VA/DOD CLINICAL PRACTICE GUIDELINE

Assessment and Management of Patients at Risk for Suicide

KEY ELEMENTS OF THE SUICIDE RISK GUIDELINE

ASSESSMENT AND DETERMINATION OF RISK

» Identify warning signs for suicide
» Assess for suicidal ideation, intent, and behavior
» Assess risk and protective factors affecting suicide risk
» Evaluate patients at intermediate and high risk for suicide by behavioral health providers

INITIAL MANAGEMENT OF PATIENT AT RISK FOR SUICIDE

» Determine level of risk for suicide attempt
» Determine appropriate care setting
» Educate patient and family on risk and treatment options
» Limit access to lethal means
» Establish a Safety Plan

TREATMENT OF PATIENT AT HIGH RISK FOR SUICIDE

Interventions addressing the suicide risk

» Suicide-focused psychotherapies shown to be effective in reducing the risk for repeated self-directed violence:
  • Cognitive therapy for suicide prevention (CT-SP)
  • Problem-solving therapy (PST) addressing the risk for suicide behaviors

Interventions addressing the underlying conditions

» Optimize treatment for any mental health and medical conditions that may be related to the risk of suicide
» Modify care for the relevant condition-focused treatments to address the risk of suicide
» Provide psychotherapy/pharmacotherapy interventions for co-occurring mental disorders to reduce the risk of suicide

FOLLOW-UP

» Close follow-up after discharge from acute care setting
» Ensure continuity of care and reassessment of continued risk for suicide

Access to full guideline and toolkit:
http://www.healthquality.va.gov or,
https://www.qmo.amedd.army.mil
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VA/DoD Evidence-Based Practice

Algorithm A: *Assessment & Management in Primary Care*

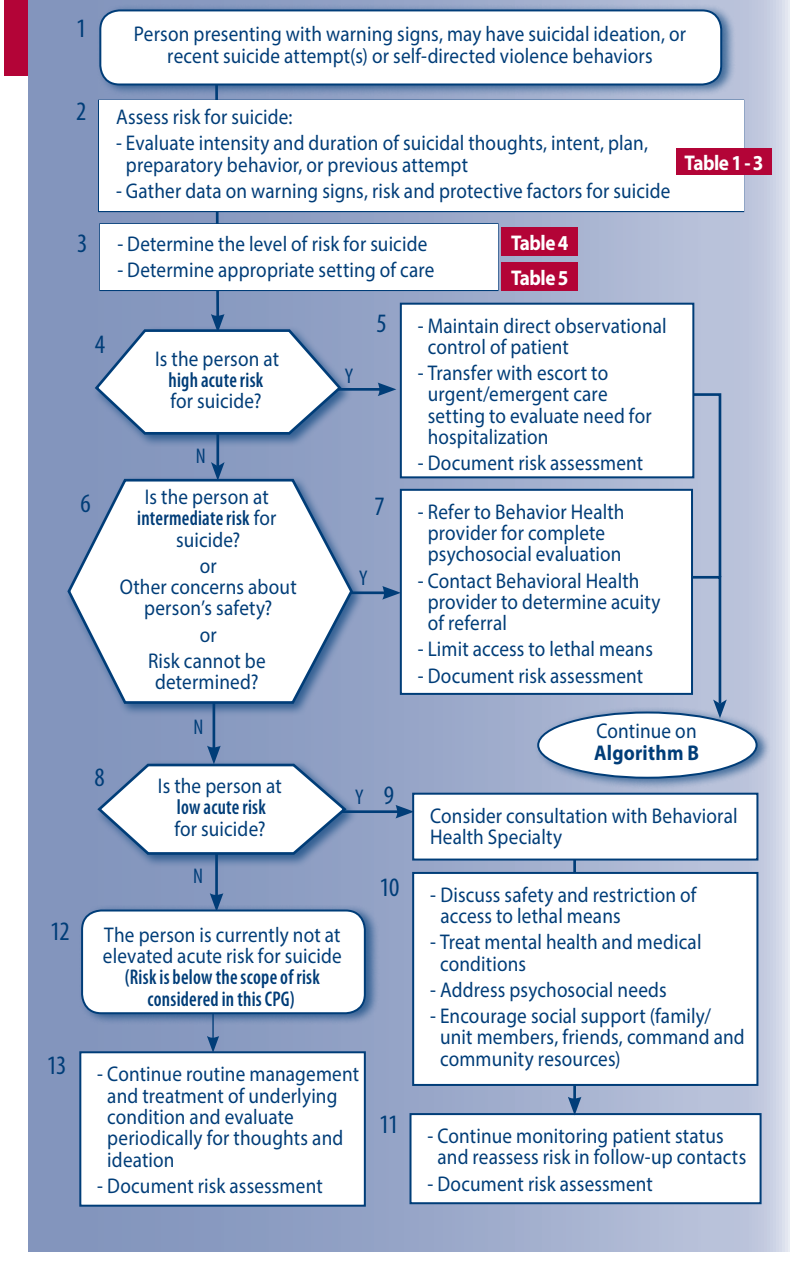


TABLE 1 WARNING SIGNS

Warning Signs: 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. Warning signs may be experienced in the absence of risk factors.

DIRECT WARNING SIGNS portend the highest likelihood of suicidal behaviors occurring in the near future:	
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	Owning or planning to acquire weapons, medications, toxins or other lethal means.
Other INDIRECT WARNING SIGNS presentation(s) or behavioral expressions that may indicate increased suicide risk and urgency in a patient at risk for suicide:	
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	Insomnia, unable to sleep or sleeping all the time
Guilt or Shame	Expressing overwhelming self-blame or remorse

TABLE 2 Risk Factors

Acute Risk Factors: 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.

Chronic Risk Factors (Pre-Existing)**:** 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.

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 offense and incarceration

Social Support
– Poor interpersonal relationship (partner, parents, children)
– Geographic isolation from support
– Recent change in level of care (discharge from inpatient psychiatry)

MEDICAL CONDITIONS

– History of Traumatic Brain Injury
– 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

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
– Trauma (psychological)

Physical Symptoms
– Chronic pain
– Insomnia
– Function limitation

TABLE 2 Risk Factors (cont.)

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

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.

TABLE 3 Protective Factors

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.

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 sense of the importance of health and wellness

TABLE 4	Level of Risk For Suicide	
Risk for Suicide Attempt	*Indicator for Suicide Risk*	*Contributing factors †*
High Acute Risk	• Persistent suicidal **ideation** or thoughts • Strong **intention** to act or plan • Not able to control **impulse** OR • **Recent suicide attempt**	• Acute state of psychiatric disorder or acute psychiatric symptoms • Acute **precipitating** event(s) • Inadequate **protective factors**
Intermediate Acute Risk	• Current suicidal **ideation** or thoughts • **No intention** to act • Able to control the **impulse** • **No recent attempt** or **preparatory behavior** or rehearsal of act	• Existence of **warning signs or risk factors** †† AND • Limited **protective factor**
Low Acute Risk	• Recent suicidal **ideation** or thoughts • No **intention** to act or plan • Able to control the **impulse** • No planning or rehearsing a suicide act • No previous attempt	• Existence of **protective factors** AND • Limited **risk factors**
Undetermined Risk	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.	

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

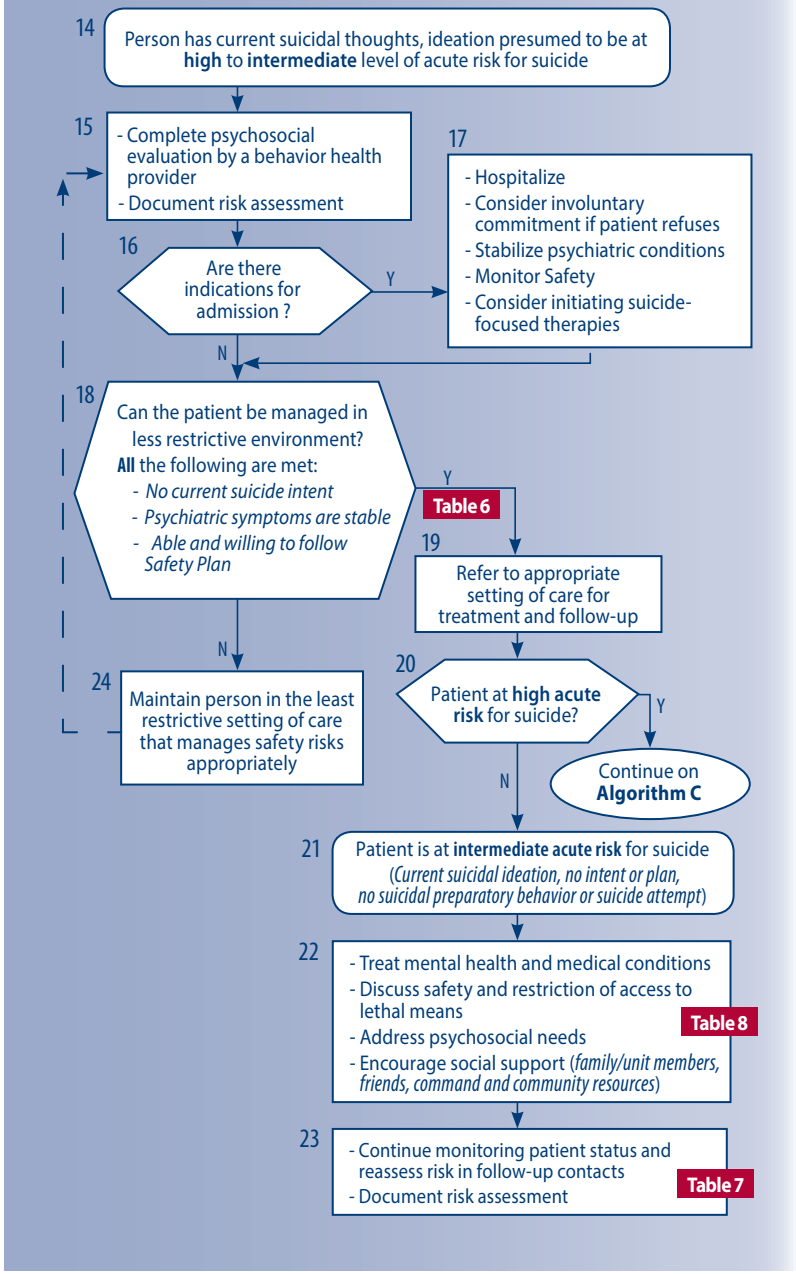
- **Acute state of substance use:** Alcohol or substance abuse history is associated with impaired judgment and may increase the severity of the suicidality and risk for suicide act
- **Access to means**: (firearms, medications, toxins) may increase the risk for suicide act
- Existence of **multiple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

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.

There is insufficient evidence to recommend any specific measurement scale to determine suicide risk.

Algorithm B: *Assessment & Management in Behavioral Health*



Algorithm C: *Management of High Risk for Suicide*

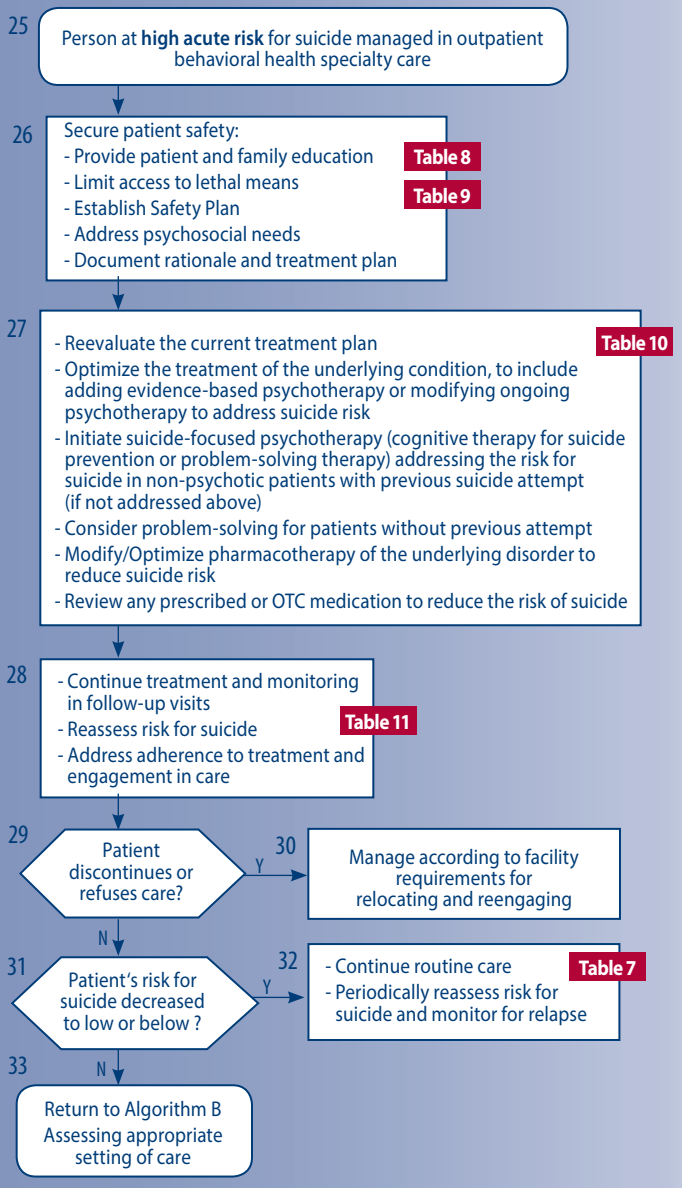


TABLE 5	Appropriate Action in Primary Care
Risk for Suicide Attempt	*Initial Action Based on Level of Risk*
High Acute Risk	• Maintain direct observational control of the patient • Limit access to lethal means • Immediate transfer with escort to urgent/emergency Care setting for Hospitalization
Intermediate Acute Risk	• Refer to Behavioral Health provider for complete evaluation and interventions • Contact Behavioral Health provider to determine acuity of referral • Limit access to lethal means
Low Acute Risk	• Consider consultation with Behavioral Health to determine: - Need for referral - Treatment • Treat presenting problems • Address safety issues • Document care and rationale for action
Undetermined Risk	• Refer to Behavioral Health provider for complete evaluation and interventions • Contact Behavioral Health provider to determine acuity of referral • Limit access to lethal means

Recovery Model: Assessment and Management of Suicidal Risk

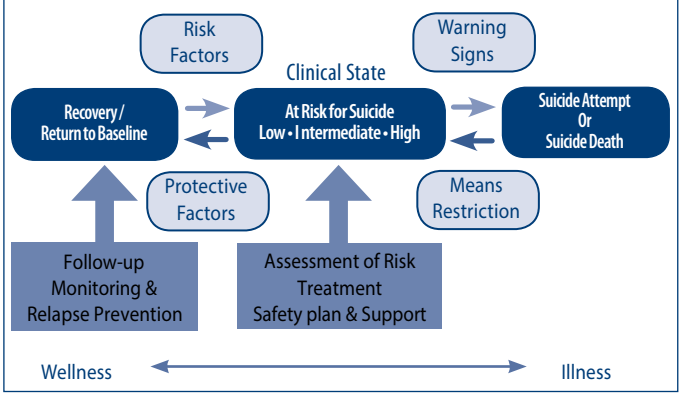


TABLE 6 Discharge to Less Restrictive Level of Care

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).

TABLE 7 Discharge Planning

Discharge planning should include the following:

- Reassessment of the Suicide Risk
- Education to patient and support system about the risks of suicide in the post-discharge timeframe
- Providing suicide prevention information (such as a crisis hotline) to the patient and family/unit members
- Post-discharge treatment plans for psychiatric conditions and for suicide-specific therapies
- Safety plan with validation of available support systems
- Coordination of the transition to appropriate care setting with warm hand-offs
- Identifying the responsible provider during the transition
- Monitoring of adherence to the discharge plan for 12 weeks

TABLE 8 Safety Planning

Component of Safety Plan:
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.

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:

1. Recognizing warning signs of an impending suicidal crisis
2. Employing internal coping strategies
3. Utilizing social contacts and social settings as a means of distraction from suicidal thoughts
4. Utilizing family members or friends to help resolve the crisis
5. Contacting mental health professionals or agencies
6. Restricting access to lethal means

TABLE 9 Management of Military Service Members

- Inform command
- Determine utility of command involvement
- Address barrier to care (including stigma)
- Ensure follow-up during transition

TABLE 10 Evidence Based Treatment to Reduce Repetition of Suicide Behavior

Psychotherapy

Treating the Suicide Risk:

- Cognitive therapy for suicide prevention
- Problem-solving therapy addressing the risk for suicide

Treating Underlying Disorder:

- Psychotherapies for patients with borderline personality disorder who are at high risk for suicide (Dialectical behavioral therapy, specific cognitive or behavioral approaches or skills training, specific psychodynamic psychotherapies)
- Treatment of high risk for suicide and comorbid substance use disorder

Pharmacotherapy

Treating Underlying Disorder:

- Drug treatment is not recommended as a specific intervention for prevention of self directed violence in patients with no diagnosis of a mental disorder
- Review all medications used by patients, consider the toxicity of prescribed drugs in overdose and limit the quantity dispensed or available to patient who self harm
- Antidepressants - monitor for emerging of suicide ideation in young (age 18-24) patients after initiation, and in patients of all ages after any change in dosage
- Antipsychotics - closely monitor patients for changes in thoughts of suicide or suicidal behaviors after an antipsychotic is added to treatment for a mood disorder
- Lithium - consider for patients with bipolar disorder to reduce the increased risk of suicide. Consider augmentation for unipolar depression
- Clozapine - consider for patients with schizophrenia and high risk for suicide
- Antiepileptics - monitor for changes in suicidal ideation or behavior
- Benzodiazepines - use caution when prescribing (avoid short half-life and use for long term)
- Methadone - consider in patients with opioid dependence to reduce risk of overdose
- Naltrexone (intranasal)- consider for patients with history of overdose

TABLE 11 Interventions to Improve Adherence

- Case- Care Management
- Facilitating access to care
- Mailing caring letters/postcards
- Telephone contact
- Outreach (home visit)
- Assertive outreach
- Counseling and other psychosocial interventions

TABLE 12	Definitions
Behavior	**Description**
Suicidal Self-Directed Violence (SDV)	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
Suicide	Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior
Suicide Attempt	A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior
Preparatory Behavior	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)
Suicidal Intent	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
Suicidal Ideation	Thoughts of engaging in suicide-related behavior. (Various degrees of frequency, intensity, and duration)
Interrupted By Self or Other	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
Physical Injury	A bodily injury resulting from the physical or toxic effects of a self-directed violent act interacting with the body
Non-Suicidal SDV 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 SDV 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 SDV	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

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.