VA/DoD Clinical Practice Guidelines

THE ASSESSMENT AND MANAGEMENT OF PATIENTS AT RISK FOR SUICIDE

Provider Summary

Version 2.0 | 2019

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

Department of Veterans Affairs

Department of Defense

Provider Summary

QUALIFYING STATEMENTS

The Department of Veterans Affairs and the Department of Defense 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.

This Clinical Practice Guideline is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

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

These guidelines are not intended to represent Department of Veterans Affairs or TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage of civilian sector care. Additional information on current TRICARE benefits may be found at www.tricare.mil or by contacting your regional TRICARE Managed Care Support Contractor.

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Introduction

The Department of Veterans Affairs (VA) and Department of Defense (DoD) Evidence-Based Practice Work Group (EBPWG) was established and first chartered in 2004, with a mission to advise the "…Health Executive Council on the use of clinical and epidemiological evidence to improve the health of the population across the Veterans Health Administration (VHA) and Military Health System (MHS)," by facilitating the development of clinical practice guidelines (CPGs) for the VA and DoD populations.[1] This CPG is intended to provide healthcare providers with a framework by which to evaluate, treat, and manage the individual needs and preferences of patients at risk for suicide, thereby leading to improved clinical outcomes. In 2013, the VA and DoD published a CPG for the Assessment and Management of Patients at Risk for Suicide (2013 Suicide Risk CPG), which was based on evidence reviewed through November 2011. Since the release of that guideline, a growing body of research has expanded the general knowledge and understanding of suicide risk. Improved recognition of the complex nature of suicide and suicide-related behaviors has led to the adoption of new strategies to manage and treat patients at risk. Consequently, a recommendation to update the 2013 Suicide Risk CPG was initiated in 2018. The updated CPG includes objective, evidence-based information on the assessment and management of suicide risk. It is intended to assist healthcare providers in all aspects of patient care, including, but not limited to, screening, assessment, and management. The system-wide goal of evidence-based guidelines is to improve the patient's health and well-being by guiding health providers who are caring for patients at risk for suicide along management pathways that are supported by evidence. The expected outcome of successful implementation of this guideline is to:

- Assess the patient's condition and determine, in collaboration with the patient, the best treatment method
- Optimize each individual's health outcomes and improve quality of life
- Minimize preventable complications and morbidity
- Emphasize the use of patient-centered care (PCC)

Throughout the CPG, efforts were made to adhere to the nomenclature adopted by VA, the Self-Directed Violence Classification System (SDVCS),[1] a taxonomy of terms and associated definitions for thoughts and behaviors related to suicidal and non-suicidal self-directed violence (SDV).[2,3] Terms and associated definitions are also presented in Appendix B of the full CPG. Whereas the outcome of interest for some of the evidence presented in this CPG was focused specifically on suicide, additional evidence pertaining to work focused on self-directed violence (e.g., nonsuicidal self-directed violent behaviors – suicide attempts, preparatory behaviors) more generally was also used.

Recommendations

The following recommendations were made using a systematic approach considering four domains as per the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach as detailed in the section on Methods and Appendix C in the full text Suicide Risk CPG. These domains include: confidence in the quality of the evidence, balance of desirable and undesirable outcomes (i.e., benefits and

[1] For more information regarding the SDVCS see: https://www.mirecc.va.gov/visn19/education/nomenclature.asp.

harms), patient or provider values and preferences, and other implications, as appropriate (e.g., resource use, equity, acceptability).

Topic	Sub-topic	#	Recommendation	Strength*	Category†
Screening and Evaluation	*a. Screening*	1.	With regard to universal screening, we suggest the use of a validated screening tool to identify individuals at risk for suicide-related behavior.	Weak for	Reviewed, New-added
		2.	With regard to selecting a universal screening tool, we suggest the use of the Patient Health Questionnaire-9 item 9, to identify suicide risk.	Weak for	Reviewed, New-added
	b. Evaluation	3.	We recommend an assessment of risk factors as part of a comprehensive evaluation of suicide risk, including but not limited to: current suicidal ideation, prior suicide attempt(s), current psychiatric conditions (e.g., mood disorders, substance use disorders) or symptoms (e.g., hopelessness, insomnia, and agitation), prior psychiatric hospitalization, recent bio-psychosocial stressors, and the availability of firearms.	Strong for	Reviewed, New-replaced
		4.	When evaluating suicide risk, we suggest against the use of a single instrument or method (e.g., structured clinical interview, self-report measures, or predictive analytic models).	Weak against	Reviewed, Amended
		5.	While it is an expected standard of care, there is insufficient evidence to recommend for or against the use of risk stratification to determine the level of suicide risk.	Neither for nor against	Reviewed, New-replaced
Risk Management and Treatment	*a. Non-pharmacologic Treatments*	6.	We recommend using cognitive behavioral therapy-based interventions focused on suicide prevention for patients with a recent history of self-directed violence to reduce incidents of future self-directed violence.	Strong for	Reviewed, New-added
		7.	We suggest offering Dialectical Behavioral Therapy to individuals with borderline personality disorder and recent self-directed violence.	Weak for	Reviewed, New-replaced
		8.	We suggest completing a crisis response plan for individuals with suicidal ideation and/or a lifetime history of suicide attempts.	Weak for	Reviewed, New-replaced
		9.	We suggest offering problem-solving based psychotherapies to: a. Patients with a history of more than one incident of self-directed violence to reduce repeat incidents of such behaviors b. Patients with a history of recent self-directed violence to reduce suicidal ideation c. Patients with hopelessness and a history of moderate to severe traumatic brain injury	Weak for	Reviewed, New-replaced
	b. Pharmacologic Treatments	10.	In patients with the presence of suicidal ideation and major depressive disorder, we suggest offering ketamine infusion as an adjunctive treatment for short-term reduction in suicidal ideation.	Weak for	Reviewed, New-added
		11.	We suggest offering lithium alone (among patients with bipolar disorder) or in combination with another psychotropic agent (among patients with unipolar depression or bipolar disorder) to decrease the risk of death by suicide in patients with mood disorders.	Weak for	Reviewed, New-replaced

Topic	Sub-topic	#	Recommendation	Strength*	Category†
Risk Management and Treatment (cont.)	*b. Pharmacologic Treatments*	12.	We suggest offering clozapine to decrease the risk of death by suicide in patients with schizophrenia or schizoaffective disorder and either suicidal ideation or a history of suicide attempt(s).	Weak for	Reviewed, Amended
	c. Post-acute Care	13.	We suggest sending periodic caring communications (e.g., postcards) for 12-24 months in addition to usual care after psychiatric hospitalization for suicidal ideation or a suicide attempt.	Weak for	Reviewed, New-replaced
		14.	We suggest offering a home visit to support reengagement in outpatient care among patients not presenting for outpatient care following hospitalization for a suicide attempt.	Weak for	Reviewed, Amended
		15.	We suggest offering the World Health Organization Brief Intervention and Contact treatment modality following presentation to the emergency department for suicide attempt, in addition to standard care.	Weak for	Reviewed, New-added
	d. Technology-based Modalities	16.	There is insufficient evidence to recommend for or against technology-based behavioral health treatment modalities for individuals with suicidal ideation. These include self-directed digital delivery of treatment protocols with minimal or no provider interaction (e.g., compact disc, web-based), and provider-delivered virtual treatment.	Neither for nor against	Reviewed, New-replaced
		17.	There is insufficient evidence to recommend for or against the use of technology-based adjuncts (e.g., web or telephone applications) to routine suicide prevention treatment for individuals with suicidal ideation.	Neither for nor against	Reviewed, New-replaced
Other Management Modalities	*a. Population & Community-based Interventions*	18.	We suggest reducing access to lethal means to decrease suicide rates at the population level.	Weak for	Reviewed, New-added
		19.	There is insufficient evidence to recommend for or against community-based interventions targeting patients at risk for suicide.	Neither for nor against	Reviewed, New-added
		20.	There is insufficient evidence to recommend for or against community-based interventions to reduce population-level suicide rates.	Neither for nor against	Reviewed, New-added
		21.	There is insufficient evidence to recommend for or against gatekeeper training alone to reduce population-level suicide rates.	Neither for nor against	Reviewed, New-added
		22.	There is insufficient evidence to recommend for or against buddy support programs to prevent suicide, suicide attempts, or suicidal ideation.	Neither for nor against	Reviewed, New-added

*For additional information, please refer to the section on Grading Recommendations in the full text Suicide Risk CPG.

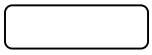
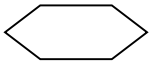
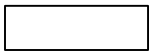
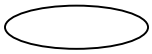
†For additional information, please refer to the section on Recommendation Categorization and Appendix C in the full text Suicide Risk CPG.

Algorithm

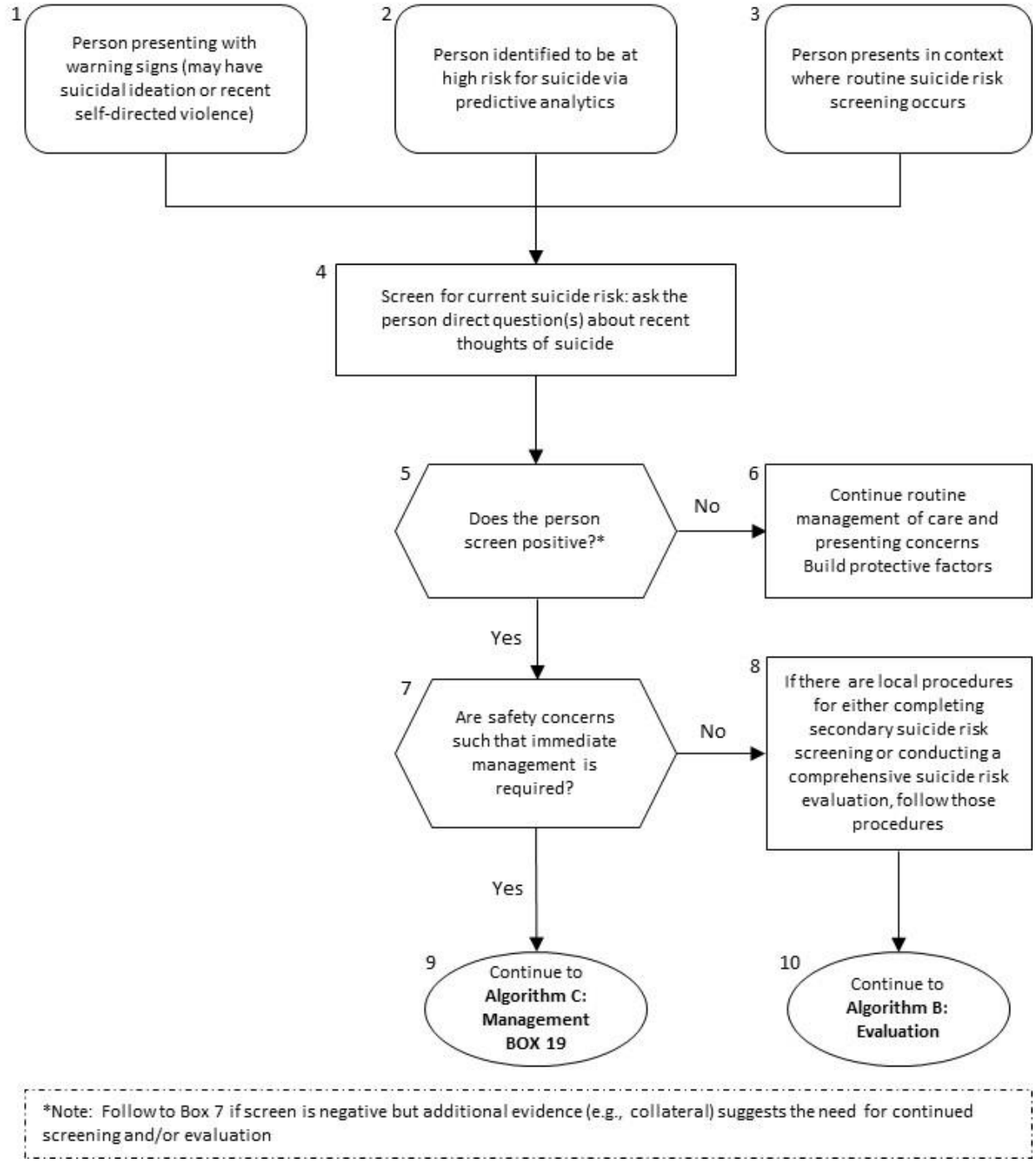
This CPG includes an algorithm that is designed to facilitate understanding of the clinical pathways and decision-making processes used in managing patients at risk for suicide. The use of the algorithm format as a way to represent patient management was chosen based on the understanding that such a format may promote more efficient diagnostic and therapeutic decision making; it also has potential to change patterns of resource use. Although the Work Group recognizes that not all clinical practices are linear, the simplified linear approach depicted through the algorithm and its format allows the provider to assess the critical information needed at the major decision points in the clinical process. It includes:

- An ordered sequence of steps of care
- Recommended observations and examinations
- Decisions to be considered
- Actions to be taken

For each guideline, the corresponding clinical algorithm is depicted by a step-by-step decision tree. 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.[4]

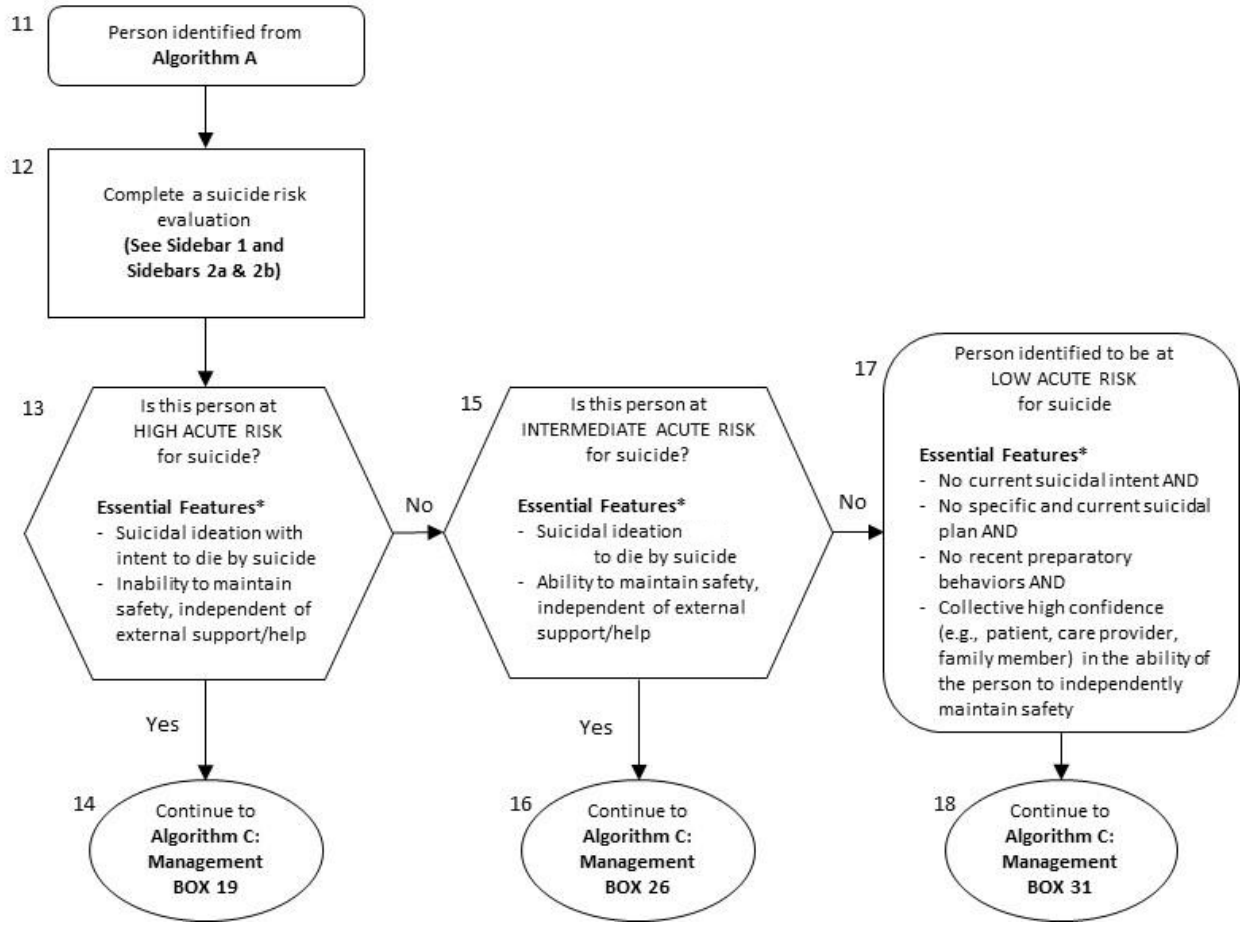
Shape	Description
	Rounded rectangles represent a clinical state or condition
	Hexagons represent a decision point in the guideline, formulated as a question that can be answered Yes or No
	Rectangles represent an action in the process of care
	Ovals represent a link to another section within the guideline.

Algorithm A: Identification of Risk for Suicide



*Note: Follow to Box 7 if screen is negative but additional evidence (e.g., collateral) suggests the need for continued screening and/or evaluation

Algorithm B: Evaluation by Provider



*Source: Rocky Mountain MIRECC Therapeutic Risk Management – Risk Stratification Table. Available at: https://www.mirecc.va.gov/visn19/trm/

Sidebar 1. Risk Factors for Suicide*
– Any prior suicide attempt – Current suicidal ideation – Recent psychosocial stressors – Availability of firearms – Prior psychiatric hospitalization – Psychiatric conditions (e.g., mood disorders, substance use disorders) or symptoms (e.g., hopelessness, insomnia, agitation) **Necessary as part of a comprehensive assessment of suicide risk, but not sufficient* **(See Recommendation 3)**

Sidebar 2a. Essential Features from Risk Stratification Table – Acute Risk[2]		
Level of Risk	**Essential Features**	**Action**
High Acute Risk	– Suicidal ideation with intent to die by suicide – Inability to maintain safety, independent of external support/help Common warning signs: – A plan for suicide – Recent attempt and/or ongoing preparatory behaviors – Acute major mental illness (e.g., major depressive episode, acute mania, acute psychosis, recent/current drug relapse) – Exacerbation of personality disorder (e.g., increased borderline symptomatology)	– Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors – These individuals may need to be directly observed until they are transferred to a secure unit and kept in an environment with limited access to lethal means (e.g., keep away from sharps, cords or tubing, toxic substances) – During hospitalization co-occurring conditions should also be addressed
Intermediate Acute Risk	– Suicidal ideation to die by suicide – Ability to maintain safety, independent of external support/help These individuals may present similarly to those at high acute risk, sharing many of the features. The only difference may be lack of intent, based upon an identified reason for living (e.g., children), and ability to abide by a safety plan and maintain their own safety. Preparatory behaviors are likely to be absent.	– Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g., acute psychosis) – Outpatient management of suicidal thoughts and/or behaviors should be intensive and include: frequent contact, regular re-assessment of risk, and a well-articulated safety plan – Mental health treatment should also address co-occurring conditions
Low Acute Risk	– No current suicidal intent AND – No specific and current suicidal plan AND – No recent preparatory behaviors AND – Collective high confidence (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety Individuals may have suicidal ideation, but it will be with little or no intent or specific current plan. If a plan is present, the plan is general and/or vague, and without any associated preparatory behaviors (e.g., "I'd shoot myself if things got bad enough, but I don't have a gun"). These patients will be capable of engaging appropriate coping strategies, and willing and able to utilize a safety plan in a crisis situation.	– Can be managed in primary care – Outpatient mental health treatment may also be indicated, particularly if suicidal ideation and co-occurring conditions exist

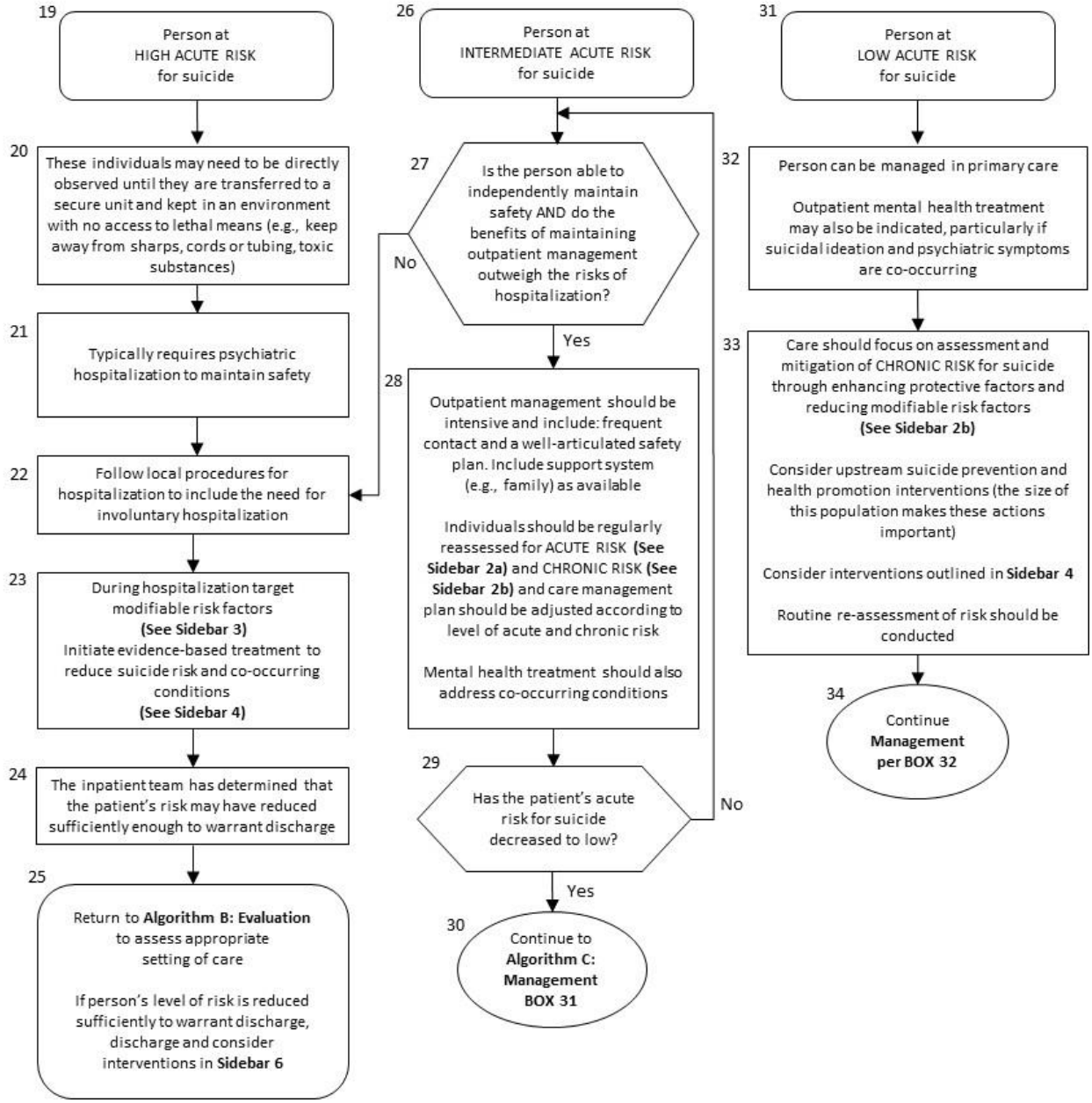
[2] Source: Rocky Mountain MIRECC Therapeutic Risk Management – Risk Stratification Table. Available at: https://www.mirecc.va.gov/visn19/trm/

Sidebar 2b. Essential Features from Risk Stratification Table – Chronic Risk[3]		
Level of Risk	**Essential Features**	**Action**
High Chronic Risk	Common warning sign: – Chronic suicidal ideation Common risk factors: – Chronic major mental illness and/or personality disorder – History of prior suicide attempt(s) – History of substance use disorders – Chronic pain – Chronic medical condition – Limited coping skills – Unstable or turbulent psychosocial status (e.g., unstable housing, erratic relationships, marginal employment) – Limited ability to identify reasons for living	These individuals are considered to be at chronic risk for becoming acutely suicidal, often in the context of unpredictable situational contingencies (e.g., job loss, loss of relationships, and relapse on drugs). These individuals typically require: – Routine mental health follow-up – A well-articulated safety plan, including lethal means safety (e.g., no access to guns, limited medication supply) – Routine suicide risk screening – Coping skills building – Management of co-occurring conditions
Intermediate Chronic Risk	– These individuals may feature similar chronicity as those at high chronic risk with respect to psychiatric, substance use, medical and pain disorders – Protective factors, coping skills, reasons for living, and relative psychosocial stability suggest enhanced ability to endure future crisis without engaging in self-directed violence	These individuals typically require: – Routine mental health care to optimize psychiatric conditions and maintain/ enhance coping skills and protective factors – A well-articulated safety plan, including lethal means safety (e.g., safe storage of lethal means, medication disposal, blister packaging) – Management of co-occurring conditions

Low Chronic Risk	– These individuals may range from persons with no or little in the way of mental health or substance use problems, to persons with significant mental illness that is associated with relatively abundant strengths/ resources
	– Stressors historically have typically been endured absent suicidal ideation
	– The following factors will generally be missing:
	  – History of self-directed violence
	  – Chronic suicidal ideation
	  – Tendency towards being highly impulsive
	  – Risky behaviors
	  – Marginal psychosocial functioning
		– Appropriate for mental health care on an as needed basis, some may be managed in primary care settings
		– Others may require mental health follow-up to continue successful treatments

[3] Source: Rocky Mountain MIRECC Therapeutic Risk Management – Risk Stratification Table. Available at: https://www.mirecc.va.gov/visn19/trm/

Algorithm C: Management of Patients at Acute Risk for Suicide



Sidebar 3. Modifiable Risk Factors

- Modifiable risk factors are things that can be changed, such as depression.[4]
- Often, such risk factors can be reduced by certain interventions, such as prescribing antidepressant medication for depression, or decreasing isolation by strengthening social support.[5]

[4] Source: Suicide Prevention Resource Center, & Rodgers, P. *Understanding risk and protective factors for suicide: A primer for preventing suicide*. Newton, MA: Education Development Center, Inc. 2011.

[5] Source: Western Michigan University. *Suicide prevention program: Risk factors*. Kalamazoo, MI: 2018. https://wmich.edu/suicideprevention/basics/risk.

Sidebar 4. Evidence-Based Treatment to Reduce Repetition of Suicide Behavior

Non-pharmacologic Treatments (See Recommendations 6-9)

- Cognitive Behavioral Therapy-based interventions for suicide prevention
- Dialectical Behavior Therapy
- Problem-Solving Therapy-based interventions

Crisis Response Plan (See Sidebar 5 and Recommendation 8)

Pharmacotherapy for Suicide Prevention* (See Recommendations 10-12)

- Ketamine infusion (among patients with suicidal ideation and major depressive disorder)
- Lithium alone (among patients with bipolar disorder) or in combination with another psychotropic agent
- Clozapine (among patients with either suicidal ideation or a history of suicide attempt)

Other (See Recommendation 18)

- Reduce access to lethal means

**Other treatments may be indicated for underlying conditions (see VA/DoD CPGs for MDD, PTSD, SUD, etc.)*

Abbreviations: CPG: Clinical practice guideline; DoD: Department of Defense; MDD: major depressive disorder; PTSD: posttraumatic stress disorder; SUD: substance use disorder; VA: Department of Veterans Affairs

Sidebar 5. Crisis Response Plan

- Semi-structured interview of recent suicide ideation and chronic history of suicide attempts
- Unstructured conversation about recent stressors and current complaints using supportive listening techniques
- Collaborative identification of clear signs of crisis (behavioral, cognitive, affective or physical)
- Self-management skill identification including things that can be done on the patient's own to distract or feel less stressed
- Collaborative identification of social support including friends and family members who have helped in the past and who they would feel comfortable contacting in crisis
- Review of crisis resources including medical providers, other professionals and the suicide lifeline (1-800-273-8255)
- Referral to treatment including follow up appointments and other referrals as needed
- Consider protective factors
- Additional steps for management of military Service Members
  - Inform command
  - Determine utility of command involvement
  - Address barriers to care (including stigma)
  - Ensure follow-up during transition
  - Enroll in risk management tracking)

(See Recommendation 8)

Sidebar 6. Interventions to Improve Adherence

- Facilitating access to care
- Outreach (e.g., telephone contact, home visit, mailing caring letters/postcards)
- Case/care management
- Counseling and other psychosocial interventions

(See Recommendations 13-15)

Scope of the CPG

This CPG is designed to assist providers in managing or co-managing patients at risk for suicide as well as any co-occurring conditions (e.g., major depressive disorder [MDD], generalized anxiety disorder, SUD, posttraumatic stress disorder [PTSD], traumatic brain injury [TBI]). Moreover, the patient population of interest for this CPG is patients at risk for suicide who are eligible for care in the VA and DoD healthcare delivery systems and those who are in the community receiving care from community-based clinicians. It includes Veterans as well as deployed and non-deployed Active Duty Service, Guard, and Reserve Members and their dependents.

The literature review encompassed interventional studies (primarily randomized controlled trials [RCTs]), observational studies, and diagnostic test studies published between November 2011 and April 2018. It targeted 12 key questions (KQs) focusing on the means by which the delivery of healthcare could be optimized for patients at risk for suicide. The selected KQs were prioritized by the Work Group from many possible KQs based on consensus as to their level of importance. Due to resource constraints, an extensive review of the evidence in all important aspects of care was not feasible for the update to this CPG.

Methods

The 2019 Suicide Risk CPG is an update to the 2013 Suicide Risk CPG. The methodology used in developing the 2019 CPG follows the *Guideline for Guidelines*, an internal document of the VA and DoD EBPWG.[1] The *Guideline for Guidelines* can be downloaded from http://www.healthquality.va.gov/policy/index.asp. The guideline development process for the 2019 CPG update consisted of the following steps: formulating and prioritizing evidence (KQs); convening patient focus groups; conducting the systematic review; convening a face-to-face meeting with the CPG Champions and Work Group members; and drafting and submitting a final CPG on the assessment and management of suicide risk to the VA/DoD EBPWG.

The Champions and Work Group used the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system to assess the quality of the evidence base and assign a grade for the strength for each recommendation. The GRADE system uses the following four domains to assess the strength of each recommendation: balance of desirable and undesirable outcomes; confidence in the quality of the evidence; patient or provider values and preferences; other implications, as appropriate (e.g., resource use, equity).[5] Using this system, the Champions and Work Group determined the relative strength of each recommendation (strong or weak). A strong recommendation indicates that the Work Group is highly confident that the desirable effects of an intervention outweigh undesirable effects. If the Work Group is less confident that the desirable effects of an intervention outweigh undesirable effects, they give a weak recommendation. It is important to note that the GRADE terminology used to indicate the confidence in the desirable effects of an intervention (i.e., strong versus weak) should not be confused with the clinical importance of the recommendation. A weak recommendation may be just as important to the clinical care of a patient as a strong recommendation.

Occasionally, instances may occur when the Work Group feels there is insufficient evidence to make a recommendation for or against a particular therapy or preventive measure. This can occur when there is an absence of studies on a particular topic that met evidence review inclusion criteria, studies included in the evidence review report conflicting results, or studies included in the evidence review report inconclusive results regarding the desirable and undesirable outcomes.

Using these elements, the grade of each recommendation is presented as part of a continuum:

- Strong for (or "We recommend offering this option …")
- Weak for (or "We suggest offering this option …")
- No recommendation for or against (or "There is insufficient evidence…")
- Weak against (or "We suggest not offering this option …")
- Strong against (or "We recommend against offering this option …")

The grade of each recommendation made in the 2019 CPG can be found in the section on Recommendations. Additional information regarding the use of the GRADE system can be found in Appendix C in the full Suicide Risk CPG.

The Work Group developed both new and updated recommendations based on the evidence review conducted for the priority areas addressed by the KQs. In addition, the Work Group considered, without complete review of the relevant evidence, the current applicability of other recommendations that were included in the 2013 Suicide Risk CPG, subject to evolving practice in today's environment. A set of recommendation categories was adapted from those used by NICE.[6,7] These categories, along with their corresponding definitions, were used to account for the various ways in which recommendations could have been updated from the 2013 Suicide Risk CPG. The categories and definitions can be found in Table 1.

Table 1. Recommendation Categories and Definitions

Evidence Reviewed*	Recommendation Category*	Definition*
Reviewed	New-added	New recommendation following review of the evidence
	New-replaced	Recommendation from previous CPG that has been carried over to the updated CPG that has been changed following review of the evidence
	Not changed	Recommendation from previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed but the recommendation is not changed
	Amended	Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed and a minor amendment has been made
	Deleted	Recommendation from the previous CPG that has been removed based on review of the evidence
Not reviewed	Not changed	Recommendation from previous CPG that has been carried forward to the updated CPG, but for which the evidence has not been reviewed
	Amended	Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has not been reviewed and a minor amendment has been made
	Deleted	Recommendation from the previous CPG that has been removed because it was deemed out of scope for the updated CPG

*Adapted from the NICE guideline manual (2012) [6] and Garcia et al. (2014) [7]
Abbreviation: CPG: clinical practice guideline

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*Additional contributor contact information is available in Appendix G in the full text Suicide Risk CPG.

Patient-centered Care

VA/DoD CPGs encourage providers to use a PCC approach that is individualized based on patient needs, characteristics, and preferences. Regardless of setting, all patients in the healthcare system should be able to access evidence-based care appropriate to their specific needs or condition. When properly executed, PCC may decrease patient anxiety, increase trust in clinicians,[8] and improve treatment adherence.[9] Improved patient-clinician communication and a PCC approach conveys openness and supports disclosure of current and future concerns. As part of the PCC approach, providers should ask each patient about any concerns he or she has or barriers to high quality care he or she has experienced.

Guideline recommendations are intended to be patient centered. Thus, treatment and care should consider a patient's needs and preferences. Effective, open communication between healthcare professionals and the patient is essential and should be supported by evidence-based information tailored to the patient's needs. Use of an empathetic and non-judgmental approach facilitates discussions sensitive to gender, culture, ethnic, and other considerations. The information that patients are given about treatment and care should be culturally appropriate and available to people with limited literacy skills. Treatment information should also be accessible to people with additional needs such as physical, sensory, or learning disabilities. Family and caregiver involvement should be considered, if appropriate.

Shared Decision Making

Throughout the VA/DoD CPG, the authors encourage clinicians to focus on shared decision making (SDM). The SDM model was introduced in *Crossing the Quality Chasm,* an Institute of Medicine (IOM) (now called the National Academy of Medicine [NAM]) report, in 2001.[10] It is readily apparent that patients, together with their clinicians, make decisions regarding their plan of care and management options. Patients at risk for suicide require sufficient information and time to be able to make informed decisions. Clinicians must be adept at presenting information to their patients regarding treatments, expected outcomes, and levels and/or locations of care. Clinicians are encouraged to use SDM to individualize treatment goals and plans based on patient capabilities, needs, goals, and preferences.

Screening and Evaluation

A. Screening

1. **With regard to universal screening, we suggest the use of a validated screening tool to identify individuals at risk for suicide-related behavior. *(Weak for; Reviewed, New-added)***
   - Consistent with previous reviews of the evidence base related to the identification of those who are at elevated risk of dying by suicide, the systematic review found that most screening tools do not accurately predict risk of suicide.[11-17]
   - There were significant considerations that limited the support for many of the screening programs and tools that were examined. These include limited sample size, follow-up window, and use of proxy outcomes for suicide-related behavior and suicide deaths.
   - The Work Group's confidence in the quality of the evidence is low.

2. **With regard to selecting a universal screening tool, we suggest the use of the Patient Health Questionnaire-9 item 9, to identify suicide risk. *(Weak for; Reviewed, New-added)***
   - Several studies were identified that support the use of the Patient Health Questionnaire-9 (PHQ-9) item 9 as a universal screening instrument to identify suicide risk.[17,18]

- As limited data exists regarding implementing the PHQ-9 item 9 in large healthcare settings, future research regarding feasibility and acceptability are warranted. Nonetheless, there is sufficient data to encourage use of item 9 to screen for risk, particularly in non-mental health settings, as a component of system-wide suicide prevention efforts.
- The overall confidence in the quality of evidence is moderate.

B. Evaluation

3. We recommend an assessment of risk factors as part of a comprehensive evaluation of suicide risk, including but not limited to: current suicidal ideation, prior suicide attempt(s), current psychiatric conditions (e.g., mood disorders, substance use disorders) or symptoms (e.g., hopelessness, insomnia, and agitation), prior psychiatric hospitalization, recent bio-psychosocial stressors, and the availability of firearms. ***(Strong for; Reviewed, New-replaced)***

- Findings suggest that a comprehensive suicide risk evaluation should include risk factors that may be modifiable and non-modifiable.[19,20]
- The evidence base in support of factors that can protect against suicidal behavior is limited. Nonetheless, evaluation of such factors, particularly those associated with reasons for living, should be included in a comprehensive suicide risk evaluation.
- Factors that increase risk for suicidal thoughts and/or behaviors with the most evidence were organized into categories including: SDV related (e.g., current suicidal ideation); current psychiatric conditions/current or past mental health treatment (e.g., prior psychiatric hospitalization); psychiatric symptoms (e.g., hopelessness); recent bio-psychosocial stressors (e.g., loss of relationship); and availability of firearms.[19-22]
- The Work Group's confidence in the quality of the evidence is moderate.

4. When evaluating suicide risk, we suggest against the use of a single instrument or method (e.g., structured clinical interview, self-report measures, or predictive analytic models). ***(Weak against; Reviewed, Amended)***

- A review of the evidence did not identify a specific risk evaluation instrument or method (e.g., structured clinical interview, self-report measures, and predictive analytic models) that is sufficient to determine future risk of suicide.[23-25]
- Given the lack of evidence supporting the use of a single instrument or method, clinicians should practice caution when conducting a suicide risk evaluation, and not rely on any of these tools alone. The research reviewed by the Work Group emphasizes the importance of using multiple tools and methods, such as structured clinical interviews augmented with valid and reliable self-report measures.
- The quality of evidence is low due to study limitations.

5. While it is an expected standard of care, there is insufficient evidence to recommend for or against the use of risk stratification to determine the level of suicide risk. ***(Neither for nor against; Reviewed, New-replaced)***

- A review of the evidence did not identify a specific risk evaluation instrument or method (e.g., structured clinical interview, self-report measures, and predictive analytic models) that is sufficient to determine future risk of suicide.[23-25]
- In both systematic reviews identified, approximately half of all suicide-related deaths occurred in the low-risk categories. Methodological variations across these studies with respect to the patient

population, as well as criteria and methods for determining different levels of risk, likely contributed to the inconsistent findings.[23,24]

- Other considerations included benefits, such as potential clinical utility of risk stratification to guide individualized, patient-centered risk management balanced with the potential harm of discouraging or preventing providers from completing comprehensive assessments informed by current risk stratification efforts.
- The Work Group's confidence in the quality of the evidence is low, and the body of evidence had limitations, including a small evidence base, fair methodological quality of individual trials, and poor sensitivity and low positive predictive value of risk models.

Risk Management and Treatment

A. Non-pharmacologic Treatments

6. We recommend using cognitive behavioral therapy-based interventions focused on suicide prevention for patients with a recent history of self-directed violence to reduce incidents of future self-directed violence. *(Strong for; Reviewed, New-added)*

- All studies reviewed for this recommendation utilized cognitive behavior therapy (CBT) to directly address suicide risk.[26-31]
- Four systematic reviews/meta-analyses have examined the effect of CBT on suicide-related outcomes.[26-29] Most studies included in these reviews specifically targeted suicide risk as part of the intervention.
- The Work Group agreed that these benefits far outweigh the potential harm of adverse events, of which there was no evidence in the included studies and which have not been observed in practice by any of the Work Group members.
- Although there may be some variation with respect to CBT's alignment with patient values and preferences, most patients typically report high satisfaction with CBT focused on suicide prevention.
- The Work Group's confidence in the quality of the evidence is moderate.

7. We suggest offering Dialectical Behavioral Therapy to individuals with borderline personality disorder and recent self-directed violence. *(Weak for; Reviewed, New-replaced)*

- Dialectical Behavior Therapy (DBT) was originally developed to treat individuals with borderline personality disorder (BPD), a subpopulation at heightened risk for non-suicidal and suicidal SDV. DBT combines elements of CBT, skills training, and mindfulness techniques with the aim of helping individuals develop skills in: (1) emotion regulation, (2) interpersonal effectiveness, and (3) distress tolerance.
- Based on a growing body of research, DBT has been found to reduce non-suicidal and suicidal SDV among patients with borderline personality disorder (BPD) and recent SDV.[27,32-35]
- Other considerations regarding this recommendation included the benefits (i.e., improved outcomes in depressive symptoms among individuals receiving DBT versus those receiving a client-centered therapy control [35]) outweighing the potential harm of adverse events, which was small.
- The Work Group's confidence in the quality of the evidence is low.

8. **We suggest completing a crisis response plan for individuals with suicidal ideation and/or a lifetime history of suicide attempts.** ***(Weak for; Reviewed, New-replaced)***
   - Completing a crisis response plan has been found to decrease suicide attempts among military personnel with an acute history of suicidal ideation during the past week and/or a lifetime history of suicide attempts.[36]
   - This recommendation is based on a study by Bryan et al. (2017) that found a statistically significant difference in the number and proportion of suicide attempts, favoring crisis response planning over treatment as usual.[36]
   - There is no evidence in the literature or in clinical expert opinion that there is any harm in completing a crisis response plan. This process is collaborative and should be patient centered. As there is no empirical evidence to support the use of "no harm" or "no suicide" contracts, implementing crisis response plans and safety plans are the preferred strategy.
   - The Work Group's confidence in the quality of the evidence is low. The body of evidence had some limitations, including small sample size and confounders in the analysis.

9. **We suggest offering problem-solving based psychotherapies to:**
   a) Patients with a history of more than one incident of self-directed violence to reduce repeat incidents of such behaviors
   b) Patients with a history of recent self-directed violence to reduce suicidal ideation
   c) Patients with hopelessness and a history of moderate to severe traumatic brain injury

   (Weak for; Reviewed, New-replaced)
   - Problem-Solving Therapy (PST) is one type of cognitive-behavioral psychotherapy specifically aimed at improving an individual's ability to cope with stressful life experiences through active problem solving.[37-42]
   - Recent research provides support for PST on the outcomes of reduced repeat SDV and suicidal ideation among patients with a history of SDV. Notably, the majority of this research has been conducted on patients with a "history of self-harm," and "self-harm" was studied as the primary outcome; these studies have not differentiated between suicidal versus non-suicidal self-harm.
   - The Window to Hope (WtoH) group treatment intervention has been found to improve hopelessness in patients at risk for suicide.[42] WtoH is structured around four core therapeutic strategies: (1) behavioral activation, (2) cognitive restructuring, (3) problem solving, and (4) relapse prevention. Findings from this RCT support the efficacy of WtoH as a psychological intervention to reduce hopelessness among those with moderate to severe TBI.
   - Additionally, the Work Group determined that the potential harm (e.g., repeated suicide attempts or self-harm, death by suicide) of not offering PST far outweighs any potential harm of offering this intervention. PST is a pragmatic approach, suitable for a sizeable proportion of patients at risk for suicide.
   - The Work Group's confidence in the quality of the evidence is low. The body of evidence had some limitations, including small sample sizes and lack of clarity around blinding of follow-up assessors.

B. Pharmacologic Treatments

10. In patients with the presence of suicidal ideation and major depressive disorder, we suggest offering ketamine infusion as an adjunctive treatment for short-term reduction in suicidal ideation. *(Weak for; Reviewed, New-added)*

- Ketamine infusion as a single dose at 0.5 mg/kg has moderate evidence for acute symptom improvement of suicidal ideation within 24 hours of treatment, with a moderate effect size that continues for one week [43] and even up to six weeks.[44]
- In a meta-analysis of ketamine trials, 55% of patients after 24 hours and 60% at seven days reported no suicidal ideation.[43] Evidence indicates there is a risk of a transient elevation in blood pressure in a small number of patients that resolved without significant sequelae.[44,45]
- These studies were done in populations with MDD and suicidal ideation; other comorbidities were not addressed. Considering the potential risk of addiction, continued repeat administration of ketamine is not recommended.
- Given the harms versus the benefits, caution should be used for repeated administrations or in other populations. Additionally, the window of effect is a short duration, with no evidence to support repeated administration for persistent suicidal ideation.[45]
- The Work Group's confidence in the quality of the evidence is moderate for the effect on suicidal ideation. The body of evidence had some limitations, including a very narrow, targeted effect on the symptom of suicidal ideation, with unknown impact on the outcomes of suicide attempt or suicide.

11. We suggest offering lithium alone (among patients with bipolar disorder) or in combination with another psychotropic agent (among patients with unipolar depression or bipolar disorder) to decrease the risk of death by suicide in patients with mood disorders. *(Weak for; Reviewed, New-replaced)*

- Lithium has been shown to reduce the risk of suicide in patients with unipolar depression or bipolar disorder. Several cohort studies and systematic reviews have shown lithium maintenance to be associated with fewer suicidal behaviors and deaths.[46-53]
- Despite general consistency in the evidence supporting the use of lithium, there is some variability in provider and patient preferences regarding this treatment. Lithium discontinuation due to a variety of side effects (e.g., gastrointestinal upset, tremor, polyuria, polydipsia, weight gain, hypothyroidism, leukocytosis) contribute to a large variation in adherence.
- When prescribing lithium to patients at risk for suicide, it is important to consider extended release versus immediate release formulations, and to pay attention to the risk of overdose by limiting the amount of lithium dispensed.
- Consider methods to reduce risk of toxicity in overdose, such as dispensing smaller quantities and safe medication storage options (e.g., having a caregiver or family member store the medication for the patient). If overdose is identified as a lethal means for the patient, consider an alternative to lithium for treatment.
- The Work Group's confidence in the quality of the evidence is moderate. The body of evidence had some limitations, including conflicting results on the primary outcome when an active pharmacologic control was used.

12. We suggest offering clozapine to decrease the risk of death by suicide in patients with schizophrenia or schizoaffective disorder and either suicidal ideation or a history of suicide attempt(s). *(Weak for; Reviewed, Amended)*

- Clozapine has been found to reduce suicidal behaviors in patients with schizophrenia or schizoaffective disorder.[54,55] The quality and consistency of the studies are highly variable, with only one RCT of moderate quality that compared clozapine to an alternative antipsychotic, olanzapine. Evidence also indicates some level of harm associated with clozapine.
- There are significant challenges to clozapine use in certain subgroups of patients, such as the elderly and the homeless, both because of the medication's side effects and difficulties accomplishing the required monitoring through the Clozapine Risk Evaluation and Mitigation Strategy (REMS) program.
- In the specific population of patients for whom the drug is indicated, the evidence may be considered sufficient with small benefit.
- The Work Group's confidence in the quality of the evidence is low for reduction in suicide attempts and suicide.

C. Post-acute Care

13. We suggest sending periodic caring communications (e.g., postcards) for 12-24 months in addition to usual care after psychiatric hospitalization for suicidal ideation or a suicide attempt. *(Weak for; Reviewed, New-replaced)*

- Sending periodic caring communications (e.g., postcards, letters) following a psychiatric hospitalization for suicidal ideation or suicide attempt has been found to reduce the rate of suicide death, attempts, and ideation for individuals receiving the communications.[56-58]
- Other considerations regarding this recommendation include: communication format (e.g., postcard, letter, email, text); use of non-demanding, supportive, culturally adapted messaging; communication delivery barriers for population subsets; and logistical considerations of staff availability to reply to communications with consideration of expectations of a time-sensitive response, such as text communications versus letters.
- Overall, caring communications are a low-cost, low-risk intervention that has proven to show a reduction in rates for suicide death, attempt, and ideation.
- The Work Group's confidence in the quality of the evidence is low for suicidal ideation and very low for suicide attempt. The body of evidence had some limitations, including varying communication intervals and cultural adaptations across studies.

14. We suggest offering a home visit to support reengagement in outpatient care among patients not presenting for outpatient care following hospitalization for a suicide attempt. *(Weak for; Reviewed, Amended)*

- A single home visit has been shown to increase outpatient treatment engagement among patients recently discharged from psychiatric inpatient care.[59-62]
- Specifically, among patients who failed to attend their initial outpatient appointment, a single home visit by a nurse resulted in a subsequent increase in treatment compliance compared to those who did not receive a home visit (51.2% versus 39.8%).
- These studies did not differentiate between suicidal and non-suicidal behavior and the interventions offered in the home setting ranged from case management to brief psychodynamic interpersonal therapy.

- Other considerations regarding this recommendation included the fact that the benefits of improving treatment engagement during an especially high-risk period (i.e., transition from inpatient to outpatient care) outweigh the potential harm of adverse events, which was small.
- The Work Group's confidence in the quality of the evidence is moderate. The body of evidence had some limitations, including confounders in the analysis and how a home visit was defined.

15. We suggest offering the World Health Organization Brief Intervention and Contact treatment modality following presentation to the emergency department for suicide attempt, in addition to standard care. *(Weak for; Reviewed, New-added)*

- The World Health Organization (WHO) Brief Intervention and Contact (BIC) treatment modality consists of "a one hour individual information session as close to the time of discharge as possible and, after discharge, nine follow-up contacts (phone calls or visits, as appropriate) according to a specific time-line up to 18 months (at 1, 2, 4, 7 and 11 week(s), and 4, 6, 12 and 18 months), conducted by a person with clinical experience (e.g., doctor, nurse, psychologist)."[63]
- WHO BIC has been found to significantly decrease suicides among patients with a history of suicide attempt in low- to middle-income countries (e.g., China, Iran, India, Brazil, and Sri Lanka).[28] In the three trials of the WHO BIC intervention, there were significantly fewer suicides in the group that received the intervention compared to those receiving usual care (3 versus 24 suicides; $p < .0001$).[28]
- The WHO BIC protocol demonstrates that systematic long-term contacts after discharge in addition to usual care can have a positive impact on preventing subsequent deaths by suicide among those presenting to the ED following a suicide attempt.
- Other considerations regarding this recommendation included the benefits, including reductions in suicide deaths, outweighing the potential harm of adverse events, which was small. Patient values and preferences were somewhat varied and generalizability to high-income countries is unclear. Thus, the Work Group decided upon a "Weak for" recommendation.
- The Work Group's confidence in the quality of the evidence is low. The body of evidence had some limitations, including attrition and selection bias, limited validity of source of data for suicide deaths, and confounders in the analysis.

D. Technology-based Modalities

16. There is insufficient evidence to recommend for or against technology-based behavioral health treatment modalities for individuals with suicidal ideation. These include self-directed digital delivery of treatment protocols with minimal or no provider interaction (e.g., compact disc, web-based), and provider-delivered virtual treatment. *(Neither for nor against; Reviewed, New-replaced)*

- Available research focused on electronic delivery of treatment protocols in lieu of face-to-face delivery.[26,64-68] None of the available studies assessed the effectiveness of telehealth as it is routinely practiced across the VA and DoD (i.e., face-to-face treatment delivered in a virtual environment).
- At follow-up, no significant between-group differences were observed in reporting of suicidal ideation or suicide attempt. However, at the post-intervention assessment there was evidence of a reduction in suicidal ideation in sub-analyses of three pre-test/post-test observational studies and five RCTs.

- Although this body of evidence suggests digital interventions may lead to short-term decreases in suicidal ideation compared to no active treatment, it does not support an assumption of equivalence with face-to-face treatment delivery.
- Despite insufficient evidence to make a recommendation for or against technology-based behavioral health treatment modalities over face-to-face delivery, the Work Group believes the benefits slightly outweigh the harms of considering these modalities as a vehicle for delivering treatment protocols to individuals with suicidal ideation, especially when there exist substantive barriers to in-person care.
- The Work Group's confidence in the quality of the evidence is very low. The body of evidence had numerous limitations, including imprecision and inconsistency in study results and risk for bias in study designs.

17. There is insufficient evidence to recommend for or against the use of technology-based adjuncts (e.g., web or telephone applications) to routine suicide prevention treatment for individuals with suicidal ideation. *(Neither for nor against, Reviewed, New-replaced)*

- Studies evaluating the effect of technology-based interventions as adjuncts to routine suicide prevention treatment are rare. The Work Group reviewed two such studies, neither of which included the critical outcomes of suicidal ideation or suicide attempt as primary study outcomes.[69,70]
- There was also no evidence of harm with any of the interventions, and technology-based adjunct treatment may help with patient engagement and self-management. The Work Group's confidence in the quality of evidence is very low based on the impact on suicidal ideation in both the Kasckow et al. (2016) and Bush et al. (2017) studies.[69,70]
- Important considerations, however, include accessibility and patients' comfort with technology-based interventions; concerns about Health Insurance Portability and Accountability Act (HIPAA) compliance and patient safety; network security and vulnerabilities; and comfort with using smartphones or other handheld devices/tablets.
- The Work Group's confidence in the quality of the evidence is very low. The body of evidence was limited by serious imprecision.

Other Management Modalities

A. Population & Community-based Interventions

18. We suggest reducing access to lethal means to decrease suicide rates at the population level. *(Weak for; Reviewed, New-added)*

- Implementing lethal means safety, including firearm restrictions, reducing access to poisons and medications associated with overdose, and barriers to jumping from lethal heights, is a means to reduce suicide in populations.[21,22]
- Means safety counseling (MSC; also referred to as "lethal means counseling") approaches have been developed in an effort to reduce deaths by firearms and other means. MSC consists of discussions between clinicians and persons at elevated risk for suicide.
- The Work Group's confidence in the quality of the evidence on lethal means safety is very low.

19. There is insufficient evidence to recommend for or against community-based interventions targeting patients at risk for suicide. *(Neither for nor against; Reviewed, New-added)*

20. **There is insufficient evidence to recommend for or against community-based interventions to reduce population-level suicide rates.** ***(Neither for nor against; Reviewed, New-added)***

21. **There is insufficient evidence to recommend for or against gatekeeper training alone to reduce population-level suicide rates.** ***(Neither for nor against; Reviewed, New-added)***

22. **There is insufficient evidence to recommend for or against buddy support programs to prevent suicide, suicide attempts, or suicidal ideation.** ***(Neither for nor against; Reviewed, New-added)***
    - Research gaps exist in community-based interventions as mechanisms to reduce suicide risk.
    - The body of evidence identified had limitations, including confounders in the analyses. Community-based interventions, including gatekeeper training and buddy support, had insufficient evidence to make recommendations for or against their use.[22,71-76]
    - There was a lack of evidence that potential benefits (e.g., definitive management of suicidality resulting in an aggregate decrease in death) outweigh the potential harm of adverse events, which could include fostering contagion or bypassing evidence-based care.
    - The Work Group evaluated a recent systematic review that looked at gatekeeper training studies in emergent community gatekeepers such as military personnel, public school staff, peer helpers, youth workers, Indigenous people, and designated healthcare worker gatekeepers, including nurses and social workers.[22] No RCT showed that gatekeeper training alone affects suicide rates.
    - No studies that addressed the effects of crisis lines or peer-to-peer counseling lines met inclusion criteria for the systematic evidence review.
    - Differences in resource use, equity, acceptability, and feasibility of interventions exist in many military and Veteran settings.
    - The Work Group's confidence in the quality of the evidence for community-based interventions is very low.

Additional Resources

Medication Safety Guidance

- Limit quantities of medications prescribed; if a patient is at higher risk, consider asking the patient to involve a family member or friend in medication management
- Ask patients to store medications in a secure area (if medications have abuse potential, consider a lockbox); dispose of any medication that is past its expiration date, no longer needed, or has not been used in 12 months
- Check with a local VA pharmacist about options and provide patients with this information

Firearm Storage Options

If Lower Risk  **If Higher Risk**	• Store unloaded firearms and ammunition separately • Use a gunlock • Store firearms in a safe, locking cabinet, or lockbox • Store firearms disassembled or remove the firing pin • Store firearms at the home of someone you trust* **State laws may limit temporary storage options; confirm the laws in your state before making recommendations to Veterans*

The GROW Framework
The **GROW** Framework can help you talk with your Veteran patients about means safety and options for safe firearm and medication storage.

• **Get ready**: Consider important factors before having the conversation.
  ○ How well do you know this patient?
  ○ Does the patient live with other people?
  ○ What is the patient's level of suicide risk?

• **Reason for the discussion**: Help the Veteran understand the rationale for the conversation.
  ○ "I'm glad you're not having thoughts about suicide, but sometimes a crisis hits, and people can experience suicidal feelings. There are some things you can do to help ensure your safety if that were to happen. Would it be OK if we talked about this for a minute?"
  ○ "Rates of suicide with firearms are high among Veterans, and depression can increase risk for suicide. I am talking with all of my patients with signs of depression about things they can do to stay safe, including about firearms and medication safety."
  ○ "It's common for teenagers to know exactly where firearms and medications are hidden in the house. Are you aware of options for safely storing firearms and medications when they are not in use?"

• **Offer brief advice**: Use collaborative language that empowers the Veteran to take steps toward improving safety.
  ○ "Many firearm accidents in the home can be prevented by making sure firearms are kept unloaded and locked up, with ammunition stored in a separate location. Does this sound like something that could be helpful?"
  ○ [Higher-risk patients:] "We know that putting time and distance between suicidal thoughts and firearms can save a life. Some Veterans choose to store their firearms away from home until they are feeling better. Is this something you might consider?"

• **We're here to help**: Offer resources to reinforce behavior change.
  ○ Firearms and medication safety brochure
  ○ National Shooting Sports Foundation Safety Kit (www.NSSF.org/safety)
  ○ Free firearm cable lock
  ○ Information on how to reach the clinic and the Veterans Crisis Line

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Access to the full guideline and additional resources are available at the following link:
https://www.healthquality.va.gov/guidelines/mh/srb/index.asp