Module A: Identification of Patients at Acute Risk for Suicide

1. Patient presenting with warning signs (may have suicidal ideation with or without intent or recent self-directed violence; see Sidebar 1).

2. Patient presents in context where suicide risk screening occurs.
   - Screen for current suicide risk using validated tool (see Recommendation 2) or Continue to Module B to complete suicide risk assessment.

3. Does the patient screen positive for or/and endorse suicidal ideation?
   - Yes
     - Continue to Module B: Assessment, Box 7
   - No
     - Continue routine management of care and presenting concerns. Build protective factors (see Sidebar 2); Consider referral to mental/behavioral health.

Module B: Comprehensive Suicide Risk Assessment by Provider

4. Patient identified from Module A

5. Complete a suicide risk assessment (see Routine Care section).

6. Is this patient at HIGH ACUTE RISK for suicide (see Sidebar 2)?
   - Core Features
     - Suicidal ideation with intent to die by suicide AND
     - Inability to maintain safety independently without external help or support
   - Yes
     - Continue to Module C: Management, Box 15
   - No
     - Continue to Module B: Assessment, Box 7

7. Is this patient at INTERMEDIATE ACUTE RISK for suicide (see Sidebar 3a)?
   - Core Features
     - May present similarly to those at high acute risk, but lack intent to act on suicidal ideation and have the ability to maintain safety independently
   - Yes
     - Continue to Module C: Management, Box 24
   - No
     - Continue to Module B: Assessment, Box 7

8. Patient identified to be at LOW ACUTE RISK for suicide (see Sidebar 3a)
   - Core Features
     - 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
   - Yes
     - Continue to Module C: Management, Box 29
   - No
     - Continue to Module B: Assessment, Box 7

Sidebar 1. Suicide Warning Signs

When performing a suicide risk assessment, we suggest including, but not limited to, the factors (see Recommendation 3 and Table 6 within the full VA/DoD CPG) within the following domains:

- SDV thoughts and behaviors; Current psychiatric conditions and current or past mental/behavioral health treatment; Psychiatric symptoms; Social determinants of health and adverse life events; Availability of lethal means; Physical health conditions; Demographic characteristics
- Mood changes: exhibits dramatic changes in mood, lack of interest in usual activities; Sleep disturbances: experiences insomnia, inability to sleep, or sleeping all the time; Guilt or shame: expresses overwhelming self-blame or remorse

Sidebar 2. Risk and Protective Factors for Suicide

When performing a suicide risk assessment, we suggest including, but not limited to, the factors (see Recommendation 3 and Table 6 within the full VA/DoD CPG) within the following domains:

- SDV thoughts and behaviors; Current psychiatric conditions and current or past mental/behavioral health treatment; Psychiatric symptoms; Social determinants of health and adverse life events; Availability of lethal means; Physical health conditions; Demographic characteristics
- Mood changes: exhibits dramatic changes in mood, lack of interest in usual activities; Sleep disturbances: experiences insomnia, inability to sleep, or sleeping all the time; Guilt or shame: expresses overwhelming self-blame or remorse

Abbreviations: CPG: clinical practice guideline; SDV: self-directed violence
*Source: Rocky Mountain MIRECC Therapeutic Risk Management – Risk Stratification Table. The 2024 Suicide Risk CPG’s systematic evidence review did not identify evidence to recommend one risk assessment or stratification tool over another. This tool, which is based on best practices, is included as an example. Available at: https://www.mirecc.va.gov/visn19/trm/

Access to the full guideline and additional resources is available at: https://www.healthquality.va.gov/.
Module C: Management of Patients at Acute Risk for Suicide

Patient at HIGH ACUTE RISK for suicide

Directly observe patients and keep them in an environment with limited access to lethal means (e.g., keep away from sharps, cords or tubing, toxic substances) until they are transferred to a safe environment or are no longer at high acute risk.

Is psychiatric hospitalization feasible and indicated to maintain safety?

Follow local procedures for hospitalization, which may include the need for involuntary hospitalization.

During hospitalization target modifiable risk and protective factors (See Sidebar 4). Initiate evidence-based treatment to reduce suicide risk and co-occurring conditions (See Sidebar 5).

Has the patient’s risk for suicide decreased to intermediate or low?

If the patient was hospitalized and is to be discharged, consider intervention in Sidebar 5. Return to Module B: Comprehensive Suicide Risk Assessment.

Continue to implement risk mitigation strategies noted in Box 20

Non-pharmacologic Treatments (See Recommendations 5-6, 18a)
- CBT-based interventions for suicide prevention
- PST-based interventions
- Self-guided digital interventions (app or web) that include, but are not limited to, cognitive-behavioral-based therapeutic content

Pharmacologic Treatments (See Recommendations 11-12a)
- Ketamine infusion (among patients with suicidal ideation and MDD)
- Clozapine (among patients with schizophrenia or schizoaffective disorder and either suicidal ideation or a history of suicide attempt)

Other (See Recommendations 16 and 21a)
- Periodic caring communications (following hospitalization for suicide risk)
- Reduce access to lethal means

Abbreviations: CBT: cognitive behavioral therapy; MDD: major depressive disorder; PST: problem-solving therapy

a Recommendations, Sidebars 3a, 3b, and 4 can be accessed in the full guideline. Available at: https://www.healthquality.va.gov/