing public health problem for America and for its Veterans. According to estimates from the Centers for Disease Control and Prevention (CDC), Veterans account for approximately 20% of the deaths from suicide in the United States. More recent estimates from VA increase the estimate to 22%. Applying these proportions to the 36,900 suicides that occurred in the United States in 2009 and the 38,600 that occurred in 2010, leads to estimates that 18-22 Veterans die from suicide each day.

It is not clear whether suicide rates in the entire population of Veterans are higher than the overall US population after controlling for relevant variables. Whether or not all Veterans are at increased risk, suicide rates are substantially increased among those who use VHA health care services. Information from the Office of Mental Health Operations on causes of death for all Veterans who use VHA health care services since 2000 demonstrates that rates among users are higher than those of the general population. Users of VHA services account for 1600-1900 suicides per year or about 5 per day with rates of approximately 36 per 100,000 patient years, 38 per 100,000 among men, and 15 per 100,000 among women. Among the deaths from suicide, approximately half had a diagnosis of a mental health condition recorded in their medical records in the year prior to their deaths, and approximately three fourths, within the past five years. For those with a mental health diagnosis within the past year, the rate of suicide is 70 per 100,000.

Since 2008, the Office of Suicide Prevention has maintained a registry of VHA suicide attempts and deaths reported by the Suicide Prevention Coordinators (SPCs) in each Medical Center. This active surveillance registry, VA-Suicide Prevention and Application Network (SPAN), was established to coordinate the identification and reporting of suicide-related events within and across facilities, to facilitate the identification of individuals at high risk to allow the targeting of interventions, and to support both program planning and evaluation. Between April 1, 2010 and March 30, 2012, SPCs reported non-fatal suicide attempts in almost 30,000 Veterans utilizing VA services. Of these, approximately half were to individuals who attempted suicide for the first time. Among those who survived, 15% had a fatal or non-fatal reattempt within a year indicating that a history of suicide attempt identifies the individuals with the highest risk of suicide attempt and completion.

### DOD

Historically, the suicide rate has been lower in the military than among civilians. This protective effect has been thought to be related to many factors to include a selection bias for healthy recruits, employment, purposefulness, access to healthcare and a strong sense of belonging. A population-based study examined potential risk factors for DoD suicides in 2005 and 2007 across the entire DoD population (2,064,183 in 2005 and 1,981,810 in 2007) by service. In 2007, suicide rates were significantly elevated across all services. History of deployment to combat was associated with increased suicides in the Army in 2005 and in all services in 2007.

In 2008 the suicide rate in the Army exceeded the age-adjusted rate in the civilian population (20.2 out of 100,000 vs. 19.2). While the stresses of the two wars, including long and repeated deployments, and post-traumatic stress and combat-related illnesses are important, a wide range of factors related to, and independent of, military service may have contributed to the rise of suicidal behavior and suicide death among service members of the military.

In 2008, the DoD Suicide Event Report (DoDSER) was established to track 250-300 data points per suicide in a standardized fashion across each military Department, including Active, Reserve and National Guard Component. The annual report is published mid-year for the previous year and is widely available on the Internet (<http://t2health.org/programs/dodser>).

While many risk factors for suicide in the general population also apply to military populations, military-specific suicide data assists clinicians assessing Service members at potential risk for suicide. Military suicide data is helpful both when it is similar to civilian data and especially when it is considerably different from the civilian population. If unknown, such variance may adversely affect a clinician's judgment of risk for suicide, as underestimating risk in younger male Service members based upon civilian suicide statistics.

While even the most accurate suicide data does not predict suicide in a given individual, thorough clinical assessment informed by demographic and other suicide-related associations may improve risk-appropriate management.

## OVERVIEW OF THE GUIDELINE

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This guideline recommends a framework for a structured assessment of person suspected to be at risk of suicide, and the immediate and long-term management and treatment that should follow once risk has been determined.

- Topics addressed by the CPG include:
- Definitions, classification of etiology, risk factors, and severity
- Assessment and determination of risk
- Management of urgent/emergent risk – indications for referral to specialty care
- Treatment interventions (modalities) based on risk level
- Safety planning for patient at risk
- Monitoring and re-assessment of patients at risk

The guideline does not address risk in children, universal screening for suicide ideation, population health interventions to reduce the risk of suicide.

### Target Population

This guideline applies to adult patients (18 years or older) with Suicidal Self-Directed Violent (SDV) behavior or related suicidal ideation (identified as being at risk for suicide) who are managed in the VA and DoD healthcare clinical settings. The population at risk includes patients who have suicidal ideation with or without an established diagnosis of a Mental or Substance Use Disorder; and patients with any level of risk for suicide ranging from thoughts of about death or suicide to SDV behavior or suicide attempt.

### Audience

The guideline is relevant to all health care professionals providing or directing treatment services to patients at risk for suicide in any VA/DoD health care setting, including both primary and specialty care, and both general and mental health care settings. This guideline may also be relevant to any provider or health care system providing care and services to military members or Veterans. Many of the recommendations are also relevant to all clinicians caring for patients at risk for suicide.

### Goals of the Guideline

- To promote evidence-based management of patients presenting with Suicidal Self-Directed Violent behavior
- To promote efficient and effective assessment of patients' risks
- To identify efficacious intervention to prevent death in individuals presenting with Suicidal Self-Directed Violent behavior
- To identify the critical decision points in management of patients at risk for Suicidal Self-Directed Violence
- To promote evidence-based management of individuals with (post-deployment) health concerns and behaviors related to Suicidal Self-Directed Violence

- To inform local policies or procedures, such as those regarding referrals to or consultation with specialists
- To motivate administrators at each of the Federal agencies and patient care access sites to develop innovative plans to break down barriers that may prevent patients from having prompt access to appropriate assessment and care.

### Rating Available Evidence

In order for the clinician to appreciate the evidence base behind the recommendations and the weight that should be given to each recommendation, the recommendations are keyed according to the level of confidence with which each recommendation is made. Each rating of strength of recommendation [SR] considers the quality of the available evidence and net benefit (benefit and harm) estimated by the available data. When evidence is limited, the level of confidence also incorporates clinical consensus with regard to a particular clinical decision.

If evidence exists, the recommendation is followed by a letter code in brackets that indicates the strength of the supporting evidence (i.e. [SR]). The Strength of Recommendation is based on the level of the evidence and graded using the USPSTF rating system (see Table: Strength of Recommendation Rating). The discussion following the recommendations for each annotation includes an evidence table identifying the studies that have been considered, the quality of the evidence, and the rating of the strength of the recommendation [SR].

### Strength of Recommendation Rating [SR]

Strength of Recommendation (SR)	
<b>A</b>	A strong recommendation that the clinicians provide the intervention to eligible patients. <i>Good evidence was found that the intervention improves important health outcomes and concludes that benefits substantially outweigh harm.</i>
<b>B</b>	A recommendation that clinicians provide (the service) to eligible patients. <i>At least fair evidence was found that the intervention improves health outcomes and concludes that benefits outweigh harm.</i>
<b>C</b>	No recommendation for or against the routine provision of the intervention is made. <i>At least fair evidence was found that the intervention can improve health outcomes, but concludes that the balance of benefits and harms is too close to justify a general recommendation.</i>
<b>D</b>	Recommendation is made against routinely providing the intervention to asymptomatic patients. <i>At least fair evidence was found that the intervention is ineffective or that harms outweigh benefits.</i>
<b>I</b>	The conclusion is that the evidence is insufficient to recommend for or against routinely providing the intervention. <i>Evidence that the intervention is effective is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.</i>

Where existing literature was ambiguous or conflicting, or where scientific data was lacking, recommendations are based on the clinical experience and expert consensus of the Working Group. Although several of the recommendations in this guideline are based on weak evidence, some of these recommendations are strongly recommended based on the experience and consensus of the clinical experts and researchers of the Working Group. Recommendations that are based on consensus of the Working Group include a discussion of the expert opinion on the given topic. No [SR] is presented for these recommendations.

The final guideline document represents a synthesis of current scientific knowledge and rational clinical practice on the assessment and treatment of adult patients with risk for suicide. It attempts to be as free as possible of bias toward any theoretical or empirical approach to treatment.

This Guideline is the product of many months of diligent effort and consensus building among knowledgeable individuals from the VA and the DoD. An experienced moderator facilitated the multidisciplinary Working Group. The draft document was discussed in a face-to-face group meeting. The content and validity of each section was thoroughly reviewed in a series of conference calls. The final document is the product of those discussions and has been approved by all members of the Working Group.

## ORGANIZATION OF THE GUIDELINE

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### Algorithm:

The clinical algorithm incorporates the information presented in the guideline in a format that maximally facilitates clinical decision-making. The algorithmic format allows the provider to follow a linear approach to critical information needed at the major decision points in the clinical process and includes decisions to be considered and actions to be taken. Standardized symbols are used to display each step in the algorithm and arrows connect the numbered boxes indicating the order in which the steps should be followed.

The guideline is organized around three clinical Algorithms:

**Algorithm A:** Assessment and Management of Risk for Suicide in Primary Care.

**Algorithm B:** Evaluation and Management of Risk for Suicide by Behavioral Health Providers.

**Algorithm C:** Management of Patient at High Acute Risk for Suicide.

### Annotations

The Annotations are presented in four modules addressing the following components of care:

**Module A: Assessment and Determination of the Risk for Suicide** – Any person who is identified as being at possible suicide risk should be formally assessed for suicidal ideation, plans, intent and behavior, the availability of lethal means, and the presence of risk factors and warning signs. A clinical judgment that is based on all the information should formulate the level of risk for suicide and the setting of care.

**Module B: Initial Management of Patient at Risk for Suicide** – All persons identified as being at risk of suicide should have a collaboratively designed safety plan prior to discharge from acute care. This should include inquiring about access to lethal means and planning, if possible, to restrict access to these means. The person at risk should be placed in the appropriate setting of care that provides the necessary supervision to ensure safety.

**Module C: Treatment of the Patient at Risk for Suicide** – Care of persons with suicide risk should be provided in the least restrictive setting using evidence based treatment. Treatment should include interventions that specifically address the suicidality and management of the underlying condition. Evidence-based management of the underlying and co-occurring mental disorder (e.g., MDD, BD, PTSD, BPD, SUD) for a patient that is at higher risk for suicide should be optimized to address (reduce) the risk of suicide.

**Module D: Follow-up and Monitoring of Patient at Risk for Suicide** – Persons with suicidal risk leaving the acute care settings should be closely followed and frequently monitored in the immediate period after discharge.

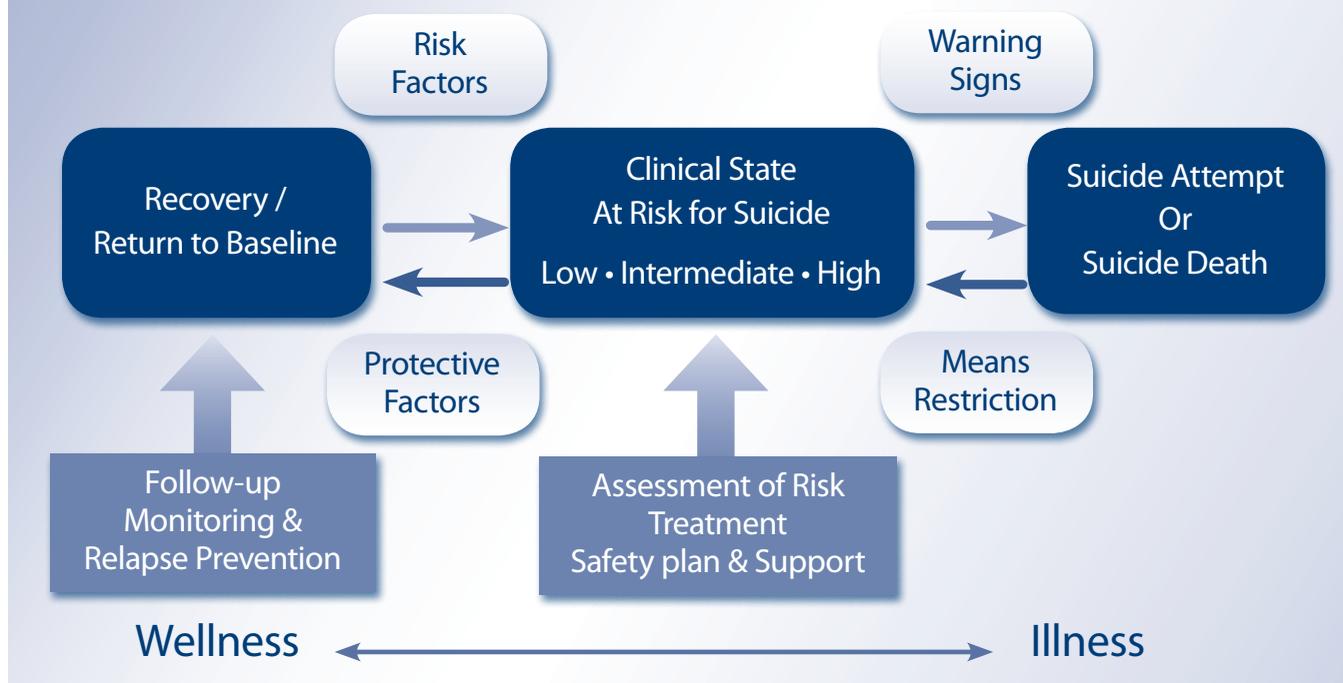
Annotations to the algorithm include background, recommendations, and discussion of the rationale and the evidence that support the recommendations. The annotations match the box numbers and letters (e.g., [A]) in the respective algorithms.

There are a limited number of recommendations that are based on published evidence. Therefore, in annotations for which there is evidence-based research that supports the recommendations, the Strength of Recommendation [SR] based on the level of evidence is presented in brackets for these recommendations. Recommendations that are not based on evidence were derived by consensus of experts. No SR is presented for these recommendations.

## RECOVERY-ORIENTED PRACTICE

Recovery-orientated practice is essential. Patients may report not being aware that recovery is even an option. Distress is increased and effectiveness of treatment reduced when patient preference is not taken into account. For example, patients may feel disenfranchised when they are not invited to attend their care meetings or do not feel that their needs are being heard.

### The Recovery Model for Assessment and Management of Suicidal Behavior



Suicide risk is not static. Many factors influence an individual's risk of suicide at any given point in time. This section offers a paradigm for understanding the continuum of risk in the assessment and management of patients. From a broad bio-psycho-social perspective, suicide risk is influenced by a number of factors. An individual is born with a genetic inheritance that interacts with experience to determine brain structure and predisposes to certain illnesses or health. Onto this substrate, life experience and learning informs adaptiveness to stress and affective regulation. Socio-cultural factors can strongly influence risk. Social support systems and interactions with others in society influence actions and reinforce beliefs. The bio-psycho-social context determines where an individual may fall on the wellness-illness continuum and their vulnerability to suicide. Certain genetic, psychological, or sociocultural protective factors, such as having robust social supports or having strong problem solving skills, diminish the risk of suicide. Illnesses or stressful life events increase vulnerability to suicidal thoughts. A person may cross a threshold and act on suicidal impulses when they experience some "last straw", some unbearable insult or burden that seems to make life unlivable. This may include the loss of sense of belongingness or feeling of being too burdensome to family members or peers. When in this state of thinking, external controls may be needed to prevent a suicidal act. Some intervention may become necessary to interfere with the trajectory toward death, such as restriction of access to the means of completing a suicidal act. This may prevent a fatal act, but does not necessarily resolve the suicidal impulse or crisis.

This model provides opportunities for clinical intervention. The clinical assessment determines the presence of treatable illnesses, coping strengths and vulnerabilities that may be a focus of intervention. The treatment plan can provide education about managing the perpetuating and protective factors to foster wellness, strategies to foster development of skills to manage the stressors and cognitive distortions, or make changes to the physical or interpersonal environment to enhance safety. With effective treatment, illnesses and perpetuating factors can be alleviated, protective factors and coping strategies can be fortified, and the patient's suicidality can resolve to a state of clinical recovery, where the acute risk has resolved and the risk of relapse has been minimized. Ongoing care may be warranted to provide early detection of recurrence.

## DEFINITIONS

<b>Suicidal Self-Directed Violence</b>	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself with evidence, whether implicit or explicit, of suicidal intent.
<b>Suicide</b>	Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.
<b>Suicide Attempt</b>	A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior.
<b>Preparatory Behavior</b>	Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away).
<b>Suicidal Intent</b>	There is past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and inferred in the absence of suicidal behavior.
<b>Suicidal Ideation</b>	Thoughts of engaging in suicide-related behavior. (Various degrees of frequency, intensity, and duration.)
<b>Interrupted By Self or Other</b>	A person takes steps to injure self but is stopped by self or another person prior to fatal injury. The interruption may occur at any point.
<b>Physical Injury</b>	A bodily injury resulting from the physical or toxic effects of a self-directed violent act interacting with the body.

*Developed in collaboration with the Centers for Disease Control and Prevention*

## Factors Contributing to Risk for Suicide

<b>Warning Signs for Suicide</b>	Warning signs are those observations that signal an increase in the probability that person intends to engage in suicidal behavior in the immediate future (i.e., minutes and days). Warning signs present tangible evidence to the clinician that a person is at heightened risk for suicide in the short term; and may be experienced in the absence of risk factors.
<b>Acute Risk Factors</b>	Acute (of brief duration) and stressful episodes, illnesses, or life events. While not usually internally derived, these events can build upon and challenge a person's coping skills.
<b>Chronic Risk Factors</b>	Relatively enduring or stable factors that may increase a person's susceptibility to suicidal behaviors, such as genetic and neurobiological factors, gender, personality, culture, socio-economic background and level of isolation
<b>(Pre-Existing)</b>	Capacities, qualities, environmental and personal resources that increase resilience; drive an individual toward growth, stability, and/or health and/or to increase coping with different life events.
<b>Protective Factors</b>	A person takes steps to injure self but is stopped by self or another person prior to fatal injury. The interruption may occur at any point.

The terms *suicidality* and *Risk for Suicide* are sometimes used interchangeably. The use of the term *Risk for Suicide* is preferred when communicating with the patient and documenting clinical care. The terms self-directed violence, risk for suicide, suicide ideation, intent, and behavior will be used throughout this document as a convention.

## DISCUSSION

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The distinction between non-suicidal self-directed violence and suicidal self-directed violence is important, as there are appropriate and different treatment options for both. Although the distinction between non-suicidal SDV behavior and suicidal SDV behavior is important and relevant to treatment planning, in some cases the distinction may be unclear.

### **Suicidal Self-Directed Violence:**

*Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. **There is evidence, whether implicit or explicit, of suicidal intent.***

### **Non-Suicidal Self-Directed Violence behavior:**

*Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. **There is no evidence, whether implicit or explicit, of intent to die.***

### **Non-Suicidal Self-Directed Violence Ideation:**

*Self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. **There is no evidence of suicidal intent.***

### **Undetermined Self-Directed Violence:**

*Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. **Suicidal intent is unclear based upon the available evidence.***

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It may be difficult to distinguish between *suicidal* self-directed violent behavior and *non-suicidal* self-directed violent behavior, as both are self-directed and dangerous. The term **Deliberate Self-harm (DSH)** has been used by some research and other guidelines (e.g., NICE 2011) to refer to both, suicidal SDV and non-suicidal SDV. The difficulty in distinguishing suicidal behaviors (i.e., suicide and suicide attempts) from non-suicidal self-directed violent behaviors is determining the person's intent for the behavior to result in death. For example, was the intention of the behavior to end the person's life, a call for help, or a means of temporary escape? Suicidal behaviors that do not result in death are considered "non-fatal," or more commonly, "suicide attempts".

Non-Suicidal SDV is often repetitive, and involves the infliction of harm to one's body for purposes other than ending one's life. These behaviors are not socially condoned (i.e. they exclude culturally accepted aesthetic modifications such as piercing) and are therefore reluctantly revealed and poorly understood.

However, many individuals who engage in self-directed violent behavior do not wish to die. Rather, they use SDV behavior as a coping mechanism that provides temporary relief from psychological distress. Though most people will know when to cease an episode of SDV behavior (i.e., when their need is satisfied), accidental death may also result. For example, a person may cut into a blood vessel without the intention or expectation of death but cannot stop the bleeding.

Health care professionals may mistakenly label cases of non-suicidal SDV behavior (as in inadvertent death by cutting without intent to die) as a suicide or suicide attempt. Likewise, professionals may mistakenly label a deliberate, self-inflicted act with the intent to die, as non-suicidal SDV behavior. The risk of error in mistaking suicidal intent for non-suicidal SDV behavior arguably carries greater risk of serious consequences in terms of serious medical injury or lethality. Thus, a conservative assessment of an act of ambiguous intent, or an act that is yet the focus of an early stage of fact-finding should have a low threshold for determination of suicidal intent (i.e. would err in the direction of presuming suicidal intent until determined to be non-lethal SDV behavior).

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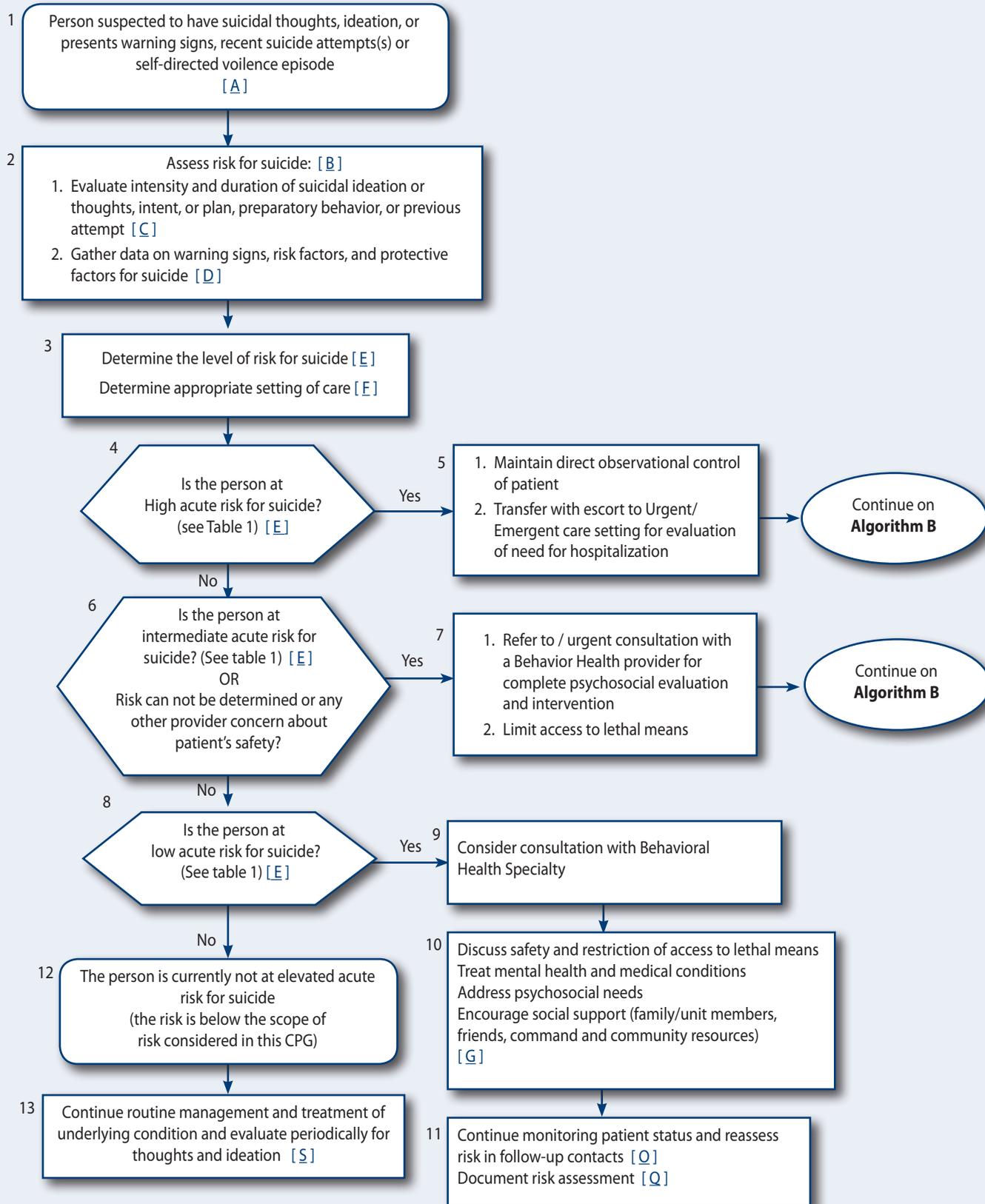
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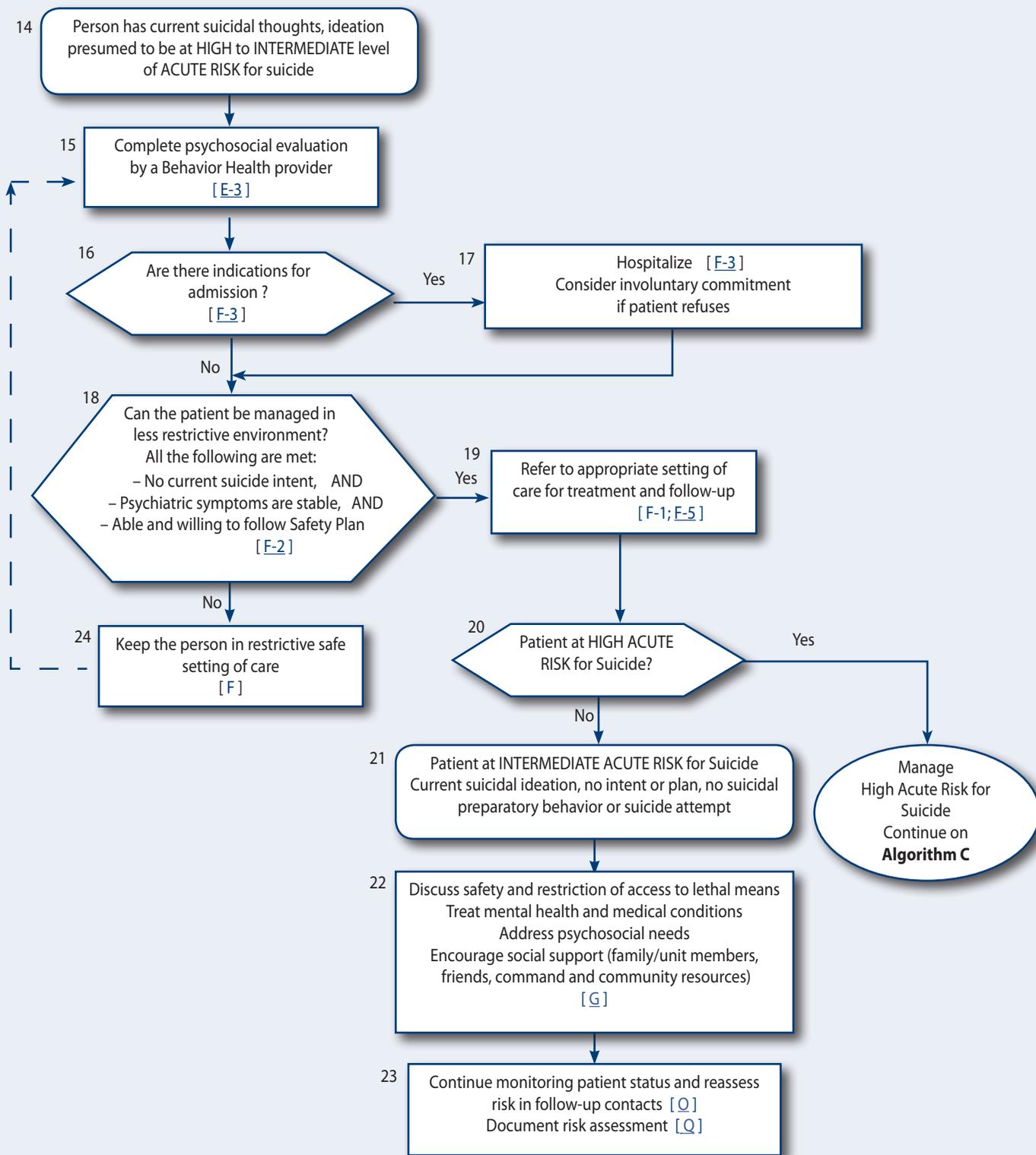
# ALGORITHM A:

# ASSESSMENT AND MANAGEMENT OF RISK FOR SUICIDE IN PRIMARY CARE



# ALGORITHM B:

# ASSESSMENT AND MANAGEMENT BY BEHAVIORAL HEALTH CARE PROVIDER



**Table 1. Determine Level of Risk for Suicide and Appropriate Action in Primary Care**

Risk of Suicide	Indicators of Suicide Risk	Contributing Factors †	Initial Action Based on Level of Risk
<b>High Acute Risk</b>	<ul style="list-style-type: none"> <li>☑ Persistent suicidal <b>ideation</b> or thoughts</li> <li>☑ Strong <b>intention</b> to act or plan</li> <li>☑ <b>Not</b> able to control <b>impulse</b> OR</li> <li>☑ Recent <b>suicide attempt</b> or preparatory behavior ††</li> </ul>	<ul style="list-style-type: none"> <li>☑ Acute state of mental disorder or acute psychiatric symptoms</li> <li>☑ Acute <b>precipitating</b> event(s)</li> <li>☑ Inadequate <b>protective</b> factors</li> </ul>	Maintain direct observational control of the patient. Limit access to lethal means Immediate transfer with escort to Urgent/ Emergency Care setting for Hospitalization
<b>Intermediate Acute Risk</b>	<ul style="list-style-type: none"> <li>☑ Current suicidal <b>ideation</b> or thoughts</li> <li>☑ <b>No</b> intention to act</li> <li>☑ Able to control the <b>impulse</b></li> <li>☑ <b>No recent suicide attempt</b> or <b>preparatory behavior</b> or rehearsal of act</li> </ul>	<ul style="list-style-type: none"> <li>☑ Existence of <b>warning signs</b> or <b>risk factors</b> †† AND</li> <li>☑ Limited <b>protective</b> factor</li> </ul>	Refer to Behavioral Health provider for complete evaluation and interventions Contact Behavioral Health provider to determine acuity of the referral Limit access to lethal means
<b>Low Acute Risk</b>	<ul style="list-style-type: none"> <li>☑ Recent suicidal <b>ideation</b> or thoughts</li> <li>☑ <b>No intention</b> to act or plan</li> <li>☑ Able to control the <b>impulse</b></li> <li>☑ <b>No</b> planning or rehearsing a suicide act</li> <li>☑ <b>No</b> previous attempt</li> </ul>	<ul style="list-style-type: none"> <li>☑ Existence of <b>protective factors</b> AND</li> <li>☑ Limited <b>risk factors</b></li> </ul>	Consider consultation with Behavioral Health to determine: <ul style="list-style-type: none"> <li>– Need for referral</li> <li>– Treatment</li> </ul> Treat presenting problems Address safety issues Document care and rationale for action

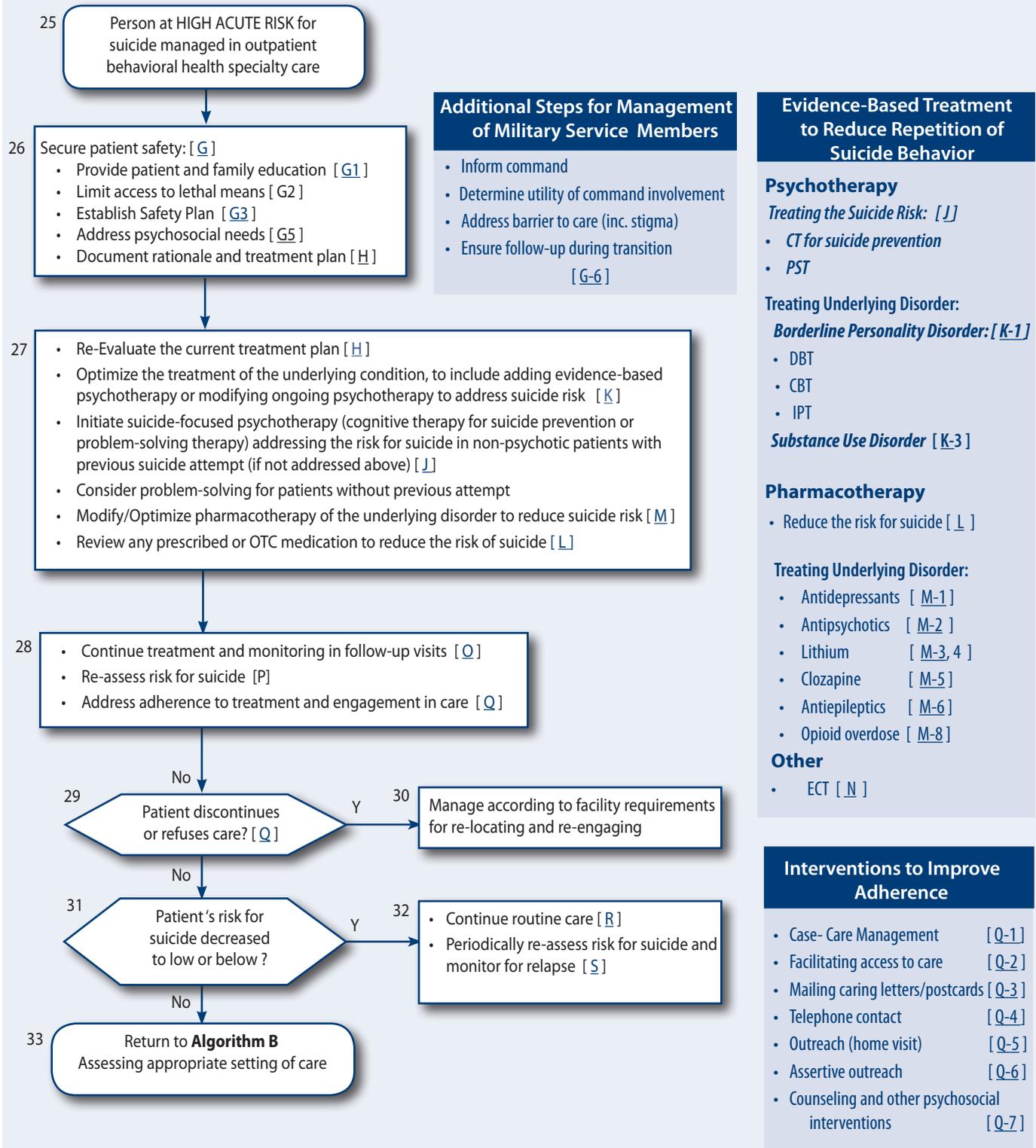
† Modifiers that increase the level of risk for suicide of any defined level:

- **Acute state of Substance Use:** Alcohol or substance abuse history is associated with impaired judgment and may increase the severity of the suicidality and risk for suicide act
- **Access to means:** (firearms, medications) may increase the risk for suicide act
- **Existence of multiple risk factors or warning signs** or lack of protective factors

†† Evidence of suicidal behavior warning signs in the context of denial of ideation should call for concern (e.g., contemplation of plan with denial of thoughts or ideation)

# ALGORITHM C:

# MANAGEMENT OF PATIENT AT HIGH ACUTE RISK FOR SUICIDE



BD – Bipolar Disorder; BPD – Borderline Personality Disorder; CT-Cognitive Therapy; CBT – Cognitive Behavior Therapy; DBT – Dialectical Behavior Therapy; IPT – Brief psychodynamic Interpersonal Therapy; MDD – Major Depressive Disorder; OTC-Over the Counter; PST – Problem Solving Therapy; SUD – Substance Use Disorder

## MODULE A:

# ASSESSMENT AND DETERMINATION OF RISK FOR SUICIDE

Ideally, an individual at risk for suicide is identified before any suicidal behavior occurs. Early identification of suicidal ideation presents the greatest opportunity to reduce the risk of suicidal behavior including death. Suicidal events begin with suicidal thoughts and progress towards behaviors that can be potentially injurious behavior with intent to die as a result of the behavior. The progression from thoughts to behaviors can occur over minutes or years. Each step along the continuum presents an opportunity to intervene to prevent an act of self-directed violence (SDV). In some cases, a person at risk for death by suicide is identified only after a suicide attempt is made.

This Module describes a recommended framework for a structured assessment of a person suspected to be at some degree of risk for suicide. Suicide risk assessment remains an imperfect science, and much of what constitutes best practice is a product of expert opinion, with a limited evidence base. That said, the objective of risk assessment is to stratify individuals into levels of risk, denoted in this guideline as low, intermediate, and high acute risk. The identified level of risk dictates, to a large extent, the appropriate precautions for maintaining safety (preventing SDV behavior) and informs decisions regarding choice of care setting, management, and treatment plans to follow.

The term “risk” is used in this guideline both to convey information regarding known long-term risk factors for suicide and in developing a conceptual framework for the assessment of acute risk to help with identifying appropriate interventions or levels of care for individuals who have been identified as potentially experiencing suicidal ideation or intent. For example, it is well known that underlying mental disorders significantly increase the lifetime risk of suicide. However, in the initial evaluation of a potentially suicidal individual, the level of ideation, intent, or preparatory behavior will largely guide the initial risk stratification in terms of determining what level of care will be immediately required. The risk assessment framework used to guide clinical recommendations in this guideline applies largely to the level of intervention required over the short-term rather than the relative strength of known risk or protective factors in predicting suicide long-term.

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**Annotation A.** *Person Suspected to Have Suicidal Thoughts (Ideation), a Recent Previous Suicide Attempt, or Self-directed Violence*

**RECOMMENDATIONS**

1. Any patient with the following conditions should be assessed and managed using this guideline:
  - a. Person is identified as possibly having risk for suicide during evaluation and management of mental disorders (Depression, bipolar, schizophrenia, PTSD), or medical condition (TBI, pain, sleep disturbance) known to be associated with increased risk for suicide
  - b. Person reports suicidal thoughts on deployment-related assessments (e.g., PDHA/PDHRA), or on annual screening tools, or other evaluation such as mental health intake
  - c. Person scores very high on depression screening tool and is identified as having concerns of suicide
  - d. Person reports suicidal thoughts on depression screening tool
  - e. Woman reports suicidal thoughts on depression screening tool during pregnancy or postpartum visits
  - f. Person is seeking help (self-referral) and reporting suicidal thoughts
  - g. Service member referred to health care provider by command, clergy, or family/unit members who have expressed concerns about the person's behavior
  - h. Person for whom the provider has concerns about suicide-based on the provider's clinical judgment
  - i. Person with history of suicide attempt or recent history of Self-Directed Violence.

**DISCUSSION**

**Indication for Assessment of Risk for Suicide:**

**Population-Based Screening:** Because of the inherent health risks of military service, the Department of Defense has developed population-based screening to facilitate early detection of health concerns that may impact military operational readiness. This routine screening occurs on a regular basis in the Periodic Health Assessment, in Pre-Deployment Health Assessments, in Post-Deployment Health Assessment immediately upon return from deployment, and again three months later during the Post-Deployment Health Re-Assessment. These screening instruments incorporate assessment tools for depression (PHQ-2), post-traumatic stress disorder (PHQ-4), and alcohol abuse (AUDIT-C).

**Universal Screening:** Recognizing the risk of depression in the general population, many healthcare systems have begun routine screening as part of regular health maintenance. Instruments like the PHQ-9 (which includes a question regarding presence of suicidal ideation) are widely accepted and administered to patients in primary care settings.

**Mental Disorders (Psychiatric Disorders):** Certain mental illnesses are considered to be risk factors for suicide and are characterized by a high rate of suicidal ideation (e.g., depression). Identification of suicidal ideation in the management of these illnesses should prompt formal comprehensive assessment and management of the risk for suicide.

**Medical Conditions (Chronic pain):** In many cases chronic pain and physical discomfort is associated with functional difficulties and disabilities that may increase of suicidal thoughts and ideation. Psychiatric comorbidity is common among individuals with a pain condition. Pain, depression, and disability are known to be mutually reinforcing. Back, neck and joint pain can be accounted for by co-morbid mental health disorders. There may be additional risk accompanying frequent headaches and 'other' chronic pain that is secondary to psychosocial processes not captured by mental disorders.

**Medical Conditions (Sleep disorder):** Sleep disturbance is prevalent in and strongly associated with a variety of psychiatric and medical conditions. Both subjective and objective sleep disturbances appear to predict elevated risk for suicide. Multiple investigations, diverse in design, methodology, and the assessment of suicidal behaviors identify insomnia and poor sleep quality symptoms as significant suicide risk factors. Nightmares also appear more common among suicidal versus nonsuicidal individuals with major depression.

**Indicated Screening:** Certain groups of patients are considered to be at elevated risk for specific health conditions by the nature of a demographic characteristic, exposure to a threat, biological, physical characteristic, or occurrence of a related illness or symptom. For example, myocardial infarction patients are at risk for depression, women during pregnancy or in

postpartum period are at risk for depression. As such, high-risk groups may be subject to focused screening. Any positive screen in these high-risk groups should be followed with a focused assessment.

**Clinical Assessment:** When patients present to a health care provider with complaints regarding symptoms of depression or suicidal thoughts, the focus is on conducting an evaluation to assess the nature, extent and other characteristics of suicidal behavior or risk for suicidal behavior with the goal of formulating a treatment plan. The patient has, in essence, self-screened for evaluation, and formal assessment is conducted to establish a diagnostic or other clinical formulation of the presenting problem. The therapeutic interventions that follow will first address the suicidal thoughts and behaviors regardless of the psychiatric diagnosis.

**Referral from Non-Clinical Sources:** Military members and Veterans interact with many helping agencies as well as commands, leaders, Chaplains, family members and unit peers. Many of these agencies and all Service members have suicide prevention training to identify persons at risk for suicide. Programs such as Applied Suicide Intervention Skills Training (ASIST) or “Ask, Care, Escort” (ACE) are conducted by helping professionals and lay persons (“gatekeepers”) to prepare Service members to identify those at risk and facilitate their referral to qualified professional help.

### *Annotation B. Assess Risk for Suicide*

Suicide risk assessment is a process in which the healthcare provider gathers clinical information in order to determine the patient’s risk for suicide. The risk for suicide is estimated based on the patient’s suicidal thoughts and intent, suicide related behavior, warning signs, risk and protective factors.

### **Estimating the Risk for Suicide**

Determination of suicide risk should include three tasks:

1. Gathering information related to the patient’s intent to engage in suicide-related behavior.
2. Evaluating factors that elevate or reduce the risk of acting on that intent.
3. Integrating all available information to determine the level of risk and appropriate setting for care.

Assessing for current intent and the degree of intent for suicide is a key component of the assessment process. The first aspect of the clinical assessment of suicide risk is the evaluation of the patient’s **thoughts** of suicide, the **intention** to act on those thoughts, and the desire or the ability of the patient to not engage in suicidal behaviors. Any evidence of action toward a suicide attempt suggests a higher level of risk. Suicidal **preparatory behaviors** include the development of a plan to end one’s life, rehearsing a plan, or taking steps to prepare for an attempt (e.g., stockpiling medications, buying a gun, tying a rope into a noose). Assessing the lethality of the plan is important, but also important is the patient’s estimation of the lethality and understanding of the probable consequences of his/her actions or potential actions. Many suicidal individuals may reveal **warning signs** or signals of their intention to engage suicidal behaviors. These warning signs are observations of precipitating emotions, thoughts, or behaviors that are most proximally associated with a suicidal act and reflect imminent risk.

Three direct warning signs portend the highest likelihood of suicidal behaviors occurring in the near future. Observing these warning signs warrants immediate attention, mental health evaluation, referral, or consideration of hospitalization to ensure the safety, stability and security of the individual:

- **Suicidal communication** – writing or talking about suicide, wish to die, or death (threatening to hurt or kill self) or intention to act on those ideas.
- **Preparations for suicide** – evidence or expression of suicide intent, and/or taking steps towards implementation of a plan. Makes arrangements to divest responsibility for dependent others (children, pets, elders), or making other preparations such as updating wills, making financial arrangements for paying bills, saying goodbye to loved ones, etc.
- **Seeking access or recent use of lethal means** – such as weapons, medications, toxins or other lethal means.

These signals are likely to be even more dangerous if the person has previously attempted suicide, has a family history of suicide and/or intends to use a method that is lethal and to which he/she has access.

Once the patient's suicidal ideation, intent and behaviors are assessed then other factors that influence risk should be considered in a systematic way to finalize the determination of risk level. These factors may include risk as well as protective factors that, if modifiable, could become the focus of clinical intervention to reduce the risk for suicide:

- **Risk Factors** – increase the likelihood of suicidal behavior and include modifiable and non-modifiable indicators.
- **Protective Factors** – are capacities, qualities, environmental and personal resources that increase resilience drive individuals towards growth, stability, and health and increase coping with different life events and decrease the likelihood of suicidal behavior.

Basing the assessment of risk on an accumulation of risk factors alone is not realistic. Many risk factors are not modifiable. Awareness of the risk factors may alert the clinician to general levels of risk, but it is the key contextual triggering factors and the person's current mental state, suicidal intent and behavior that are most immediately important.

Finally, the formulation of the level of risk for suicide should also determine the most appropriate care environment in which to address the risk and provide the care needs. The first priority in determining the care setting is safety. Patients assessed as having a clear intention of taking their lives will require higher levels of safety protection than those who are able to maintain their own safety. Patients who are at high-risk for suicide require evaluation by mental health professions, and possible inpatient care to provide for increased level of supervision and higher intensity of care. Those at intermediate and low risk may be referred to an outpatient care setting and with appropriate supports and safety plans, may be able to be followed-up in the community.

## RECOMMENDATIONS

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1. A suicide risk assessment should first evaluate the three domains: suicidal thoughts, intent, and behavior including warning signs that may increase the patient's acuity. (See [Annotation C](#))
2. The suicide risk assessment should then include consideration of risk and protective factors that may increase or decrease the patient's risk of suicide. (See [Annotation D](#))
3. Observation and existence of warning signs and the evaluation of suicidal thoughts, intent, behaviors, and other risk and protective factors should be used to inform any decision about referral to a higher level of care. (See [Annotation E](#))
4. Mental state and suicidal ideation can fluctuate considerably over time. Any person at risk for suicide should be re-assessed regularly, particularly if their circumstances have changed.
5. The clinician should observe the patient's behavior during the clinical interview. Disconnectedness or a lack of rapport may indicate increased risk for suicide.
6. The provider evaluating suicide risk should remain both empathetic and objective throughout the course of the evaluation. A direct non-judgmental approach allows the provider to gather the most reliable information in a collaborative way, and the patient to accept help.

## *Annotation C. Assessment of Suicidal Ideation, Intent and Behavior*

Assess the patient's thoughts of suicide, the intention to act on those thoughts, and behaviors that demonstrate warning signs.

## *Annotation C1. Suicidal Ideation/Thoughts*

Ask the patient if he/she has thoughts about wishing to die by suicide, or thoughts of engaging in suicide-related behavior. The distinction between non-suicidal self-directed violence and suicidal behavior is important.

### **BACKGROUND**

The assessment of risk for suicide begins with query regarding ideation and gaining an understanding of the patient's suicidal thoughts with the goal of identifying suicidal intent. Suicidal thoughts can lead to suicidal behavior. Thoughts may be persistent or fleeting, with the former being more likely to compel action than the latter. Therefore it is important to understand the nature, intensity, frequency and duration of any suicidal thoughts a person is experiencing as part of any suicide risk assessment. Inquire about recent ideation (preceding 2 weeks) and past events. In addition, explore if the suicidal thoughts are current, being experienced by the patient during the interview itself.

The nature and frequency may or may not be related to suicidal intent. Suicidal ideation is assumed to be present in the majority of suicide attempts and completed suicides; however many who attempt suicide deny suicidal ideation prior to attempt, and many individuals have suicidal thoughts without making attempts.

Remember, asking directly does not increase patient's ideation, but rather indicates that you are ready to listen and help.

### **RECOMMENDATIONS**

1. Patients should be directly asked if they have thoughts of suicide and to describe them. The evaluation of suicidal thoughts should include the following:
  - a. Onset (When did it begin)
  - b. Duration (Acute, Chronic, Recurrent) Intensity (Fleeting, Nagging, Intense)
  - c. Frequency (Rare, Intermittent, Daily, Unabating)
  - d. Active or passive nature of the ideation ('Wish I was dead' vs. 'Thinking of killing myself')
  - e. Whether the individual wishes to kill themselves, or is thinking about or engaging in potentially dangerous behavior for some other reason (e.g., cutting oneself as a means of relieving emotional distress)
  - f. Lethality of the plan (No plan, Overdose, Hanging, Firearm)
  - g. Triggering events or stressors (Relationship, Illness, Loss)
  - h. What intensifies the thoughts
  - i. What distract the thoughts
  - j. Association with states of intoxication (Are episodes of ideation present or exacerbated only when individual is intoxicated? This does not make them less serious; however may provide a specific target for treatment)
  - k. Understanding regarding the consequences of future potential actions

<i>Example of Questions on Ideation:</i>
<i>"With everything that has been going on, have you been experiencing any thoughts of killing yourself?"</i>
• <i>When did you begin having suicidal thoughts?</i>
• <i>Did any event (stressor) precipitate the thoughts?</i>
• <i>How often do you have thoughts of suicide?</i>
• <i>How long do they last?</i>
• <i>How strong are the thoughts of suicide?</i>
• <i>What is the worst they have ever been?</i>
• <i>What do you do when you have these (suicidal) thoughts?</i>
• <i>What did you do when they were the strongest ever?</i>
• <i>Do thoughts occur or intensify when you drink or use drugs?</i>

**Annotation C2. Suicidal Intent**

Assess for past or present evidence (implicit or explicit) that the individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions.

**BACKGROUND**

Assessing for current intent and the degree of intent for suicide is a key component of the assessment process. The presence of intent to act upon suicidal thoughts is generally indicative of high risk for suicide. Therefore it is important to understand the extent to which the patient: 1) wishes to die; 2) means to kill him/herself; 3) and understands the probable consequences of his/her actions or potential actions.

Patients with active suicidal ideation may have the intent to act, a plan to act, both, or neither. The evolution of intent can occur over minutes or years. In some cases the intent stage may be very brief and the suicidal ideation may propel to a behavior or suicide act.

**RECOMMENDATIONS**

1. Patients should be asked the degree to which they wish to die, mean to kill him/herself, and understand the probable consequences of his/her actions or potential actions
2. The evaluation of intent to die should be characterized by:
  - a. Strength of the desire to die
  - b. Strength of determination to act
  - c. Strength of impulse to act or ability to resist the impulse to act
3. The evaluation of suicidal intent should be based on indication that the individual:
  - a. Wishes to die
  - b. Means to kill him/herself
  - c. Understands the probable consequences of the actions or potential actions
  - d. These factors may be highlighted by querying regarding how much the individual has thought about a lethal plan, has the ability to engage that plan, and is likely to carry out the plan

#### Example of Questions on Intent:

- Do you wish you were dead?
- Do you intend to try to kill yourself?
- Do you have a plan regarding how you might kill yourself?
- Have you taken any actions towards putting that plan in place?
- How likely do you think it is that you will carry out your plans?

### Annotation C3. Preparatory Behavior

Assess if the patient has begun to show actual behavior of preparation for engaging in Self-Directed Violence (e.g., assembling a method, preparing for one's death).

#### BACKGROUND

Assessment of risk for suicide may find that the patient has already begun to take specific action in implementing their plan to kill themselves (e.g., buying a gun, collecting pills, assembling methods), or started to make preparation for the aftermath of their death (e.g., giving away their belonging, changing a will, or sending notes to loved ones). These acts and behaviors are defined as preparatory behaviors and put the patient at the high risk for suicide. Research has shown that resolved plans and preparatory behavior predicted death by suicide and history of suicide attempts.

Gathering information regarding preparatory behaviors may require exploring other sources of information about the patient. This may require a careful discussion with the patient and obtaining the patient's consent. Peers, unit members, and command elements may play a critical role in corroborating information regarding psychosocial functioning and preparatory behavior.

#### RECOMMENDATIONS

1. Clinicians should evaluate preparatory behaviors by inquiring about:
  - a. Preparatory behavior like practicing a suicide plan. For example:
    - Mentally walking through the attempt
    - Walking to the bridge
    - Handling the weapon
    - Researching for methods on the internet
  - b. Thoughts about where they would do it and the likelihood of being found or interrupted?
  - c. Action to seek access to lethal means or explore the lethality of means.  
For example: (See [Annotation D5](#))
    - Acquiring a firearm or ammunition
    - Hoarding medication
    - Purchasing a rope, blade, etc.
    - Researching ways to kill oneself on the internet
  - b. Action taken or other steps in preparing to end one's life:
    - Writing a will, suicide note
    - Giving away possessing
    - Reviewing life insurance policy
2. Obtain collateral information from sources such as family members, medical records, and therapists.

<i>Examples of Questions on Preparation:</i>
• <i>Do you have a plan or have you been planning to kill yourself?</i>
<i>If so, how would you do it? Where would you do it?</i>
• <i>Do you have the (drugs, gun, rope) that you would use? Where is it right now?</i>
• <i>Do you have a timeline in mind for killing yourself?</i>
• <i>Is there something (an event) that would trigger acting on the plan?</i>
• <i>How confident are you that your plan will end your life?</i>
• <i>What have you done to begin to carry out the plan?</i>
• <i>Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?</i>

**Annotation C4. Previous Suicide Attempt**

Obtain information from the patient and other sources about previous suicide attempts. Historical suicide attempts may or may not have resulted in injury, and may have been interrupted by the patient or by another person prior to fatal injury.

**RECOMMENDATIONS**

1. The assessment of risk for suicide should include information from the patient and collateral sources about previous suicide attempt and circumstances surrounding the event (i.e., triggering events, method used, consequences of behavior, role of substances of abuse) to determine the lethality of any previous attempt:
  - a. Inquire if the attempt was interrupted by self or other, and other evidence of effort to isolate or prevent discovery
  - b. Inquire about other previous and possible multiple attempts
  - c. For patients who have evidence of previous interrupted (by self or other) attempts, obtain additional details to determine factors that enabled the patient to resist the impulse to act (if self-interrupted) and prevent future attempts.

**Annotation C5. Warning Signs – Indications for Urgent/Immediate Action**

Recognize precipitating emotions, thoughts, or behaviors that are most proximally associated with a suicidal act and reflect high risk

Many suicidal individuals reveal warning signs or signals of their intention to engage suicidal behaviors, thereby providing clinicians or other supportive persons the opportunity to recognize an impending suicidal crisis and intervene.

Three **direct** warning signs portend the highest likelihood of suicidal behaviors occurring in the near future. Observing these warning signs warrants immediate attention, mental health evaluation, referral, or consideration of hospitalization to ensure the safety, stability and security of the individual:

- **Suicidal communication** – writing or talking about suicide, wish to die, or death (threatening to hurt or kill self)
- **Seeking access or recent use of lethal means:** such as weapons, medications, or other lethal means
- **Preparations for suicide** – evidence or expression of suicide intent, and/or taking steps towards implementation of a plan. Makes arrangements to divest responsibility for dependent others (children, pets, elders), or making other preparations such as updating wills, making financial arrangements for paying bills, saying goodbye to loved ones, etc.

These signals are likely to be even more dangerous if the person has previously attempted suicide, has a family history of suicide and/or intends to use a method that is lethal and to which he/she has access.

Other indirect warning sign presentation(s) or behavioral expressions that may indicate increased suicide risk and urgency in a patient at risk for suicide

#### RECOMMENDATIONS

1. Assess for other warning signs that may indicate likelihood of suicidal behaviors occurring in the near future, and require immediate attention:
  - **Substance abuse** – increasing or excessive substance use (alcohol, drugs, smoking)
  - **Hopelessness** – expresses feeling that nothing can be done to improve the situation
  - **Purposelessness** – express no sense of purpose, no reason for living, decreased self-esteem
  - **Anger** – rage, seeking revenge
  - **Recklessness** – engaging impulsively in risky behavior
  - **Feeling Trapped** – expressing feelings of being trapped with no way out
  - **Social Withdrawal** – withdrawing from family, friends, society
  - **Anxiety** – agitation, irritability, angry outbursts, feeling like wants to “jump out of my skin”
  - **Mood changes** – dramatic changes in mood, lack of interest in usual activities/friends
  - **Sleep Disturbances** – insomnia, unable to sleep or sleeping all the time
  - **Guilt or Shame** – Expressing overwhelming self-blame or remorse

#### *Annotation D. Assessment of Factors that Contribute to the Risk for Suicide*

Assess factors that are known to be associated with suicide (i.e., risk factors, precipitants) and those that may decrease the risk (i.e., protective factors).

#### RECOMMENDATIONS

1. Providers should obtain information about risk factors during a baseline evaluation – recognizing that risk factors have limited utility in predicting future behavior.
2. Providers should draw on available information including prior history available in the patient’s record, inquiry and observation of the patient, family or military unit members and other sources where available.
3. Assessment tools may be used to evaluate risk factors, in addition to the clinical interview, although there is insufficient evidence to recommend one tool over another.
4. The baseline assessment should include information about risk factors sufficient to inform further assessment if conditions change such as firearm in the home, social isolation, history of depression, etc.
5. Risk factors should be considered to denote higher risk individuals (e.g., those with a history of depression) and higher risk periods (e.g., recent interpersonal difficulties).
6. Risk factors should be solicited and considered in the formulation of a patient’s care.
7. Reassessment of risk should occur when there is a change in the patient’s condition (e.g., relapse of alcoholism) or psychosocial situation (e.g., break-up of intimate relationship) to suggest increased risk. Providers should update information about risk factors when there are changes in the individual’s symptoms or circumstances to suggest increased risk.
8. Patients ages 18 to 25 who are prescribed an antidepressant are at increased risk for suicidal ideation and warrant increase in the frequency of monitoring of these patients for such behavior

9. For Military Service person in transition the provider should:
  - a. Inquire about changes in the patient's life and be aware of other indicators of change (retirement physical, overseas duty screening, etc.).
  - b. Be willing to discuss and consider methods to strengthen social support during the transition time if there are other risk factors present.

### **Annotation D1. Risk Factors / Precipitants**

Risk factors distinguish a higher risk group from a lower risk group. Risk factors may be modifiable or non-modifiable and both inform the formulation of risk for suicide. Modifiable risk factors may also be targets of intervention.

#### **PSYCHOLOGICAL FACTORS**

- Suicide of relative, someone famous, or a peer
- Suicide bereavement
- Loss of loved one (grief)
- Loss of relationship (divorce, separation)
- Loss of status/respect/rank (public humiliation, being bullied or abused, failure work/task)

#### **SOCIAL FACTORS**

##### **Stressful Life Events (acute experiences)**

- Breakups and other threats to prized relationships
- Other events (e.g., fired, arrested, evicted, assaulted)

##### **Chronic Stressors (ongoing difficulties)**

- Financial Problems
  - Unemployment, underemployment
  - Unstable housing, homeless
  - Excessive debt, poor finances (foreclosure, alimony, child support)
- Legal Problems (difficulties)
  - DUI/DWI
  - Lawsuit
  - Criminal offence and incarceration
- Social Support
  - Poor interpersonal relationship (partner, parents, children)
  - Geographic isolation from support
  - Barriers to accessing mental health care
  - Recent change in level of care (discharge from inpatient psychiatry)

#### **MENTAL DISORDERS**

- Mood or affective disorder (major depression, bipolar, post-partum)
- Personality disorder (especially borderline and antisocial)
- Schizophrenia
- Anxiety (PTSD, Panic)
- Substance Use Disorder (alcohol, illicit drugs, nicotine)

- Eating disorder
- Sleep disturbance or disorder (See [Appendix B-4](#))
- Trauma (psychological)

#### **MEDICAL CONDITIONS**

- History of Traumatic Brain Injury (TBI)
- Terminal disease
- HIV/AIDS
- New diagnosis of major illness
- Having a medical condition
- Worsening of chronic illness
- Intoxication
- Substance withdrawal (alcohol, opiates, cocaine, amphetamines)
- Use of prescribed medication w/ warning for increased risk of suicide (See [Appendix B-3](#))

#### **Physical Symptoms**

- Chronic pain
- Insomnia
- Function limitation

#### **MILITARY-SPECIFIC**

- Disciplinary actions (UCMJ, NJP)
- Reduction in rank
- Career threatening change in fitness for duty
- Perceived sense of injustice or betrayal (unit/command)
- Command/leadership stress, isolation from unit
- Transferring duty station (PCS)
- Administrative separation from service/unit
- Adverse deployment experience
- Deployment to a combat theater

#### **PRE-EXISTING & NON-MODIFIABLE**

- Age (young & elderly)
- Gender (male)
- Race (white)
- Marital status (divorce, separate, widowed)
- Family history of:
  - Suicide/ attempt
  - Mental illness (including SUD)
  - Child maltreatment trauma-physical/psychological/sexual
  - Sexual trauma
- Lower education level
- Same sex orientation (LGBT)
- Cultural or religious beliefs

## *Annotation D2. Impulsivity*

### **RECOMMENDATIONS**

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1. The assessment of risk for suicide should include evaluation of impulsivity by determining whether the patient is feeling out of control, engaging impulsively in risky behavior
2. Assess if impulsive recklessness and risk-taking characterize the pattern of behavior and life style of the individual and therefore may limit the ability to control his/her behavior.

## *Annotation D3. Protective Factors*

Protective factors are capacities, qualities, environmental and personal resources that drive individuals towards growth, stability, and health and may reduce the risk for suicide.

### **RECOMMENDATIONS**

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1. Assessment should include evaluation of protective factors, patient's reason to for living, or other factors that mitigate the risk for suicide.

#### **Social Context Support System**

- Strong interpersonal bonds to family/unit members and community support
- Employed
- Intact marriage
- Child rearing responsibilities
- Responsibilities/duties to others
- A reasonably safe and stable environment

#### **Positive Personal Traits**

- Help seeking
- Good impulse control
- Good skills in problem solving, coping and conflict resolution
- Sense of belonging, sense of identity, and good self-esteem
- Cultural, spiritual, and religious beliefs about the meaning and value of life
- Optimistic outlook – Identification of future goals
- Constructive use of leisure time (enjoyable activities)
- Resilience

#### **Access to Health Care**

- Support through ongoing medical and mental health care relationships
- Effective clinical care for mental, physical and substance use disorders
- Good treatment engagement and a sense of the importance of health and wellness

## Annotation D4. Substance Abuse and Disorder

### BACKGROUND

Substance use disorders are a prevalent and strong risk factor for suicide attempts and suicide. The recommendations for assessment of risk for suicide in this (Module) guideline generally apply to individuals with substance use disorders and should be followed.

Three key additional issues to bear in mind in working with this population refer to assessing intoxicated patients, differentiating unintentional and intentional overdose events, and special assessment considerations.

Individuals at acute risk for suicidal behavior who appear to be under the influence of alcohol or other drugs, either based on clinical presentation or objective data (e.g., breath or laboratory tests), should be maintained in a secure setting until intoxication has resolved. Risk assessment needs to be repeated once the patient is sober in order to determine appropriate next steps. Risk management options include, but are not limited to, admitting the patient for inpatient hospital care, making a referral for residential care, detoxification, or ambulatory care, or scheduling outpatient follow-up in the near future.

Intentional overdose is the most common method of attempted suicide. Therefore, the possibility that an overdose event was an intentional act of self-directed violence should always be considered. Obtaining additional information from family members, treatment providers, medical records, etc., can be invaluable in making the determination between intentional and unintentional overdose in equivocal cases.

The same factors that confer risk for suicidal behavior in non-substance abusers generally also confer risk among individuals with substance use disorders. For example, depression is a potent risk factor in both substance abusers and non-substance abusers. The presence of comorbidities (e.g., substance use disorder plus mood disorder) is the rule rather than the exception in high-risk clinical populations.

### RECOMMENDATIONS

1. All patients at acute risk for suicide who are under the influence (intoxicated by drugs or alcohol) should be evaluated in an urgent care setting and be kept under observation until they are sober.
  - a. Patients who are under the influence should be reassessed for risk for suicide when the patient is no longer acutely intoxicated, demonstrating signs or symptoms of intoxication, or acute withdrawal
  - b. Obtaining additional information from family members, treatment providers, medical records, etc., can be invaluable in making the determination between intentional and unintentional overdose in equivocal cases.
  - c. Intoxicated or psychotic patients who are unknown to the clinician and who are suspected to be in at acute risk for suicide should be transported securely to the nearest crisis center or emergency department for evaluation and management. These patients can be dangerous and impulsive; assistance in transfer from law enforcement may be considered.
2. Intoxication with drugs or alcohol impairs judgment and increases the risk of suicide attempt. Use of drugs or alcohol should routinely be assessed with all persons at any risk for suicide.
3. Assess the presence of psychiatric and behavioral comorbidities (e.g., mood, anxiety disorder, aggression) in patients with substance use disorder at risk for suicide.
4. Recognize that assessment of social risk factors such as disruptions in relationships and legal and financial difficulties are important in individuals with substance use disorders.

### *Annotation D5. Assess Access to Lethal Means*

Assess the availability or intent to acquire lethal means including firearms and ammunition, drugs, poisons and other means in the patient's home. For Service members, this includes assessing privately owned firearms.

#### **BACKGROUND**

Military Service members and Veterans are at risk for lethal suicidal behavior and are more likely to use firearms as the suicide method; the increased risk for use of firearms is notable, given that this population has extensive exposure to firearms, and ample opportunities to have access to them. Certain military occupations have daily access to firearms; and the majority of military personnel have at least some weapons training.

Providers should assess the presence and the access to lethal means including firearms and ammunition, as well as prescribed and over the counter drugs, poisons and other means in the patient's home.

#### **RECOMMENDATIONS**

1. Assessment of presence and access to lethal means should include:
  - a. Fire Arms: Always inquire about access to fire arms and ammunition (including privately-owned firearm) and how they are stored
  - b. Medications: Perform medication reconciliation for all patients. For any current and/or proposed medications consider the risk/benefit of any medications which could be used as a lethal agent to facilitate suicide. Consider prescribing limited supplies for those at elevated risk for suicide, or with histories of overdose or the availability of a caregiver to oversee the administration of the medications.
  - c. Household poisons: Assess availability of chemical poisons, especially agricultural and household chemicals. Many of these are highly toxic.

### *Annotation E. Determine the Level of Risk for Suicidal Self-Directed Violence (Severity of Suicidality)*

Determine the level of the risk for suicidal self-directed violence to establish the appropriate setting of care and to implement treatment interventions targeting the specific level of risk.

#### **BACKGROUND**

The formulation of the level of risk for suicide guides the most appropriate care environment in which to address the risk and provide safety and care needs. The first priority is safety. Patients assessed as having a clear intention of taking their lives will require higher levels of safety protection than those with less inclination toward dying. Patients who are at high-risk for suicide may require inpatient care to provide for increased level of supervision and higher intensity of care. Those at intermediate and low acute risk may be referred to an outpatient care setting and with appropriate supports and safety plans, may be able to be followed-up in the community.

Considering all the information gathered in the assessment, the clinician will formulate the level of risk in one of the following categories: (See Table 1 on Page 32, for indications of risk level)

## HIGH ACUTE RISK FOR SUICIDE

**High-acute risk patients** include those with warning signs, serious thoughts of suicide, a plan and/or intent to engage in lethal self-directed violence, a recent suicide attempt, and/or those with prominent agitation, impulsivity, psychosis. In such cases, clinicians should ensure constant observation and monitoring before arranging for immediate transfer for psychiatric evaluation or hospitalization.

## INTERMEDIATE ACUTE RISK FOR SUICIDE

**Intermediate acute risk patients** include those patients with suicidal ideation and a plan but with no intent or preparatory behavior. Combination of warning signs and risk factors to include history of self-directed violence (suicide attempt) increases a person's risk for suicide. Patients at intermediate risk should be evaluated by a Behavioral Health provider. The decision whether to urgently refer a patient to a mental health professional or emergency department depends on that patient's presentation. Patient who is referred may be hospitalized if further evaluation reveals that the level of illness or other clinical findings warrant it. The patient may be managed in outpatient care if patient and provider collectively determine that the individual is capable of maintaining safety by utilizing non-injurious coping methods and utilize a safety plan.

## LOW ACUTE RISK FOR SUICIDE

**Low acute risk patients** include those with recent suicidal ideation who have no specific plans or intent to engage in lethal self-directed violence and have no history of active suicidal behavior. Consider consultation with Behavioral Health to determine need for referral to treatment addressing symptoms, and safety issues. These patients should be followed up for reassessment.

**NOT AT ELEVATED ACUTE RISK FOR SUICIDE** (Risk outside the scope of risk classification considered in this CPG for the purpose of determining action)

Persons with mental disorder who are managed appropriately according to evidence-based guidelines and do not report suicidal thoughts are outside the scope of the classification of risk for suicide in this CPG. Patients that at some point in the past had reported thoughts about death or suicide, but currently don't have any of these symptoms are not considered to be at acute risk of suicide. There is no indication to consult with behavioral health specialty in these cases, and the patients should be followed in routine care, continue to receive treatment for their disorder and be re-evaluated periodically for thoughts and ideation.

## RECOMMENDATIONS

1. Patients at HIGH ACUTE RISK should be immediately referred for a specialty evaluation with particular concern for insuring the patient's safety and consideration for hospitalization.
2. Patients at INTERMEDIATE ACUTE RISK should be evaluated by Behavioral Health specialty.
3. Patients at LOW ACUTE RISK should be considered for consultation with or referral to a Behavioral Health Practitioner.
4. Patients at NO elevated ACUTE RISK should be followed in routine care with treatment of their underlying condition, and evaluated periodically for ideation or suicidal thoughts.
5. Patient for whom the risk remains UNDETERMINED (no collaboration of the patient or provider concerns about the patients despite denial of risk) should be evaluated by a Behavioral Health Practitioner.

**Table 1. Determine Level of Risk for Suicide and Appropriate Action in Primary Care**

Risk of Suicide	Indicators of Suicide Risk	Contributing Factors †	Initial Action Based on Level of Risk
<b>High Acute Risk</b>	<ul style="list-style-type: none"> <li>☑ Persistent suicidal <b>ideation</b> or thoughts</li> <li>☑ Strong <b>intention</b> to act or plan</li> <li>☑ <b>Not</b> able to control <b>impulse</b> OR</li> <li>☑ Recent <b>suicide attempt</b> or preparatory behavior ††</li> </ul>	<ul style="list-style-type: none"> <li>☑ Acute state of mental disorder or acute psychiatric symptoms</li> <li>☑ Acute <b>precipitating</b> event(s)</li> <li>☑ Inadequate <b>protective</b> factors</li> </ul>	Maintain direct observational control of the patient. Limit access to lethal means Immediate transfer with escort to Urgent/ Emergency Care setting for Hospitalization
<b>Intermediate Acute Risk</b>	<ul style="list-style-type: none"> <li>☑ Current suicidal <b>ideation</b> or thoughts</li> <li>☑ <b>No</b> intention to act</li> <li>☑ Able to control the <b>impulse</b></li> <li>☑ <b>No recent suicide attempt</b> or <b>preparatory behavior</b> or rehearsal of act</li> </ul>	<ul style="list-style-type: none"> <li>☑ Existence of <b>warning signs</b> or <b>risk factors</b> †† AND</li> <li>☑ Limited <b>protective</b> factor</li> </ul>	Refer to Behavioral Health provider for complete evaluation and interventions Contact Behavioral Health provider to determine acuity of the referral Limit access to lethal means
<b>Low Acute Risk</b>	<ul style="list-style-type: none"> <li>☑ Recent suicidal <b>ideation</b> or thoughts</li> <li>☑ <b>No intention</b> to act or plan</li> <li>☑ Able to control the <b>impulse</b></li> <li>☑ <b>No</b> planning or rehearsing a suicide act</li> <li>☑ <b>No</b> previous attempt</li> </ul>	<ul style="list-style-type: none"> <li>☑ Existence of <b>protective factors</b> AND</li> <li>☑ Limited <b>risk factors</b></li> </ul>	Consider consultation with Behavioral Health to determine: <ul style="list-style-type: none"> <li>– Need for referral</li> <li>– Treatment</li> </ul> Treat presenting problems Address safety issues Document care and rationale for action

† Modifiers that increase the level of risk for suicide of any defined level:

- **Acute state of Substance Use:** Alcohol or substance abuse history is associated with impaired judgment and may increase the severity of the suicidality and risk for suicide act
- **Access to means:** (firearms, medications) may increase the risk for suicide act
- **Existence of multiple risk factors or warning signs** or lack of protective factors

†† Evidence of suicidal behavior warning signs in the context of denial of ideation should call for concern (e.g., contemplation of plan with denial of thoughts or ideation)

**Annotation E1. Suicide Risk Assessment Instruments**

Risk factors can inform the assessment for any given individual, but are not predictive by themselves. While suicide risk assessment scales are no substitute for comprehensive evaluation and clinical judgment based on the history of the person, they may provide a structure for systematic inquiry about risk factors for repeated suicide attempts.

**BACKGROUND**

Rating scales can be helpful in the assessment process. However, a clinical assessment by a trained professional is required to assess suicide risk. This professional must have the skills to engage patients in crisis and to elicit candid disclosures of suicide risk in a non-threatening environment. The assessment should comprise a physical and psychiatric

examination including a comprehensive history (with information from patient, parents and significant others whenever possible) to obtain information about acute psychosocial stressors, psychiatric diagnoses, current mental status and circumstances of prior suicide attempts. Assessment tools may be used to evaluate risk factors, in addition to the clinical interview, although there is insufficient evidence to recommend one tool over another.

## RECOMMENDATIONS

1. Formulation of the level of suicide risk should be based on a comprehensive clinical evaluation that is aimed to assess suicidal thoughts, intent and behavior and information about risk and protective factors for estimating the level of risk.
2. Behavioral Health provider use of a standardized assessment framework may serve to inform a comprehensive clinical evaluation. The framework should:
  - a. Estimate the level of risk
  - b. Support clinical decision-making
  - c. Determine the level of intervention and indication for referral
  - d. Allow monitoring of risk level over time
  - e. Serve as the foundation for clinical documentation
  - f. Facilitate consistent data collection for process improvement
3. Assessment of risk for suicide should not be based on any single assessment instrument alone and cannot replace a clinical evaluation. The assessment should reflect the understanding [recognizing] that an absolute risk for suicide cannot be predicted with certainty.
4. There is insufficient evidence to recommend any specific measurement scale to determine suicide risk.

### *Annotation E2. Detection, Recognition and Referral (in Primary Care)*

#### **Assessment of Suicide Risk in the Primary Care Settings:**

##### BACKGROUND

An integrated understanding of the individual biological, psychological, social and cultural factors impacting suicide and recognition of warning signs is necessary for effective risk assessment and determination. This understanding needs to be translated into effective evidence based screening and assessment framework that can be efficiently and broadly applied in the general medical setting.

The primary care provider must have a high index of suspicion to identify patients at risk for suicide. Somatic complaints are often a proxy for depression and anxiety. Patients presenting with insomnia, fatigue, pain, headaches, or memory loss should be screened for depression, anxiety, substance use and presence of acute stressors. When present, suicide screening and assessment may be appropriate.

Several risk-stratification protocols are used in primary care to recognize the urgency of medical conditions (e.g., chest pain, respiratory distress) and identify those patients needing referral and/or hospitalization. Similarly, primary care providers would benefit having an efficient way for assessing suicide risk in patients who have potential thoughts of self-harm. The assessment should distinguish the rare patient that need urgent referral to an emergency department/hospital from the majority of patients who can have initial treatment in collaboration with a behavioral health provider.

Primary care providers may find it useful to develop an office, or clinic, protocol that they can follow to streamline the process once a patient is identified as being at high or imminent risk--particularly if referral to emergency services is indicated. Also, it may be useful for PCPs to identify a mental health provider in the area who they can call for assistance or a quick consultation.

Providers should follow a consistent framework that will structure the assessment process and include the key component for assessment of suicide risk. Real time availability for consultation with Behavioral Health staff is essential. Formulation of the level of risk will allow matching treatment in the appropriate context for the individual patient.

## RECOMMENDATIONS

1. Whether they have mental disorder or not, patients identified as having suicidal ideation (e.g., through routine screening for major depression or other health conditions) should receive a complete suicide risk assessment as defined in this guideline (See [Annotation B](#)).
2. When evidence of a mood, anxiety, or substance use disorder is present, patients should be asked about suicidal thoughts and behavior directly.
3. If suicidal ideation is present, the initial suicide risk assessment should be performed (See [Annotation B](#)).
4. Referral to specialty behavioral health care should be based on the level of risk and the available resources:
  - a. Patients at HIGH ACUTE RISK should remain under constant observation and monitoring before arranging for immediate transfer for psychiatric evaluation or hospitalization
  - b. Patients at INTERMEDIATE ACUTE RISK should be referred to, and managed by Behavioral Health Specialty Provider.
  - c. Patients at LOW ACUTE RISK should be considered for consultation with a Behavioral Health Practitioner.
  - d. When risk is UNDETERMINED (due to difficulty in determining the level of risk, or provider concerns about the patient despite denial of ideation or intent) the patient should be immediately referred for an evaluation by a Behavioral Health Specialty Provider.

### Guidance for the Assessment of Suicide Risk in Emergency Department / Urgent care Settings:

Patient at HIGH ACUTE-RISK for suicide should be assessed and initially treated in emergency acute care setting

## BACKGROUND

There are many paths to the Emergency Department for patients at risk for suicide. Patients may be referred by a healthcare provider, a Suicide Lifeline, EMS or Police, a friend or loved one, or on their own initiative. As in primary care, a low index of suspicion is appropriate to screen for suicidal ideation or attempt. When suicidal ideation or behavior becomes the focus of attention, the patient should be managed to minimize the risk of death. In a busy Emergency Department, psychiatric patients can often be triaged as a low acuity; or placed out of sight, out of mind in a quiet room for evaluation by the behavioral health consultant. This approach places the patient and staff at risk of harm due to inadequate medical assessment and inadequate management of potentially disruptive behavior.

The evaluating clinician must also consider the safety of the clinic, the availability of support staff, and the availability of the necessary additional diagnostic capability when deciding on the appropriate setting for the evaluation.

## RECOMMENDATIONS

1. The setting for the initial evaluation should ensure the safety of the patient and the clinical staff so that potentially life-threatening conditions can be managed effectively. Providers should make the appropriate steps to:
  - a. Secure all belongings to prevent access to lethal means and elopement from the Emergency Department.
  - b. Monitor the patient in a visible area, away from exits, with limited access to equipment that may be used to harm self or others.
  - c. Conduct a focused medical assessment to identify and manage any life-threatening conditions such as overdose, and assess medical stability.
    - Vital Signs, Physical Exam, Neurologic Exam, Mental Status Exam
    - ECG, Toxicology Screen, BAL, and other tests as indicated.
    - Treat life-threatening conditions.
  - d. Request Behavioral Health Consultation to conduct a thorough suicide risk assessment and recommend a treatment plan.

### Annotation E3. Comprehensive Assessment for Risk for Suicide by Behavioral Health Provider

An experienced behavioral health practitioner should evaluate patients at intermediate to high acute risk for suicide

#### BACKGROUND

The initial assessment of suicide risk must consider the existence of medically unstable conditions, and these must be evaluated and stabilized before the psychological and suicide evaluation can be safely performed. The initial medical evaluation should include a thorough history of recent suicidal behavior, use of any medications or substances of abuse, and any recent self-injurious behavior. A physical examination to include vital signs, cardiopulmonary examination, mental status examination, and neurological examination should be performed. When indicated, further diagnostic evaluation to include electrocardiogram, and laboratory screening to include hematology, renal and hepatic function, toxicology and alcohol/drug testing should also be considered.

After determining that the patient is medically stable, the goal is to gain a complete understanding of the patient's medical, social, and mental health history and recognize current risk factors for suicide as well as any signs and symptoms of psychiatric illness for diagnostic and treatment purposes.

The Behavioral Health practitioner must evaluate and integrate all available information to determine the patient's risk for suicide and formulate a plan that ensures the patient's safety as suicide-specific treatments are initiated. While the practitioner seeks to gain all available information and insights, many barriers exist that can obscure the assessment. Patients may present barriers to gaining a full assessment by withholding information due to defensiveness or embarrassment, or by simply being too depressed or intoxicated to reliably recall important aspects of their history. Due to the potential for unreliability in the acute crisis, collateral sources of information should be sought to validate the history. The accessibility of collateral sources also informs the treatment plan as it identifies potential sources of support for the patient.

#### Components of the Clinical Assessment of the Patient with Suicide Risk

1. Medical history to rule out relevant conditions
2. Psychiatric history
3. Suicidal behavior history (previous attempts)
4. Substance use history
5. Psychosocial history to include history of life stressors, impulsivity, aggression and relationships
6. Family psychiatric history to include history of suicide
7. Physical examination
8. Mental status examination (MSE)
9. Relevant laboratory tests
10. Drug inventory, including over-the-counter (OTC) drugs and supplements

#### RECOMMENDATIONS

1. Gather collateral history from family/unit members, the medical record, escorts, unit commanders (or their representatives), referring physicians, EMS, and police as appropriate.
2. Approach the patient with a non-judgmental, collaborative attitude with the aim of fully understanding the patient's suicidality.

3. Secure all belongings to prevent access to lethal means and elopement from the clinic.
4. Choose the setting for the initial evaluation to ensure the safety of the patient and the clinical staff so that potentially life-threatening conditions can be managed effectively. If the patient is intoxicated, re-evaluate when intoxication has resolved.
5. Conduct a mental status examination and a comprehensive assessment of mental health history that includes:
  - a. Past and present suicidal thoughts, intent, and behaviors, impulsivity, hopelessness and the patient view of the future
  - b. Alcohol use assessed per standardized tools (Audit-C), and other substance abuse history, since impaired judgment may increase the severity of the suicidality and risk for suicide act
  - c. Psychiatric illness, comorbid diagnoses, and history of treatment interventions.
  - d. Elicit family history of suicidal behavior.
6. Assess for access and past use of lethal means (firearms, drugs, toxic agents).
7. Assess social history of support system, living situation and potential stressful life events.
8. Consider suicidal thinking, intent, behavior, risk factors and protective factors to stratify the risk.
9. Consider the use of a standardized suicide risk assessment framework to inform the evaluation for estimating the risk for suicide.
10. Determine appropriate setting for further evaluation and management based on level of risk, legal guidance, and local policy.
11. Document in detail the data supporting the assigned level of risk, the level of care required, and treatment plans to reduce suicide risk.

Three areas must be addressed in the initial management of the suicidal patient; a safety plan, limitation of access to lethal means, and patient and family education. Family education should focus on risks and benefits of alternative treatment options and include a detailed discharge plan. With military Service members, the command element should also be involved in education, safety planning, treatment planning and implementation of duty limitations. Additional areas to address are the medical and other specific patient’s needs. These may be psychosocial, socioeconomic or spiritual in nature.

The initial setting and level of care will be determined based on the conclusion of the assessment and the estimation of the risk of suicide. The capacity of the patient to follow through on a safety plan, the availability of a support system and the assurance that access to lethal means can be restricted will allow transition to a less restrictive care setting. These types of factors inform level of care determinations and must be addressed in the acute care setting prior to discharge planning for long-term and follow-up care.

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*Annotation F. Determine the Appropriate Care Setting*

*Annotation F1. Matching Care level to Level of Risk*

Choose the appropriate care setting that provides the patient at risk of suicide maximal safety in the least restrictive environment

**BACKGROUND**

The difference in care settings reflects the actual or perceived level of safety that can be offered to both the patient and the clinicians involved in the care of the suicidal patient. Care settings include:

- Inpatient hospital wards ■ partial hospitalization programs ■ outpatient specialty care clinics, ■ primary care clinics
- emergency departments ■ and numerous care options in deployed situations.

Care also can be provided for the patient who has already attempted suicide and is now in an intensive care unit or medical ward for assessment and treatment of conditions related to the attempt.

The acutely high-risk suicidal patient should be immediately evaluated and treated for medical instability or intoxication and acute psychiatric symptoms, such as anxiety, agitation, insomnia, depression and psychosis. The patient's safety should be the primary concern and hospitalization should be taken into consideration. With the patient's consent family members and, if necessary, social services should be involved in the treatment plan.

#### RECOMMENDATIONS

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1. Consider hospitalization for patients at high acute risk for suicide who need crisis intervention, intensive structure and supervision to ensure safety, management of complex diagnoses, and delivery of intensive therapeutic procedures.
2. The inpatient psychiatric hospital setting is particularly suitable for the treatment of acute risk for suicide rather than chronic risk.
3. An individualized treatment plan should be determined to meet the patient's needs and aimed to allow as much self-control and autonomy as possible, balanced against the risk level.
4. Although suicidality may persist, the treatment goal is to transition the patient toward a less restrictive environment based on clinical improvement and the assessment that the suicide risk has been reduced.

#### *Annotation F2. Criteria for Transition to Less Restrictive Settings*

#### BACKGROUND

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Discharging a patient to a lower level of care is a clinical decision based on numerous factors unique both to the individual patient and to the treatment environment. As such, no "check box" algorithm could ever be totally comprehensive in describing this task. The following criteria are provided more as a framework from which to start rather than definitive guidance for all conceivable clinical situations. In some cases, where psychiatric symptoms are present, the level of care may be contingent upon where these symptoms can be safely stabilized. The final decision is based on clinical judgment and the experience of the provider.

#### RECOMMENDATIONS

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1. A patient may be discharged to a less restrictive level of care from an acute setting (emergency department/hospital/acute specialty care) after a behavioral health clinician evaluated the patient, or a behavioral health clinician was consulted, **and all** three of the following conditions have been met:
  - A. Clinician assessment that the patient has no current suicidal intent

**AND**

  - B. The patient's active psychiatric symptoms are assessed to be stable enough to allow for reduction of level of care

**AND**

  - C. The patient has the capacity and willingness to follow the personalized safety plan (including having available support system resources).

### *Annotation F3. Hospitalization*

Despite insufficient evidence to demonstrate the effectiveness of acute hospitalization in the prevention of suicide, hospitalization is indicated in suicidal patients who cannot be maintained in less restrictive care setting.

#### **BACKGROUND**

Inpatient hospitalization is a common measure for maximizing safety for individuals who are imminently at risk for suicide. While it is a useful setting for initiating treatment interventions in a safe environment, hospitalization has not been demonstrated to prevent eventual death by suicide.

#### **RECOMMENDATIONS**

1. Any patient with suicidal intent or behavior who cannot be maintained in a less restrictive environment requires hospitalization in order to provide an optimal controlled environment to maintain the patient's safety and initiate treatment.
2. A complete biopsychosocial assessment should be performed upon hospitalization to determine all direct and indirect contributing factors to suicidal thoughts and behaviors. Patient and family education should be provided on techniques to manage these factors.

### *Annotation F4. Partial Hospitalization, Intensive Outpatient Program (IOPs)*

#### **BACKGROUND**

In general, partial hospitalization is not a specific treatment intervention for suicidality, but rather a specialized setting where such treatments can be provided. The advantages offered by choosing to place a patient with suicidality in this setting are the intensity of treatment, which approaches the same level as the inpatient setting, and the ability to monitor the patients' response to treatment closely. Patients in this setting typically are only "on their own" during the weekdays from close of business one day until the beginning of the next morning and then for the whole weekend. If a patient is able and willing to engage in managing suicidal risk, most treatment modalities can be performed in a partial hospitalization setting.

#### **RECOMMENDATIONS**

1. There is insufficient evidence to recommend that partial hospitalization is preferable to other treatment settings for reducing the risk of suicide.

### *Annotation F5. Discharge Planning*

#### **BACKGROUND**

Discharge planning begins upon admission and is defined as the activities that facilitate a patient's movement from one health care setting to another, or to home. It is a multidisciplinary process involving physicians, nurses, social workers, and possibly other health professionals. The goal of discharge planning is to enhance continuity of care and mitigate risk factors that could contribute to suicide post-discharge.

Patients discharged from a psychiatric inpatient hospital stay are at increased risk for suicidal behavior upon discharge. The highest risk period for suicide attempts occurs within the first week of hospitalization and immediately upon discharge from the hospital through the subsequent 12 weeks. As such, discharge planning must be a comprehensive and well-coordinated effort to minimize this risk.

Several factors may contribute to the elevated risk of suicide after admission and discharge from a psychiatric hospital. The structure and restrictive safe environment of the acute care setting – around the clock observation, supervision, caring, and support – are abruptly lost at discharge. At the same time, re-exposure to risk factors such as inadequate social supports, rejection by others, facing unsolved psychological and social stressors, resuming use of alcohol or drugs, and limited engagement and follow-up by outpatient providers may increase the risk of a suicide behavior in the critical immediate period after discharge. In addition, the stigma surrounding psychiatric illness and the awareness of being mentally ill may diminish one’s self-esteem and raise risk for reattempt.

## RECOMMENDATIONS

1. A collaborative discharge plan should be developed to allow a suicidal patient to be discharged from inpatient psychiatric care or the Emergency Department in order to mitigate the increased risk of suicide post discharge.
2. Patients who are discharged from acute care (hospitalization, Emergency Department) remain at high risk for suicide and should be followed up within seven days of discharge.
3. Discharge planning should include the following:
  - a. Re-assessment of the Suicide Risk
  - b. Education to patient and support system about the risks of suicide in the post-discharge timeframe
  - c. Providing suicide prevention information (such as a crisis hotline) to the patient and family/unit members.
  - d. Post-discharge treatment plans for psychiatric conditions and for suicide-specific therapies
  - e. Safety plan with validation of available support systems
  - f. Coordination of the transition to appropriate of care setting with warm hand-offs
  - g. Identifying the responsible provider during the transition
  - h. Monitoring of adherence to the discharge plan for 12 weeks

(For further recommendations and discussion see [Module D: Follow-up and Monitoring](#))

### *Annotation G.      Securing Patient’s Safety*

### *Annotation G1.      Education for Patient and Family*

Health care professionals should provide adults and their families/caregivers/command, if appropriate, with education regarding suicide, stigma, treatment options, and management strategies.

## BACKGROUND

Suicidal patients may benefit from education about the way their emotional responses, thoughts, and behaviors to negative life events may be associated with suicidal crises. Education can include information about: various available evidence-informed treatment options associated with decreases in suicide ideation, intent, and/or planning and increases in factors that prevent suicide, such as hopefulness, problem-solving, and effective interpersonal communication. Family members often struggle with conflicting feelings about the patient’s suicidal behavior. Education and an opportunity to discuss their feelings can help.

## RECOMMENDATIONS

1. The patient should be educated about conditions that are associated with their suicidal crisis, factors that increase and decrease their risk of suicide, and the risks and benefits associated with treatment options included in the treatment plan to target suicidality and associated conditions.
2. Patient and family should receive information about the resources available through the Veterans or Military Crisis Line (including phone, chat and text services).

3. The patient and family education should be done with empathy, and appropriate respect for autonomy and patient privacy. Family/unit members should be engaged with the patient consent. This education should aim to instill hope of recovery and reduce stigma and shame.
4. Strongly recommend advising all patients at intermediate to high acute risk for suicide against the use of alcohol and non-prescribed medications, and educate on the potential for drug-drug and drug-alcohol interactions that can impair decision-making and increase the risk of impulsive suicide attempts.
5. Patient and family education should be provided with the following characteristics:
  - a. Tailored to the needs (e.g. language and educational level) and situational factors of the identified family or supports and patient
  - b. Ensure specific focus on self-directed violence or suicide behaviors
  - c. Allow plenty of time to answer patient and family member questions and establish a collaborative relationship
6. At a minimum, patient and family education should include:
  - a. The nature of self-directed violence or suicide behaviors, the episodic recurrent nature of suicide risk and the applicable biological, cognitive, emotional, or psychosocial risk factors
  - b. The impact of any existing psychiatric diagnoses or high risk situational stresses
  - c. Risk factors associated with suicide
  - d. Warning signs, reviewing any particular warning signs the patient may have demonstrated prior to any attempts or reported ideation
  - e. The protective role of positive family relationships and the potential harmful impact of negative family interaction on risk mitigation
  - f. The importance of assisting the patient with his/ her safety plan and means restriction, removing potentially lethal means of self-harm (e.g. firearms, medications, knives, or razor blades) from the person and their home environment, particularly if the person has mentioned specific means.
  - g. Methods for contacting the patient's provider and other medical or community support resources (e.g. hotlines) should the family member become concerned
  - h. The importance of encouraging the patient to comply with a collaboratively established treatment plan and follow-up care.

### **Annotation G2.      *Limiting Access to Lethal Means (Firearms, Drugs, Toxic Agents, Other)***

Consider ways to restrict access to lethal means that Service members/Veterans could use to take their own lives. This includes, among others, restriction of access to firearms and ammunition, safer prescribing and dispensing of medications to prevent intentional overdoses, and modifying the environment of care in clinical settings to prevent fatal hangings. For Service members concerns about firearms must include privately owned guns and ammunition.

#### **BACKGROUND**

Various strategies to reduce access to lethal means in order to prevent suicide deaths of an impulsive nature have been developed and implemented in several countries. Means restriction is considered a key component in a comprehensive suicide prevention strategy and has been shown to be effective in reducing suicide rates.

Health care providers should routinely assess the presence and the availability (access) of lethal means including firearms and ammunition, drugs, poisons, and other means in the patient's home. (See [Module A, Annotation D-3: Assessment of Access to Lethal Means](#), for review of the means used by Service members and Veterans in suicide). Patient, family or other caregivers should be educated about actions to reduce the associated risks, how to store and secure lethal means of self-harm appropriately and promote vigilance among families and friends of people who have attempted suicide.

## RECOMMENDATIONS

1. Provide education about actions to reduce associated risks and measures to limit the availability of means with emphasis on more lethal methods available to the patient:
  - a. Firearms (military or privately owned): For patients at highest risk, exercise extreme diligence to ensure firearms are made inaccessible to the patient. For all patients at intermediate to high acute risk of suicide, discuss the possibility of safe storage of firearms with the patient, command, and family (e.g., lock firearms up, use trigger locks or store firearms at the military armory, at a friend's home, or local police station. Store ammunition separately.)
  - b. Medications: When clinically possible, include limiting access to medications that carry risk for suicide, at least during the periods when patient is at high acute risk for suicide. This may include prescribing limited quantities, supplying the medication in blister packaging, providing printed warnings about the dangers of overdose, or ensuring that currently prescribed medications are actively controlled by a responsible party.
  - c. Household Poisons: Educate how to secure chemical poisons, especially agricultural and household chemicals, to prevent accidental or intentional ingestions. Many of these chemicals are highly toxic.

### *Annotation G3. Safety Plan for Patient at Risk of Suicide*

Establish an individualized Safety Plan for all persons who are at high acute risk for suicide as part of discharge planning, regardless of inpatient or outpatient status. The Safety Plan is designed to empower the patient, manage the suicidal crisis, and engage other resources.

Discuss safety with patients at intermediate and low risk and consider offering education about safety, and a copy of a Safety Plan handout.

## BACKGROUND

Safety planning is a provider-patient collaborative process – not a “no harm” contract. The safety planning process results in a written plan that assists the patient with restricting access to means for completing suicide, problem-solving and coping strategies, enhancing social supports and identifying a network of emergency contacts including family members and friends, and ways to enhance motivation. These plans are tailored to the patient by assisting the patient with identifying his or her specific warning signs and past effective coping strategies.

Thus, suicidal crises involve experiences and thoughts that are intensely personal; comforting strategies for one patient are not necessarily helpful to another. A behavioral health provider alone cannot develop a safety plan. Formulation of a personal (individualized) safety plan is a process best accomplished with a patient and provider anticipating together likely triggers for future suicidal crises, and collaboratively planning coping strategies that make sense for a given patient.

## RECOMMENDATIONS

1. Safety planning that is developed collaboratively with the patient should be part of discharge planning for all patients who were evaluated with high acute risk for suicide before being released to a lower level of care.
2. For patients at intermediate acute risk for suicide, the safety planning process can be abbreviated to recognizing signs of elevating safety concerns and listing of practical steps for individual coping, safety precautions and support-seeking.
3. For patient at low risk, provider should discuss signs that the patient can use to recognize escalating stress or risk, provide key phone numbers and resources for help, and educate about lethal means restriction. A handout can be used to reinforce the discussion.

4. A Safety plan should be:
  - a. Collaborative between the provider team and the patient
  - b. Proactive—by explicitly anticipating a future suicidal crisis
  - c. Individually tailored
  - d. Oriented towards a no-harm decision
  - e. Based on existing social support
5. The Safety plan should include the following elements, as appropriate:
  - a. Early identification of warning signs or stressors
  - b. Enhancing coping strategies (e.g., to distract and support)
  - c. Utilizing social support contacts (discuss with whom to share the plan)
  - d. Contact information about access to professional help
  - e. Minimizing access to lethal means (as, weapons and ammunition or large quantities of medication)
6. The development of the safety plan with the person, family/unit members, should anticipate and discuss contingencies to address possible obstructions to plan implementation and where to keep the plan.
7. The safety plan should be reviewed and updated by the health care team working with the patient as needed and shared with family/unit members and other related if the patient consents.
8. Safety plans should be updated to remain relevant during changes in clinical state and transitions of care.
9. Providers should document the safety plan within the medical record or reasons for not completing such a plan (i.e. "Patient admitted. Inpatient provider to complete safety plan at time of discharge.")

<i>Component of Safety Plan:</i>
<i>The Safety Plan should consist of a written, prioritized list of coping strategies and sources of support that patients can use to alleviate a suicidal crisis.</i>
<i>Patients are instructed first to recognize when they are in crisis (Step 1) and then to utilize Steps 2 through 5 as needed to reduce the level of suicide risk:</i>
<i>1. Recognizing warning signs of an impending suicidal crisis</i>
<i>2. Employing internal coping strategies</i>
<i>3. Utilizing social contacts and social settings as a means of distraction from suicidal thoughts</i>
<i>4. Utilizing family members or friends to help resolve the crisis</i>
<i>5. Contacting mental health professionals or agencies</i>
<i>6. Restricting access to lethal means.</i>

### **For patient at Low-Risk for Suicide**

Primary care providers can initiate brief safety planning or may be involved in updating plans developed with other providers. Although individuals in the midst of ongoing stressors (such as relationship turmoil or legal proceedings) may not report suicidal ideation during assessment, their state can change quickly in response to proximate stresses. Safety planning is vital in these cases.

Primary care providers should be trained to collaboratively formulate a safety plan for those at intermediate risk of suicide when located where immediate specialty behavioral health assessment and specialty safety planning is not available.

At a minimum, in low risk patients, the provider should discuss signs that the patient can use to recognize escalating stress or risk, provide key phone numbers and resources for help, and educate about lethal means restriction. A handout can be used to reinforce the discussion.

Consider the following Example Safety Plan handout for a patient at low to intermediate acute risk:

<i>When I am feeling overwhelmed and thinking about suicide, I'll take the following steps:</i>
<i>• Take a deep breath and try to identify what's troubling me right now.</i>
<i>• Write down all of the feelings (sad, mad, lonely, helpless, scared, etc.) as a record for later.</i>
<i>• Try and do things that help me feel better for at least 30 minutes (e.g. have a bath, phone a friend, walk the dog, or listen to music).</i>
<i>• Write down individual negative thoughts and provide an alternative response that changes the perspective.</i>
<i>• If suicidal thoughts continue, I will call my emergency contact person who is _____ at: _____</i>
<i>• If that person is not available, I will call the 24-hour crisis line at: _____ or the 1-800 273-TALK line.</i>
<i>• If I still feel suicidal and out-of-control, I will go to the nearest hospital emergency department.</i>

#### **Annotation G4. No-Suicide Contracts**

There is no empirical evidence for the usage of “no harm” or “no-suicide” contracts. A safety plan is a preferred strategy for preventing suicide.

##### **BACKGROUND**

No-Suicide contract documents have been developed to document that a patient agreed to not killing himself/herself over a specified time period. Additionally, evidence indicates that no-suicide contracts are not sufficient to protect individuals against litigation, and may possibly increase liability.

Nothing should replace a thorough evaluation of a patient’s risk factors and current warning signs for suicide. A safety plan or a crisis plan is a preferred strategy that has supportive and anecdotal evidence for preventing suicide.

##### **RECOMMENDATIONS**

1. Recommend against the use of no-suicide contracts as intervention to prevent future suicide in patients at high acute risk for suicide.
2. Patient management should include a comprehensive evaluation of current risk factors and warning signs for suicide, a personalized safety plan that best anticipates triggers for future suicidal thoughts and collaboratively develops coping strategies that make sense for the individual patient.

#### **Annotation G5. Addressing Needs (Engaging Family, Community; Spiritual and Socioeconomic Resources)**

##### **BACKGROUND**

Patients at risk for suicide may have a persistent incapacitating mental disorder marked by severe and intolerable symptoms; marital, social, and vocational disability; and extensive use of psychiatric and community services. These

patients may sometimes benefit from therapeutic intervention that facilitates developing skills for coping with, by utilizing case management, as well as from psychotherapy or pharmacotherapy.

Problem-solving training or other intervention for promoting resilience should be provided to help patients cope with difficulties or adjustment to stressful life events and other risk factors. A problem-solving approach is practical and designed to enhance a patient's skills to resolve stressors, obstacles, or conflicts that increase distress and the risk of suicidal behavior. Increasing one's personal effectiveness through this approach empowers healthy behaviors and reduces isolation, burdensomeness, and despondency.

Programs may emphasize adaptive behavior, healthy decisions, resiliency, mindfulness, and mobilizing a Service member's resources to provide support. Additional targets of such initiative could include: (1) unemployment, (2) financial difficulties, (3) legal issues, (4) lack of supportive relationships (may be self-induced), (5) homelessness or housing instability, (6) lack of social support (may be self-induced), (7) inability to organize comprehensive care, and (8) substance abuse.

Such programs are often conducted in a group setting and may be more supportive and directive than other forms of therapy. Other formats include individual meetings, workshops, and small group counseling led by other members of the care team, not necessarily the BH clinicians. Community services, chaplains, and others may maintain similar services. They may be included in some evidence based treatment regimens.

## RECOMMENDATIONS

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1. Providers should consider psychosocial interventions to address unique family, social, cultural, spiritual and socioeconomic needs of the individual identified by the treatment team and patient.
2. Providers should refer the patient to available psychosocial resources to address the identified individual patient needs.
3. Provider should maintain awareness of available coping skills programs and use clinical judgment in determining if a particular patient will benefit from referral or inclusion in such a program. These modalities may not be appropriate for some Service members.
4. Underlying psychosocial factors impacting the provision of care may include:
  - a. Unemployment
  - b. Homelessness or housing instability
  - c. Financial difficulties
  - d. Legal issues
  - e. Lack of social support (i.e. self-induced or circumstantial)
  - f. Substance abuse
  - g. Inability to coordinate comprehensive care
  - h. Spiritual issues

Survivors of suicide attempts and other patients at high risk may need information about financial, rehabilitation, legal, and other services available to them, as well as education about common obstacles to pursuing needed services. Evaluate psychosocial function and refer for psychosocial rehabilitation, as indicated. Available resources include, but are not limited to: Chaplains, Pastors, Family Support Centers, Exceptional Family Member Programs, VA benefits counselors, occupational or recreational therapists, Vet Centers, and peer support groups.

**Table B-2 Adjunctive Problem Focused Method/Services**

	Domain	Service/training
1	Unemployment or lack of a job that provides adequate income and/or fully uses person’s training and skills	Implement vocational rehabilitation training; comprehensive employment readiness through training, resume building, and referral
2	Financial difficulties	Social services referral and evaluation; consider housing, employment, or public assistance requirements
3	Legal issues	Consider to referral to Veteran’s Justice Outreach, military base Community Services, or local community resources
4	Relationship (Lack of family or friends that are knowledgeable and actively supportive)	Family advocacy & counseling. Implement family skills training, spiritual counseling, group therapy, social engagement
5	Homelessness (Lack of safe, decent, affordable, stable housing that is consistent with treatment goals)	Address independent living skills, refer to supported housing services, and reconnection with family members HCHV
7	Lack of social support (i.e. self-induced or circumstantial, and is socially inactive or isolated)	Implement social skills training, assessment of personal support network and re-engagement
8	Inability to coordinate and locate personal services	Use of case management services
9	Patient/family and other significant social supports are not fully informed about aspects of health needs	Provide education, include in treatment planning as patient allows.
10	Requests spiritual support	Provide information /access to religious and spiritual advisors or other support
6	Substance abuse	Integrated substance abuse treatment

**Annotation G6. Additional Steps for Management of Military Service Members (SMs)**

**BACKGROUND**

The management of the Active Duty Service member with suicidality can be complicated by many factors inherent in military service. The environment where a patient may manifest suicidality may frequently not mirror any of the care settings already described and/or immediate accessibility to a mental health provider may be limited. In these instances the care provider must determine the need for an evacuation to a more distant location where appropriately trained providers, medical support, and the ability to more adequately control the environment are available. Additional differences include the inherent quality of the relationship of Service members to their commands, which does not exist in other care settings. A final distinct difference, particularly in deployments to combat zones and in certain training environments is the fact that Service members often have readily available access to either their own, or other Service members’ weapons.

One of the significant challenges in managing suicide risk in Military member is the “Clash of Cultures” between the military and the medical mindsets (Bryan 2012). Military members and leaders value ideals like mental and physical toughness in the face of adversity. The Warrior Ethos demands a sense of collectivism. That one is part of, and reliant

on the whole, while highly adaptive for military operational success, results in diminished focus on the individual. The individual focus of most suicide prevention efforts must be adapted to resonate with the belief that the group is only as strong as its members in a way that capitalizes on cohesion as a protective factor. Warriors also value self-reliance and self-sacrifice in service of the unit, the mission, and the Nation. In order to achieve the military objective, this selflessness is burnished with a fearlessness of death and significant denial about one's own mortality. Self-sacrifice and desensitization to death are important factors to understand in the management of service members at risk for suicide.

Military culture and the warrior ethos adopted stoicism as an ideal. This stoicism, while adaptive in combat, creates a significant barrier to the recognition of, and help seeking behaviors for, emotional issues (Sherman 2005). The effective management of suicide risk must take these important and adaptive qualities of military culture into consideration and adapt all communication and attitudes to resonate with the warrior ethos. The challenge is always how best to capitalize on the strengths of military culture while protecting against the potential for marginalization of a member who is at risk for suicide.

The following apply both to Active Duty Service members managed by DoD and to activated Reserve and National Guard members who may be receiving care from either the Veterans Administration Health Care System or from the DoD.

### RECOMMENDATIONS

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1. Providers must take reasonable steps to limit the disclosure of Protected Health Information (PHI) to the minimum necessary to accomplish the intended purpose.
2. Providers should involve command in the treatment plan of Service member at high acute risk for suicide to assist in the recovery and the reintegration of the patient to the unit. For SM at other risk levels, provider should evaluate the risk and benefit of involving command and follow service Department policies, procedures, and local regulations.
3. When performing a medical profile, the provider should discuss with command the medical recommendation and the impact on the SM's limitations to duty and fitness for continued service.
4. Provider should discuss with Service members the benefit of having command involved in their plan and assure them their rights to Protected Health Information with some exceptions regarding to the risk for suicide.
5. As required by pertinent military regulations, communicate to the Service member's chain of command regarding suicidal ideation along with any recommended restrictions to duty, health and welfare inspection, security clearance, deployment, and firearms access. Consider redeployment to home station any Service member deployed to a hazardous or isolated area.
6. Service members at high acute risk for suicide who meet criteria for hospitalization and require continuous (24-hours) direct supervision should be hospitalized in almost all instances. If not, the rationale should specifically state why this was not the preferred action with appropriate documentation.
7. During operational deployment conditions or other extreme situations during which hospitalization or evacuation is not possible, 'Unit watch' may be considered as appropriate in lieu of a high level care setting (hospitalization) and service Department policies, procedures, and local regulations should be followed.
8. Because of the high risk of suicide during the period of transition providers should pay particular attention to ensure follow-up, referral, and continuity of care during the transition of Service members at risk for suicide to a new duty station, after separation from unit, or separation from military service.

## MODULE C:

# TREATMENT OF THE PATIENT AT RISK FOR SUICIDE

The treatment plan for a patient at high risk for suicide should be based on the balance of potential benefits and harm of specific medical treatment as well as the potential benefits of psychotherapies and psychosocial interventions. After assessing evidence quality for suicide prevention distilled from surveillance of 16,500 English language post-2005 studies, with a final analysis of 35 relevant randomized controlled studies and 38 systematic reviews, the Working Group concluded, “there is a lack of strong evidence for any interventions in preventing suicide and suicide attempts”. The dearth of quality research available on effective suicide prevention practices is mainly due to the difficulty conducting randomized controlled trials (RCTs) in high risk for suicide population and the low base rates of suicide and suicide attempts, even in groups at higher risk for suicide.

In formulating recommendations in this guideline, the working group evaluated the empirical evidence-base, considering RCT as the highest level of the evidence-based hierarchy. Although therapy provided in clinical trial settings differs from therapy practiced in day-to-day care, the recommendations can only represent the techniques and protocols as they were studied and reported in RCTs.

The recommendations are based on the best available evidence in suicide prevention in the civilian context. Results of studies currently under way may be informative regarding the usefulness of interventions in the military and identify relative efficacy of different evidence-based strategies of risk reduction and potential differences in patient-based outcomes.

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## *Annotation H. Determine Treatment Plan*

Establish a treatment plan for patients at risk for suicide addressing the patient's potential (risk) for suicide, fostering the therapeutic alliance, and addressing mental health or medical disorders, and a range of available treatment alternatives from outpatient follow-up to hospitalization with constant observation and assurance of safety.

### **BACKGROUND**

Developing of a treatment plan for a patient with suicidal thoughts or behaviors should be based on the balance of potential benefits and harm of specific medical treatment as well as the potential benefits of psychosocial interventions, including specific psychotherapies. Many patients with suicidal thoughts, intent, or behaviors will benefit most from a combination of these treatments. Treatment should address the modifiable potentiating factors identified in the initial suicide assessment.

Treatment should be a collaborative process between the patient, clinical team and, if the patient consents, others such as family members, unit members/ command, community organizations or other resources available to the patient. The clinician should continue to make re-assessments of suicide risk during the course of treatment. In general, therapeutic approaches should target the suicide risk and the specific psychiatric conditions and associated symptoms such as depression, anxiety, aggression, pain, and sleep disturbance. Treatment goals of psychosocial interventions may be broader and longer term, including achieving improvements in interpersonal relationships, providing training in coping skills and addressing psychosocial functioning.

### **RECOMMENDATIONS**

1. Patients should receive optimal evidence-based treatment for any mental health and medical conditions that may be related to the risk of suicide. Patients diagnosed with a mental health and/or medical condition should receive evidence-based treatments for their underlying condition following Evidence-based Clinical Practice Guidelines:
  - a. Substance Use Disorders
  - b. Major Depressive Disorder
  - c. Psychosis (Schizophrenia)
  - d. Bipolar Disorder
  - e. Post-traumatic Stress Disorder
  - f. Traumatic Brain Injury
  - g. Chronic Pain
  - h. Medically Unexplained Symptoms
2. Care for the relevant condition-focused treatments may need to be modified to address the risk of suicide. For example, limiting the quantities of medications dispensed at any one time, enhancing social support, hospitalization and protection from harm, increasing the frequency of follow-up, increasing efforts to monitor and promote treatment adherence.
3. Treatment interventions that have been shown to be effective in reducing the risk for repeated self-directed violence or preventing suicide in patients with specific conditions need to be considered or optimized in those with these conditions who are at risk for suicide (e.g., lithium for patients with bipolar disorder, suicide-focused psychotherapy).
4. Family/unit members should be involved in the treatment plan when the patient consents. For Active Duty Service members the command should always be involved in the treatment plan of a high-risk suicidal patient.

## Annotation I. Psychotherapy

### BACKGROUND

Focal psychotherapies are effective for the treatment of a range of common psychiatric and behavioral problems. Most evidence-based psychotherapy interventions for prevention of suicide can be considered broadly as treatment designed to influence dysfunctional cognitions, emotions, and behaviors through a goal-oriented, systematic procedure. Much of the evidence base for reducing suicide risk has concerned cognitive-behavioral approaches. Cognitive-behavioral therapy (CBT) can be seen as an umbrella term that encompasses many different therapies sharing a conceptual foundation in behavior learning theory, cognitive theory, emotional processing theory, and interpersonal relationship theory approaches. The objective is typically to identify and monitor thoughts, assumptions, beliefs, and behaviors that are related and accompanied by debilitating, inaccurate and dysfunctional emotions. This is done in an effort to replace them with more realistic and useful ones. For the prevention of suicide, the primary goal of CBT is to teach suicidal patients that death is not the only option.

CBT includes a variety of approaches and therapeutic systems. The vast majority of interventions that have been evaluated in clinical trials involve a combination of the following core therapeutic components:

- Cognitive (irrational negative thoughts, core beliefs and cognitive distortions, problem solving deficits)
- Emotional (avoidance of unpleasant experiences that was activated prior to the suicide attempt)
- Behavioral (reduced activity, impulsive behavior)
- Interpersonal (poor communication and impaired social function)

Therapeutic techniques vary among cognitive and behavioral approaches according to the types of issues addressed. The interventions include various activities such as Socratic questioning, keeping a positive diary, positive self-verbalization, increasing tolerance of distress, mindfulness training, using existing coping skills, learning new coping skills, changing cognitions related to loss of control, skills training through modeling or role playing, removing obstacles to social support, and psychoeducation as an important component of all interventions. However, very few studies have dismantled these individual components to assess the relative efficacy of each one independently.

The treatment interventions for prevention of suicide have been packaged in various ways, and the majority of interventions included in the RCTs were grouped into four main categories based on the components most emphasized or the specific names used in the published literature: 1) Cognitive-Behavioral Therapy (CBT), 2) Problem Solving Therapy (PST), 3) Dialectical Behavior Therapy (DBT), and 4) Interpersonal therapy (IPT). All of these four categories include the components described above in different combinations.

**Cognitive-Behavioral Therapies (CBT)** emphasize the modification of core beliefs and schemas related to perception of self, the world, and the future. The approach involves changing problematic behaviors through cognitive restructuring (challenging automatic or acquired beliefs, such as beliefs about safety or trust) but also include relaxation techniques and discussion/narration of the potentiating factors (circumstances at the time of the episode, motives and reasons for self-harm).

Another form of behavioral therapy emphasizes skills-training interventions. This approach is premised on an assumption that dysfunctional behaviors stem from underlying skills deficits. Their goal is to decrease suicidal behaviors by increasing adaptive coping strategies such as distress tolerance, emotion regulation, and interpersonal skills. Another skill training intervention is **Problem Solving Therapy (PST)** that emphasizes the emotional and maladaptive ways that individuals react to stressful conditions when facing of significant problems. The goal of problem solving is to increase the person's understanding of the links between his/her current distress and his/her current problems, the ability to define his/her problems, and to teach specific strategies for problem solving. PST is based on the principle that the most adaptive response to significant problems is to engage in problem solving. However, in the face of significant problems, many individuals may be overwhelmed, and react in emotional and maladaptive ways that can lead to depression, other mental health conditions, or suicide.

Problem solving interventions are included in several studies as a pragmatic approach that involves patients learning and practicing problem solving as a coping skill. Safety planning is one example of a structured problem solving approach to help the patient cope with a crisis situation.

Several studies evaluated the effectiveness of skills training for reducing suicidal behavior in individuals with personality disturbance using manual-assisted cognitive therapy (MACT).

**Dialectical Behavior Therapy (DBT)** was initially developed by Linehan (1993) after having found that cognitive behavior therapy (CBT) is problematic for chronically suicidal individuals such as those suffering from personality disorders. DBT places more emphasis on managing the patient's multiple, severe problems, suicidal behavior, and extreme emotional sensitivity by providing structured, staged treatment and multiple sources of support for both patient and provider. DBT assumes that emotion dysregulation is the core disorder in Borderline Personality Disorder and a main causal pathway for suicide-related behaviors. Lack of adequate coping skills for dealing with emotional distress may lead to an attempt to escape through suicide. DBT also uses mindfulness techniques to increase self-awareness and strategies from other therapeutic approaches to help the individual move toward accepting that change is possible and to learn new coping skills necessary to begin to make such changes. Some trials have used self-learning reading material that follows the DBT approach.

**Interpersonal therapy (IPT)** focuses on impaired social functioning and addresses interpersonal difficulties that lead to psychological problems. The goal of this treatment is to provide new interpersonal learning experiences to overcome grief due to loss, interpersonal disputes, role transitions, and interpersonal skill deficits. IPT that is delivered in a group setting provides opportunities to resolve interpersonal conflicts by addressing the "here-and-now" interpersonal transactions. Relational information provided through the transactions in the group allows for a shift in the patient's self-schema.

**Psychodynamic therapies** have not been directly targeted at the problem of suicide. Recent trials have been conducted to evaluate specific forms of **psychodynamic therapy**, titled transference focused psychotherapy and schema-focused therapy as an integrative approach that combines aspects of CBT, experiential therapy, attachment theory, and psychodynamic theory. **Mentalization-Based Therapy (MBT)** is a psychodynamic approach that emphasizes the relational aspect of personality disturbance, with treatment strategies focusing on the attachment relationship and on restructuring the individual's self-image and understanding of others. According to MBT, borderline pathology, including suicidal behaviors, stems from a disorganized attachment system resulting in impaired relationships and emotional instability.

Although not targeted specifically to suicide or suicidal behaviors, other psychosocial treatments (e.g., treating alcohol and other substance use disorders that are themselves associated with increased rates of suicide and suicidal behaviors) may be helpful in reducing symptoms and improving functioning in individuals with psychiatric disorders. For patients at risk for suicide, specific psychosocial interventions such as intensive care plus outreach, brief psychological interventions and follow-up; or family, couples/group therapies may be useful despite limited evidence for their efficacy.

The following overarching principles should guide providers in selecting the appropriate type of evidence-based therapy for patients at risk for suicide:

- The benefits and risks of evidence-based psychotherapies for suicide prevention should be evaluated, discussed amongst providers, and documented in treatment planning for all patients who have survived a suicide attempt and others at high risk for suicide.
- The goal of therapy and the identification of the problem areas upon which therapy will focus should be based on the way the individual's prior experiences influences current cognitions, emotions, behavior and relations.
- The selection of individual specific therapy between effective evidence-based treatment options should be based on the patient's diagnosis and preference, the provider training and experience, comfort in pursuing the technique, and available resources in the care setting.

## **Annotation J.** *Suicide-Focused Psychotherapy Addressing the Suicide Risk*

### **BACKGROUND**

Specific forms of cognitive therapy have been shown to decrease the risk of suicide. A provider using the cognitive therapy model identifies the suicidal behavior as the primary problem rather than as a symptom of a psychiatric disorder. Similar to cognitive therapy protocols for other problems, the provider pursues evidence of cognitive distortions in a patient's core beliefs and schemas that fuel suicidal behavior. The provider can then address these

distortions by evaluating cognitive processes that will lead the patient to the conclusion that death is not the only solution.

Evidence-based cognitive therapy (CT) for suicide prevention can be utilized by providers to treat suicidal patients regardless of non-psychotic psychiatric diagnosis and can be used in conjunction with other forms of treatment that the suicidal patient is receiving.

There is some evidence that cognitive therapy and skills training can be used to address patient's problems associated with self-harm behaviors and suicidal thoughts regardless of the psychiatric disorder. Suicidal patients may have deficits in problem solving such that dying by suicide may be perceived as the only solution to their perceived life problem(s). While a range of theories and psychotherapies has been studied, some research supports structured, problem-solving approaches that specifically target and treat suicidal ideation and behavior (independent of diagnosis).

Providers should recognize the benefit of evidence-informed practices in teaching patients about effective problem solving. Problem solving training can be integrated into other CBT interventions, or offered as a stand-alone treatment.

#### RECOMMENDATIONS

1. Suicide-focused psychotherapies that have been shown to be effective in reducing risk for repeated self-directed violence should be included in the treatment plan of patients at high risk for suicide, if the risk for suicide is not adequately addressed by psychotherapy specific to the underlying condition. Psychotherapy may include:
  - a. Cognitive therapy (CT) for suicide prevention for non-psychotic patients who have survived a recent suicide attempt [B] and others at high risk. [I]
  - b. Problem-solving therapy (PST) that directly addresses the risk for suicide related behaviors for non-psychotic patients with more than one previous suicide attempt [B], and for other patients at high risk. [C]

#### *Annotation K. Psychotherapy for Co-occurring Mental Disorders Associated with Suicide Risk*

When the self-harming behavior or suicide risk is associated with a psychiatric illness then that illness needs to be identified and treated and the treatment plan needs to be modified to specifically address the risk of suicide.

#### BACKGROUND

Evidence supports the efficacy of psychotherapy in the treatment of specific psychiatric disorders associated with increased suicide risk. Treatment of the underlying disorders and psychiatric symptoms is important to support the prevention of suicide. If the self-directed violence behavior or suicide risk is attributable to a psychiatric illness then that illness needs to be identified and treated and treatment plan need to be modified to specifically address the risk of suicide.

#### *Annotation K1. Psychotherapy for Co-occurring Mental Disorders Associated with Suicide Risk*

#### RECOMMENDATIONS

1. There is inconsistent evidence regarding the efficacy of psychotherapy in reducing the risk for repetition of self-directed violence in patients with co-occurring disorders. Specific psychotherapies may be considered in the following contexts:

### *Annotation K2. Psychotherapy for Borderline Personality Disorder Associated with Suicide Risk*

2. Dialectical Behavioral Therapy (DBT) for patients with Borderline Personality Disorder (BPD) or other personality disorders characterized by emotional dysregulation and a history of suicide attempts and/or self-harm. [ I ]
3. Specific psychotherapies based on cognitive or behavioral approaches or skills training (i.e., CBT for Borderline Personality Disorder, MACT, Acceptance Based Emotion Regulation Group Intervention) for patients with BPD who are at high risk for suicide. [ I ]
4. Specific psychodynamic psychotherapies (i.e., MBT, brief psychodynamic interpersonal therapy) for patients with BPD who are a high risk for suicide. [ I ]

### *Annotation K3. Psychotherapy for Suicide in Schizophrenia Associated with Suicide Risk*

#### **RECOMMENDATIONS**

1. There is insufficient evidence to recommend for or against use of CBT to reduce the risk of suicide behavior in patients with schizophrenia [ I ]

### *Annotation K4. Treatment of High Risk for Suicide and Comorbid Substance Use Disorder (SUD)*

#### **BACKGROUND**

As documented throughout this guideline, substance use disorders are a prevalent and potent risk factor for suicide attempts and suicide. The recommendations for management and treatment made throughout this guideline generally apply to individuals with substance use disorders and should be followed.

#### **RECOMMENDATIONS**

1. Ongoing management of suicidal patients with SUD should include treatment by a licensed mental health practitioner.
2. In addition to suicidality-focused interventions, treatment should be provided for an underlying SUD condition (e.g., addiction). Ensure that management of suicide risk is coordinated or integrated with treatment for substance use disorder and comorbid conditions
3. Intervention strategies in patients in whom suicide risk is associated with using substances should emphasize safety, relapse prevention, and addressing the substance use.
4. In the effort to limit access to lethal means, pay special attention in this population to restriction of lethal means as firearms, and prescribed medication (dosage and quantities).

### *Annotation L. Pharmacotherapy to Reduce Risk of Suicide*

#### **RECOMMENDATIONS**

1. This Guideline recommends against the use of drug treatment as a specific intervention for prevention of self-directed violence in patients with no diagnosis of a mental disorder
2. When a person expresses thoughts of self-harm or has demonstrated self-harm behavior, the patient's medication regimen [prescription drugs, over-the-counter medications, and supplements (e.g., herbal remedies)] should be reviewed for medications associated with suicidal thoughts or behavior. The continuation of such medications should be carefully evaluated and documented. (See [Appendix B-3 Table: Drugs Associated with Suicidality](#))

**Annotation M.**      *Pharmacological Treatment to Reduce Risk for Suicide in Patients with Mental Disorders*

When self-harm behavior or suicide risk is attributable to a psychiatric illness, that illness needs to be identified and treated and the treatment plan modified when appropriate to specifically address the risk of suicide.

**RECOMMENDATIONS**

1. Pharmacological intervention may be markedly helpful in managing underlying mental disorders and the danger of repeated or more dangerous self-directed violence.
2. All medications (prescription drugs, over-the-counter medications, and supplements [e.g., herbal remedies]) used by patients at risk for suicide should be reviewed to assure effective and safe treatment without adverse drug interactions.
3. When prescribing drugs to people who self-harm, consider the toxicity of prescribed drugs in overdose and limit the quantity dispensed or available, and/or identify another person to be responsible for securing access to medications. The need for follow-up and monitoring for adverse events should also be considered.

**Annotation M1.**      *Use of Antidepressants to Prevent Suicide in a Patient with a Mood Disorder*

Closely monitor patients for changes in thoughts of suicide or suicidal behaviors after antidepressant treatment has been initiated or the medication dose is changed.

**RECOMMENDATIONS**

1. Antidepressants may provide benefit to address suicidal behavior in patients with mood disorders. Treatment for the underlying cause should be optimized according to evidence-based guidelines for the respective disorder.
2. Young adults (18-24) started on an antidepressant for treatment of depression or another psychiatric disorder should be monitored and observed closely for emergence or worsening of suicidal thoughts or behaviors during the initiation phase of treatment. [B]
3. Patients of all age groups who are managed with antidepressants should be monitored for emergence or worsening of suicidal thoughts or behaviors after any change in dosage.
4. When prescribing antidepressants for patients at risk for suicide, to pay attention to the risk of overdose and limit the amount of medication dispensed and refilled.

*See VA/DoD CPGs for Management of Major Depressive Disorder and Bipolar Disorder*

**Annotation M2.**      *Use of Antipsychotics to Prevent Suicide in a Patient with a Non-Psychotic Disorder*

Closely monitor patients for changes in thoughts of suicide or suicidal behaviors after an antipsychotic is added to treatment for a mood disorder.

**BACKGROUND**

Atypical antipsychotics may be used as treatment augmentation in the management of MDD and treatment of bipolar depressive disorders. Aripiprazole, quetiapine, and olanzapine in combination with fluoxetine include depressive

disorders in their label indications. Their labels also include the same box warning as antidepressants for an increased risk of suicidal thinking and behaviors. There is no evidence to support this increased risk in adults, albeit atypical antipsychotics have not been as extensively studied as antidepressants.

#### RECOMMENDATIONS

1. There is no evidence that antipsychotics provide additional benefit in reducing the risk of suicidal thinking or behavior in patients with co-occurring psychiatric disorders. Treatment for the psychiatric disorder should be optimized according to evidence-based guidelines for the respective disorder.
2. Patients who are treated with antipsychotics should be monitored for changes in behavior and emergence of suicidal thoughts during the initiation phase of treatment or after any change in dosage.
3. When prescribing antipsychotics in patients at risk for suicide pay attention to the risk of overdose and limit the amount of medication dispensed and refilled.

#### *Annotation M3. Use of Lithium for Reducing Suicide in Patients with Unipolar Depressive Disorder*

Providers should consider treating patients with a unipolar depression disorder with lithium in an effort to reduce the risk of suicide.

#### RECOMMENDATIONS

1. Lithium augmentation should be considered for patients diagnosed with unipolar depressive disorder who have had a partial response to an antidepressant and for those with recurrent episodes who are at high risk for suicidal behavior, provided they do not have a contraindication to lithium use and the potential benefits outweigh the risks. [C]
2. Lithium should be avoided or used in caution in patients with impaired renal function, those taking concurrent medications that increase or decrease lithium concentrations or those with other risk factors for lithium toxicity.
3. When prescribing lithium to patients at risk for suicide, it is important to pay attention to the risk of overdose by limiting the amount of lithium dispensed and the form in which it is provided.

#### *Annotation M4. Use of Lithium for Reducing Suicide in Patients with Bipolar Disorder*

Providers should consider treating patients with a bipolar disorder with lithium in an effort to reduce the risk of suicide.

#### RECOMMENDATIONS

1. Lithium should be considered for patients diagnosed with bipolar disorder who do not have contraindications to lithium as it has been shown to reduce the increased risk of suicide associated with this illness. [B]
2. Lithium should be avoided or used in caution in patients with impaired renal functions, taking concurrent medications that increase or decrease lithium concentrations or other risk factors for lithium toxicity.
3. When prescribing lithium to patients at risk for suicide, it is important to pay attention to the risk of overdose by limiting the amount of lithium dispensed, and to the form in which it is provided.

*See VA/DoD CPG for Management of Bipolar Disorder*

### *Annotation M5. Use of Clozapine in the Treatment of a Patient with Schizophrenia Risk for Suicide*

Providers should consider treating patients with schizophrenia with clozapine who have a history of suicide attempt, high risk for suicide, or who are symptomatic after two adequate trials with other antipsychotics.

#### **RECOMMENDATIONS**

1. Clozapine should be considered for patients diagnosed with schizophrenia at high risk for suicide, who do not have contraindications to clozapine, and will be compliant with all required monitoring. [C]

### *Annotation M6. Use Antiepileptic Drugs (AEDs) and the Risk of Suicide*

Closely monitor patients for changes in thoughts of suicide or suicidal behaviors after an antiepileptic drug is initiated for any indication.

#### **RECOMMENDATIONS**

1. Patients started or who are managed with antiepileptics should be monitored for changes in behavior and the emergence of suicidal thoughts.
2. There is no evidence that AEDs are effective in reducing the risk of suicide in patients with a mental disorder

### *Annotation M7. Use of Anti-Anxiety Agents in Suicidal Patients*

Anxiety is a significant and modifiable risk factor for suicide. The use of anti-anxiety agents may have the potential to decrease this risk.

#### **RECOMMENDATIONS**

1. Use caution when prescribing benzodiazepines to patients at risk for suicide. It is important to pay attention to the risk of disinhibition from the medication, and respiratory depression (particularly when combined with other depressants) by limiting the amount of benzodiazepines dispensed. Avoid benzodiazepines with a short half-life and the long-term use of any benzodiazepine to minimize the risk of addiction and depressogenic effects.

### *Annotation M8. Use of Methadone and Naloxone to Reduce Death from Opioid Overdose*

#### **RECOMMENDATIONS**

1. Methadone substitution therapy should be considered in opiate dependent patients to reduce the risk of death by overdose. (See [VA/DoD Guideline for Management of SUD](#))
2. Providers should consider dispensing intranasal naloxone for patients with history of opioid overdose and those who are at high risk. When dispensed, patient and family or other caregiver should be educated on the use of the intranasal naloxone to treat the overdose while waiting for the emergency team to arrive.

## Annotation N. *Electroconvulsive Therapy (ECT) in the Prevention of Suicide*

Consider ECT for rapid resolution of suicidal symptoms in patients with Major Depressive Disorder, Manic Episodes, Bipolar I Depression, PTSD, and Acute Schizophrenia.

### RECOMMENDATIONS

1. ECT is recommended as a treatment option for severe episodes of major depression that are accompanied by suicidal thoughts or behaviors indicating imminent risk for suicide, considering patient preferences.
2. Under certain clinical circumstances and, considering patient preference, ECT may also be considered to treat suicidal patients with schizophrenia, schizoaffective disorder, or mixed or manic episodes of bipolar disorder.
3. The decision of whether to initiate ECT treatment should follow evidence-based recommendation for the specific disorder, and be based on documented assessment of the risks and potential benefits to the individual, including: the risks associated with the anesthetic; current co-morbidities; anticipated adverse events; and the risks of not having treatment.
4. Since there is no evidence of a long-term reduction of suicide risk with ECT, continuation or maintenance treatment with pharmacotherapy or with ECT is recommended after an acute ECT course.
5. ECT should be performed by experts in centers that are properly equipped and experienced in the treatment.
6. In general, the following conditions increase the indications to use ECT:
  - a. A history of prior good response to ECT
  - b. Need for rapid, definitive treatment response
  - c. Risks of other treatments outweigh the risks of ECT
  - d. History of poor response to medication treatment
  - e. Intolerable side effects to medication treatments
  - f. Patient preference.
7. The risk-versus-benefits ratio must be considered in patients with relative contraindications such as [B]:
  - a. Space occupying lesions
  - b. Elevated intracranial pressure
  - c. Cardiovascular problems to include recent myocardial infarction, severe cardiac ischemic disease, or profound hypertensive illness.
  - d. Degenerative skeletal disease
  - e. Monamine Oxidase Inhibitors should be discontinued two weeks prior to ECT to prevent possible hypertensive crisis
  - f. Lithium: patients may develop neurotoxic syndrome with confusion, disorientation, and unresponsiveness
  - g. Retinal detachment
  - h. Pheochromocytoma
  - i. High Anesthesia Risk: American Society of Anesthesiologists level 4 or 5.

## MODULE D:

# FOLLOW-UP AND MONITORING OF PATIENT AT RISK FOR SUICIDE

Among patients with high suicide risk, particularly those who have attempted suicide, immediate follow-up and continuity of care are crucial to promoting positive outcomes. Patients leaving the ED or hospital inpatient unit after a suicide attempt, or otherwise at a high acute risk for suicide, require rapid, proactive follow-up. This Module focuses on the critical steps that should be followed in the immediate and long-term follow-up of patients at high acute risk for suicide. A previous suicide attempt is one of the most important risk factors for later death by suicide. This risk is particularly high in the weeks and months following the attempt, including the period after discharge from acute care settings such as EDs and inpatient psychiatric units.

A few studies support continued contact or outreach following a crisis, as recommended in this module. Studied programs proven successful sent caring letters following hospital discharge, provided patients an emergency card to facilitate easy access, or a suicide prevention counselor coordinated care following hospital discharge. However, a review of other studies found insufficient evidence to establish clinical effectiveness for psychosocial interventions as: case management, intensive inpatient and community care, or assertive approaches. Thus, most recommendations are based on consensus of practicing clinicians informed by the results of these studies. There is still a need for further research to identify specific aspects of these interventions, in particular the populations served by the Military Healthcare System and the VHA.

## ANNOTATIONS

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### *Annotation O. Follow-up and Monitoring*

Follow patients at risk of suicide regularly and reassess risk frequently, particularly when the patient's situation changes. Follow-up should commence in the immediate period after discharge from acute care settings. The 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 can be helpful even when telephone, letters, or brief intervention provides it.

## RECOMMENDATIONS

### Follow-Up

1. Establish timely and ongoing follow-up care for those who attempt suicide and others at high acute risk in the immediate period after discharge from acute care settings and identify the responsible provider during this period.

2. Patient should be re-evaluated following an inpatient or Emergency Department discharge, as soon as possible, but not later than 7 days.
3. High acute risk patient should be actively managed to assure adherence and coordinated care.
4. Patients at high acute risk should be followed closely (e.g., weekly for the first month) after they are identified or after inpatient or ED discharge.
5. Consider contacting the patient before initial follow-up appointment to monitor transition to the outpatient care plan and to reinforce adherence to the discharge plan.
6. The frequency of outpatient follow-up should be determined on a case-by-case basis. It should be greatest after attempts and related behaviors, after change in treatment, or after transitions to a less restrictive setting of care. Once the patient stabilizes and is engaged in care the frequency of follow-up can be decreased based on:
  - a. The current level of risk
  - b. The requirement of the treatment modality
  - c. The patient's preference

### **Duration of Care Focused on Suicide Prevention**

7. Patients who survived a suicide attempt or identified as high acute risk for suicide should be monitored for at least **one year**. Patients identified as intermediate acute risk for suicide (who have never engaged in suicidal behaviors) should be followed for at least **six months** after suicidal ideation has resolved. Patients who have been identified as low acute risk may be followed by their primary care provider and periodically re-assessed for suicide risk.

### **Annotation P. Reassessment and Monitoring**

1. Follow-up appointments should include:
  - a. Reassessment of: interim events, changes in suicide risk; symptoms of mental disorder; and medical conditions
  - b. Provision of specific treatment targeting suicidality
  - c. Continuation of treatment of co-occurring underlying conditions
  - d. Monitoring the symptoms of co-occurring conditions
  - e. Assessment of adherence and adverse effects
  - f. Modification of treatment, as indicated
  - g. Support, reinforcement, and update of the safety plan
  - h. Addressing patient/family concerns
  - i. Determination of the frequency of future follow-up

### **Annotation Q. Adherence to Treatment and Follow-up care Strategies**

Assess and address access-to-care obstacles may become barriers to follow-up and prove overwhelming for many patients at risk for suicide. Efforts to improve follow-up, continuity of care, and prevent repetition of self-harm should target higher-risk patients prone to disengagement and non-adherence.

### **RECOMMENDATIONS**

1. A follow-up care plan should be developed with input from the patient and, where appropriate, available support system (e.g., family, unit, friends), to address the treatment of conditions that may have contributed to the risk of suicide.
2. Follow-up care should be coordinated by an interdisciplinary team and communicated with the patient through a single identified point of contact.

3. Barriers to adherence to the care plan after discharge may be addressed by follow-up programs that include the use of:
  - a. Telecommunications (phone, web based, v-tel) [ I ]
  - b. Mailing multiple “caring letters” [ I ]
  - c. Community workers reaching out to those at high acute risk
  - d. Methods to enhance and facilitate access to care (“Green cards”) [ I ]
  - e. Home visits to support engagement [ I ]
  - f. A facility-based registry of all high acute risk patients [ I ]

### **Patient Who Refuse Care**

4. Patients who continue to be at risk for suicide and do not arrive to their follow-up appointment require a reassessment of risk, since not showing may demonstrate a risk behavior. The assessment should include: locating the patient and establishing contact, reassessment of level of risk, reinforcement of the safety plan, and directing the patient to the appropriate level of care.
5. If patient contact cannot be established, available data should be used to reassess the level of risk and corresponding effort should be made to locate the patient through direct contacts (e.g., next of kin), other points of available contacts (friends, peers, command), or, in cases of high acute risk, local emergency response (mobile crisis team, law enforcement).
6. Consider the use of caring letters for suicide attempters who refuse treatment. [ I ]
7. Home visit may be considered to support re-engagement of patients at high acute risk who discontinue outpatient care. [ C ]

### **Annotation R. Continuity of Care**

#### **BACKGROUND**

Continuity of care should be maintained when patients who are, or have been at risk for suicide, transition between care facilities, as to and from DoD and VA care facilities or between other health systems or provider organizations. Care for patients at risk for suicide must pay attention to several potential contexts where there are risks for discontinuities during transitions between care settings. These may include transitions from:

- Primary Care to Behavioral Health Specialty care;
- Emergency Departments to ambulatory services;
- Inpatient units to other setting (e.g., ambulatory services, nursing homes, rehabilitation in the community including domiciliary or other residential treatment settings as for PTSD);
- Nursing homes and residential care units to ambulatory services.

A multidisciplinary team approach to the treatment of suicidal patients maximizes providers’ ability to provide optimal management and services to their patients.

Mechanisms for bridging across transitions and for providing information to new providers must be developed on a system-by-system basis. Sustaining the treatment and safety plans is enhanced during transitions of care when provider-to-provider contact and a follow-on appointment with the receiving provider are established. Transition support services (as telephone contact with contracted behavioral health providers) may further enhance transition safety should there be a delay in follow-on services.

#### **RECOMMENDATIONS**

### **Annotation R1. Coordination and Collaboration of Care**

1. When patients are identified in primary care with intermediate or high acute risk for suicide they should be evaluated by behavioral health providers. Warm handoffs are helpful in ensuring that patients receive the evaluations they require without interruption.

2. All providers involved in the patient's care must actively attempt to connect with others in the suicidal patients' chain of healthcare (e.g., primary care) and with the patient's consent, helping services network (e.g., chaplains) to ensure timely communication, coordination of care, and aftercare.
3. As patients are recovering from crisis and reduce their risk for suicide they may also be transitioning to less restrictive care settings, as to routine care by primary clinicians. It is the responsibility of the healthcare team to update the patient's written Safety Plan over time.

### *Annotation R2. Documentation of Clinical Care*

4. Adequate clinical documentation of the care provided to suicidal patients is required for optimizing continuity of care. Providers must consider ethical, clinical, and legal issues when documenting their assessment, management and treatment of suicidal patients.

### *Annotation S. Monitoring after Recovery*

#### **BACKGROUND**

With effective treatment, illnesses and perpetuating factors can be alleviated, protective factors and coping strategies can be fortified, and the patient's suicidality can resolve to a state of clinical recovery whereby the acute risk has resolved. Nevertheless, the risk of relapse remains. Maintenance treatment with suicidality ("disease") surveillance is warranted to provide early detection of recurrence.

Routine screening of adults in a primary care population for suicidal ideation has not been proven to be of benefit. The US Preventive Services Task Force (USPSTF) concluded that there is insufficient evidence to recommend for or against routine screening. However, in the patient who has a history of suicidal intent or behavior, and especially in the patient who has a diagnosis of a mental disorder, future monitoring and periodically re-assessing the risk for suicide may be justified.

#### **RECOMMENDATIONS**

1. Patients with a history of suicide attempt or behavior should continue to be evaluated for risk of relapse on a regular basis.



## APPENDICES

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*Full guideline can be accessed at <http://www.healthquality.gov/>*

## APPENDIX B-2: SUMMARY OF FACTORS ASSOCIATED WITH DOD SUICIDES\*

(2009 through 2011)

Source:

DoD Suicide Event Report (DoDSER) Calendar Year 2011

Access at: <https://t2health.org/programs/dodser>

\* Listed factors occurring in > 5% of suicides as averaged over 3 years

\*\* CY 2011 Rate: number of suicides per 100,000 persons per year

*Italicized factors are of high interest but occurred in < 5% of suicides*

*Intra-category factors ranked-ordered by prevalence percentage*

	%	Rate**
<b>GENDER</b>		
Male	(96%)	20.05
<b>RACE</b>		
White/Caucasian	(79%)	19.69
Black/African American	(12%)	13.41
Asian or Pacific Islander	(5%)	
<b>AGE RANGE</b>		
<25	(44%)	19.30
25-29	(26%)	22.79
30-34	(12%)	12.52
35-39	(11%)	18.76
40-44	(6%)	16.21
<b>RANK</b>		
E1-E4	(53%)	21.14
E5-E9	(40%)	19.02
Officer	(7%)	9.72
<b>COMPONENT</b>		
Regular	(91%)	18.03
National Guard	(6%)	16.15
<b>EDUCATION</b>		
High School Grad	(67%)	18.79
GED	(11%)	42.51
<b>MARITAL STATUS</b>		
Married	(52%)	17.85
Never Married	(37%)	16.53
Divorced	(9%)	27.65
<b>SUICIDE EVENT LOCATION</b>		
United States	(81%)	
Iraq	(6%)	
Afghanistan	(5%)	
<b>SUICIDE EVENT SETTING</b>		
Residence	(58%)	
Residence of friend or family	(9%)	
Work/Job site	(7%)	
Auto (away from residence)	(5%)	
<b>EVENT METHOD</b>		
Firearm, non-military issue	(46%)	
Hanging	(23%)	
Firearm, military issue	(14%)	
<b>SUBSTANCE ABUSE DURING THE EVENT</b>		
Alcohol Used	(21%)	
Any Drugs Used	(8%)	
<b>COMMUNICATED INTENT</b>		
No known communication	(71%)	
Verbal mode of communicated intent	(18%)	
Communicated intent to spouse	(10%)	
Communicated to other or unidentified	(7%)	
Multiple communications of intent	(7%)	
Communicated intent to friend	(5%)	
<b>HISTORY</b>		
Firearm in Immediate Living Environment	(50%)	
Hx of OIF Deployment	(29%)	
Known Prior Self-Injury	(15%)	
Hx of Direct Combat	(14%)	
Hx of OEF Deployment	(10%)	

	%	%
<b>TREATMENT HISTORY</b>		
Seen at Military Treatment Facility		(59%)
Within 90 days of suicide	(47%)	
Within 30 days of suicide	(36%)	
Outpatient Behavioral Health Care		(40%)
Within 90 days of suicide	(26%)	
Within 30 days of suicide	(20%)	
Used Substance Abuse Services		(18%)
Within 90 days of suicide	(9%)	
Within 30 days of suicide	(7%)	
Inpatient Behavioral Health		(14%)
Within 90 days of suicide	(6%)	
Used Chaplain Services		(10%)
Within 90 days of suicide	(8%)	
Within 30 days of suicide	(7%)	
In Family Advocacy Program		(8%)
<b>BIOLOGICAL FACTORS</b>		
Physical Health Problem		(20%)
Within 30 days of suicide	(11%)	
Within 90 days of suicide	(14%)	
<b>PSYCHOLOGICAL FACTORS</b>		
Psychotropic Med Use		(25%)
Hx Substance Abuse		(24%)
Mood D/O		(21%)
1 Behavioral Health Diagnosis		(21%)
Anxiety D/O		(16%)
2 Behavioral Health Diagnoses		(13%)
3 Behavioral Health Diagnoses		(6%)
Psychotic & Personality D/O's & TBI		(each < 5%)
<b>SOCIAL FACTORS</b>		
Failed Intimate Relationship		(49%)
Failed Other Relationship		(12%)
Hx of Family Behavioral Health Problem		(12%)
Hx as Perpetrator of Physical Abuse		(8%)
Hx of Death of Family Member		(7%)
Hx as Victim of Physical Abuse		(6%)
Hx as Victim of Emotional Abuse		(6%)
Hx of Family Member Suicide		(5%)
Unknown		(35%)
<b>ADMIN &amp; LEGAL HISTORY</b>		
Any Admin/Legal Issue		(40%)
Hx Article 15 or Non-Judicial Punishment		(19%)
Multiple Admin/Legal Issues		(17%)
Hx of Civil Legal Problems		(13%)
Hx of Administrative Separation		(8%)
Hx of AWOL		(8%)
Hx Non-Selection for Promotion		(7%)
Hx of Medical Board		(6%)
Hx of Courts Martial		(5%)
<b>FINANCIAL/WORKPLACE DIFFICULTIES</b>		
Hx Job Loss/Instability		(22%)
Hx of Poor Work Evaluation		(16%)
Hx Supervisor/Coworker Issues		(12%)
Excessive Debt/Bankruptcy		(10%)

## APPENDIX B-3: DRUGS ASSOCIATED WITH SUICIDALITY

Drug	FDA Label Summary
Antidepressants	See Module C: <a href="#">Annotation M1</a>
Antiepileptics	See Module C: <a href="#">Annotation M6</a>
Antipsychotics	All have label warning that the possibility of a suicide attempt is inherent in psychotic illness or bipolar disorder; use with caution in high-risk patients during initiation of therapy.  Antipsychotics with label indications for depressive disorders the the identical box warning as antidepressants.
Acamprosate	Attempted and completed suicides have occurred in acamprosate-treated patients; use with caution in suicidal ideation. In controlled clinical trials of acamprosate, adverse events of a suicidal nature (suicidal ideation, suicide attempts, completed suicides) were infrequent overall, but were more common in acamprosate-treated patients than in patients treated with placebo (1.4% vs. 0.5% in acamprosate studies of 6 months or less; 2.4% vs. 0.8% in year-long studies). Completed suicides occurred in 3 of 2272 (0.13%) patients in the pooled acamprosate group from all controlled studies and 2 of 1962 patients (0.10%) in the placebo group. Adverse events coded as “depression” were reported at similar rates in acamprosate-treated and placebo-treated patients. Although many of these events occurred in the context of alcohol relapse, and the interrelationship between alcohol dependence, depression and suicidality is well-recognized and complex, no consistent pattern of relationship between the clinical course of recovery from alcoholism and the emergence of suicidality was identified. Alcohol-dependent patients, including those patients being treated with acamprosate, should be monitored for the development of symptoms of depression or suicidal thinking. Families and caregivers of patients being treated with acamprosate should be alerted to the need to monitor patients for the emergence of symptoms of depression or suicidality, and to report such symptoms to the patient’s health care provider.
Belimumab	Deaths due to suicide were higher in belimumab patients compared to placebo during clinical trials. New onset or worsening of existing depression, and suicide, has been reported; most patients had a history of a psychiatric disorder and were already receiving treatment. Monitor for new or worsening depression, suicidal ideation or other mood changes.
Efavirenz	Serious psychiatric side effects have been associated with use, including severe depression, suicide, paranoia, and mania; use with caution in patients with a history of mental illness/drug abuse (predisposition to psychological reactions).
Emtricitabine, Rilpivirine, and Tenofovir	May cause depression, depressed mood, dysphoria, mood changes, negative thoughts, suicide attempts, or suicidal ideation; if symptoms are noted, patients should be advised to seek professional intervention immediately; reevaluate risk versus benefit of continued combination therapy.
Interferon Alfacon-1 Peginterferon Alfa-2a Peginterferon Alfa-2b	U.S. Boxed Warning: May cause severe psychiatric adverse events (eg, depression, psychosis, mania, suicidal behavior/ideation) in patients with and without previous psychiatric symptoms; use with extreme caution in patients with a history of depression. Careful neuropsychiatric monitoring is required during therapy. Patients developing severe depression may require discontinuation of treatment. Although dose reduction or discontinuation may resolve symptoms, depression may persist; suicides have been reported after therapy with alfa interferons has been discontinued. Use with caution in patients with seizure disorders, brain metastases, or compromised CNS function.

Drug	FDA Label Summary
Lithium	See Module C: <a href="#">Annotation M4</a>
Metoclopramide	Mental depression has occurred, symptoms range from mild to severe (suicidal ideation and suicide); use with caution in patients with a history of mental illness.
Milnacipran	Same U.S. Boxed Warning as antidepressants
Rilpivirine	May cause depression, depressed mood, dysphoria, mood changes, negative thoughts, suicide attempts, or suicidal ideation; if changes are noted, seek professional intervention immediately; reevaluate risk versus benefit of continued rilpivirine therapy.
Sodium Oxybate	May cause confusion, psychosis, paranoia, hallucinations, agitation, depression and sleepwalking; use caution with history of depression or suicide attempt.
Tramadol	Avoid use in patients who are suicidal; use with caution in patients taking tranquilizers and/or antidepressants, or those with an emotional disturbance including depression
Varenicline	U.S. Boxed Warning: Serious neuropsychiatric events (including depression, suicidal thoughts, and suicide) have been reported with use; some cases may have been complicated by symptoms of nicotine withdrawal following smoking cessation. Smoking cessation (with or without treatment) is associated with nicotine withdrawal symptoms and the exacerbation of underlying psychiatric illness; however, some of the behavioral disturbances were reported in treated patients who continued to smoke. Neuropsychiatric symptoms (eg, mood disturbances, psychosis, hostility) have occurred in patients with and without pre-existing psychiatric disease; many cases resolved following therapy discontinuation although in some cases, symptoms persisted. Monitor all patients for behavioral changes and psychiatric symptoms (eg, agitation, depression, suicidal behavior, suicidal ideation); inform patients to discontinue treatment and contact their healthcare provider immediately if they experience any behavioral and/or mood changes.
Ziconotide	U.S. Boxed Warning: Severe psychiatric symptoms and neurological impairment have been reported; interrupt or discontinue therapy if cognitive impairment, hallucinations, mood changes, or changes in consciousness occur. May cause or worsen depression and/or risk of suicide.
Zolpidem	Use with caution in patients with depression; worsening of depression, including suicide or suicidal ideation has been reported with the use of hypnotics. Intentional overdose may be an issue in this population. The minimum dose that will effectively treat the individual patient should be used. Prescriptions should be written for the smallest quantity consistent with good patient care.

## APPENDIX C: SPECIAL POPULATION – OLDER ADULTS

### BACKGROUND

Older adults are the fastest growing segment of the U.S. population. VHA defines older adult as being 65 years of age or older. According to a recent report, *Older Americans 2010*, published by the Federal Interagency Forum on Aging-Related Statistics, adults 65 years and older made up 13 percent of the total population in 2008, and the older adult population will grow to almost 20 percent of the population as we approach 2030. A high proportion of Veterans are older adults, and the vast majority of whom are men. Census 2000 found that there were 9.7 million Veterans aged 65 years and older in the U.S. and Puerto Rico. In fact, two of three men age 65 and older were Veterans (U.S. Census Bureau, 2010).

Older adult men have a higher rate of suicide than other segments of the population. This fact, plus other characteristics of suicidal behavior that distinguish older adults from younger and middle aged people, pose special challenges for the VA. In this annotation, we examine issues in each topic area for which special consideration should be given to older adults.

### KEY POINTS

#### Risk Factors

- Among elderly men, rates of suicide increase with aging. No one can be considered past the age of risk.
- Among the mental health conditions, depression may be a more specific risk factor in late life. The risk associated with depression appears to extend beyond major depression to include other types of clinically significant depression.
- Other sources of risk can include social isolation, accumulating disabilities, concerns about being a burden to others, and the lack of a sense of meaning in life
- Substance use may be less common. However, alcohol use as a risk factor remains important.
  - Older individuals are more sensitive to the effects of alcohol as a result of age-related changes in both the liver and the brain
  - Misuse of prescribed medications may be important as a risk factor for suicide
- Although individuals with severe dementia may be at decreased risk for suicide, there is need to include evaluations for depression and the risk of suicide when older patients complain about memory loss, when mild cognitive impairment is recognized, when dementia is diagnosed, and when disability increases.
- A past history of suicide attempts is less common than at younger ages, but when present represents substantially elevated risk for death by suicide.
- Medical illness is associated with increased risk for suicide as well, but high base rates of illness in later life make its utility as a signal.
- Older adults are, in general, receiving multiple medications for multiple conditions. Provider should review and reconcile medications on a regular basis to identify potential drug-drug and drug-disease interactions that may contribute to the risk for suicide, and to identify and ensure safe management of medications that may be dangerous in overdose.
- Functional impairment and pain are other common factors in older adults that are associated with increased risk for suicide. When disability leads to a loss of autonomy and an increased dependence on others, the risks may be increased.
- Social isolation, loss, and bereavement are common risk factors
  - Part of the care of older Veterans must include evaluations of their support systems and recognition that suicide risk may be increased when care needs are not being met.

## ASSESSMENT AND TREATMENT PLANNING

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- Suicide risk is more difficult to assess in older adults than younger people, requiring greater vigilance by providers.
  - Older adults are less likely to report depressive symptoms and suicidal ideation
  - Because older individuals may be less likely to complain of depression and express suicidal ideation, information from family-members and friends can be useful in identifying individuals at risk for suicide.
  - A smaller proportion of older adults who take their own lives have a past history of suicide attempts
  - Older adults are less likely to seek care from a mental health provider, but more likely to see a primary care provider
  - It may be difficult to evaluate the significance of thoughts about death in older people; they may reflect a normal developmental processes or a signal about increased risk for suicide. Thoughts of death may be adaptive and appropriate to the life-stage, and may not be indicators of the risk of suicide. Conversely, plans or intent must always be viewed as clinically significant.
  - The association of suicide with depressive disorders is stronger in older adults than younger people.
    - Systematic screening for depression should be conducted with older adult patients in primary care. When the screening leads to positive findings, they should be followed with an evaluation of the risk for suicide
    - Depression should be treated aggressively, whether or not suicide ideation or other risk factors are present.
  - The risk of suicide following a suicide attempt is greater in older adults than younger people. An older person who attempts suicide should always be referred for specialty mental health care.
  - Non-fatal suicide attempts are uncommon in the elderly. Therefore, any attempts must be viewed as indicators of serious risk. Conversely, observations of indirect life-threatening behavior, including non-adherence with medical symptoms, motor vehicle accidents, and what may appear to be accidental overdoses, should prompt evaluation for depression, and for suicide plans and intent.

## MANAGEMENT AND TREATMENT

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- Recognizing and treating late life depression must be viewed as an important component of suicide prevention in late life.
  - Interventions for depression in late life should not be limited to pharmacological treatment. The full spectrum of array of psychotherapeutic, psychosocial, and somatic treatments should be used when appropriate.
  - Symptoms of depression, death ideation, and suicidal ideation may be manifestations of physical illness, indicating the need for comprehensive medical evaluations.
  - Stepped, collaborative care models have been shown effective in reducing suicide risk in older adults with depression.
  - Multi-modal interventions that combine psychological, pharmacological, and social/environmental components are an important approach.
  - Engaging family members and friends as partners in care is important, both as sources of information and as resources for alleviating isolation.
- Clinicians should encourage older Veterans to be as actively engaged in their treatment planning, management, and care processes as possible, helping them to identify and capitalize on existing strengths and coping mechanisms.
- Interventions that serve to increase social connections and engagement in communities should be emphasized in the care of older adults at risk. It may be useful to engage in problem-solving about how to maintain connections and engagement in spite of disability
- Antidepressants should be considered for older adults with depression, with or without overt suicide risk. Recent concerns about the risk of suicide with antidepressant medications in adolescents and young adults are not relevant to the elderly.

- Providers should consider psychotherapy for treatment of depression in older adult patients at risk for suicide. Interpersonal therapy may have advantages over other approaches. Problem solving therapy and cognitive behavior therapy may also be beneficial

#### **SAFETY PLANNING**

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- Older men who take their own lives are more likely than younger ones to utilize firearms. It is especially important to determine if an older adult at risk has access to a firearm and, if present, to arrange for safe storage. This is true, even if the patient denies intent to use a firearm to end his or her life. The safe storage of firearms remains an important component of safety planning in the elderly.

#### **FOLLOW-UP/CONTINUITY**

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- Because multiple, interacting conditions are common in late life, communication and coordination between all providers is important.
- It is important to recognize that most older Veterans are Medicare eligible, and that they may receive services from community providers as well as VA
- Continuity of care across care settings is important in late life
- In additions to the transitions that are important throughout the lifespan, it is important to recognize and intervene to minimize risks for older Veterans entering or being discharged from Community Living Centers or nursing homes, and from rehabilitation services.

## APPENDIX D: ACRONYM LIST

AHCPR	Agency for Healthcare Policy and Research	MDD	Major Depressive Disorder
APA	American Psychiatric Association	MH	Mental Health
AUDIT	Alcohol Use Disorders Identification Test	MIRECC	Mental Illness Research Education and Clinical Center
BDI-II	Beck Depression Inventory II	MMSE	Mini-Mental State Examination
BHS	Beck Hopelessness Scale	OEF	Operation Enduring Freedom
BPD	Borderline Personality Disorder	OIF	Operation Iraqi Freedom
C-CASA	Columbia Classification Algorithm of Suicide Assessment	OTC	Over-the-counter
C-SSRS	Columbia Suicide Severity Rating Scale	PCL	Posttraumatic Stress Disorder Checklist
CAMS	Collaborative Assessment and Management of Suicidality	PCP	Primary Care Provider
CBT	Cognitive Behavioral Therapy	PE	Physical examination
CDC	Center for Disease Control and Prevention	PST	Problem Solving Therapy
CDR	Commander	PTSD	Posttraumatic stress disorder
CI	Confidence interval	QE	Quality of evidence
CT	Cognitive Therapy	RCT	Randomized controlled trial
DBT	Dialectical Behavioral Therapy	SAFEVET	Safety Planning Intervention for Veterans
DCoE	Defense Centers of Excellence	SAMHSA	Substance Abuse and Mental Health Services Administration
DoD	Department of Defense	SDV	Self-Directed Violence
DoDSER	Department of Defense Suicide Event Reports	SM	Service member
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders (4th ed.)	SPRC	Suicide Prevention Resource Center
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders	SR	Strength of Recommendation
dx	Diagnosis	SSI	Scale for Suicide Ideation
EBM	Evidence-based medicine	SSRIs	Selective Serotonin Reuptake Inhibitors
ECT	Electroconvulsive therapy	SUD	Substance Use Disorder
ED	Emergency Department	TAU	Treatment as Usual
EtoH	Ethanol	TBI	Traumatic Brain Injury
FDA	U. S. Food and Drug Administration	TCAs	Tricyclic Antidepressants
IPT	Interpersonal Therapy	Tx or RX	Treatment
ITT	Intention to Treat	USPSTF	U.S. Preventive Service Task Force
LGB	Lesbian, Gay, Bisexual	VA	Veterans Affairs
MAOIs	Monoamine oxidase inhibitors	VAMC	Veterans Affairs Medical Center
MBT	Mentalization Based Therapy	Vets	Veterans
		VHA	Veterans Health Administration







<http://www.healthquality.va.gov>  
<https://www.qmoamedd.army.mil>