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
Algorithm A: Assessment & Management in Primary Care

1. Person presenting with warning signs, may have suicidal ideation, or recent suicide attempt(s) or self-directed violence behaviors

2. Assess risk for suicide:
   - Evaluate intensity and duration of suicidal thoughts, intent, plan, preparatory behavior, or previous attempt
   - Gather data on warning signs, risk and protective factors for suicide

3. - Determine the level of risk for suicide
   - Determine appropriate setting of care

4. Is the person at high acute risk for suicide?
   - Y

5. - Maintain direct observational control of patient
   - Transfer with escort to urgent/emergent care setting to evaluate need for hospitalization
   - Document risk assessment

6. Is the person at intermediate risk for suicide? or Other concerns about person’s safety? or Risk cannot be determined?
   - N

7. - Refer to Behavior Health provider for complete psychosocial evaluation
   - Contact Behavioral Health provider to determine acuity of referral
   - Limit access to lethal means
   - Document risk assessment

8. Is the person at low acute risk for suicide?
   - Y

9. Consider consultation with Behavioral Health Specialty

10. The person is currently not at elevated acute risk for suicide (Risk is below the scope of risk considered in this CPG)
    - N

11. - Discuss safety and restriction of access to lethal means
    - Treat mental health and medical conditions
    - Address psychosocial needs
    - Encourage social support (family/unit members, friends, command and community resources)

12. - Continue routine management and treatment of underlying condition and evaluate periodically for thoughts and ideation
    - Document risk assessment

13. - Continue monitoring patient status and reassess risk in follow-up contacts
    - Document risk assessment

Table 1 - 3
Table 4
Table 5

Continue on Algorithm B
### TABLE 1 WARNING SIGNS

**Warning Signs:** Observations that signal an increase in the probability that a 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:

<table>
<thead>
<tr>
<th>Suicidal communication</th>
<th>Writing or talking about suicide, wish to die, or death (threatening to hurt or kill self) or intention to act on those ideas.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparations for suicide</td>
<td>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.</td>
</tr>
<tr>
<td>Seeking access or recent use of lethal means</td>
<td>Owning or planning to acquire weapons, medications, toxins or other lethal means.</td>
</tr>
</tbody>
</table>

#### Other INDIRECT WARNING SIGNS presentation(s) or behavioral expressions that may indicate increased suicide risk and urgency in a patient at risk for suicide:

<table>
<thead>
<tr>
<th>Substance abuse</th>
<th>Increasing or excessive substance use (alcohol, drugs, smoking)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hopelessness</td>
<td>Expresses feeling that nothing can be done to improve the situation</td>
</tr>
<tr>
<td>Purposelessness</td>
<td>Express no sense of purpose, no reason for living, decreased self-esteem</td>
</tr>
<tr>
<td>Anger</td>
<td>Rage, seeking revenge</td>
</tr>
<tr>
<td>Recklessness</td>
<td>Engaging impulsively in risky behavior</td>
</tr>
<tr>
<td>Feeling Trapped</td>
<td>Expressing feelings of being trapped with no way out</td>
</tr>
<tr>
<td>Social Withdrawal</td>
<td>Withdrawing from family, friends, society</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Agitation, irritability, angry outbursts, feeling like wants to “jump out of my skin”</td>
</tr>
<tr>
<td>Mood Changes</td>
<td>Dramatic changes in mood, lack of interest in usual activities/friends</td>
</tr>
<tr>
<td>Sleep</td>
<td>Insomnia, unable to sleep or sleeping all the time</td>
</tr>
<tr>
<td>Guilt or Shame</td>
<td>Expressing overwhelming self-blame or remorse</td>
</tr>
</tbody>
</table>
### 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.)

<table>
<thead>
<tr>
<th>MILITARY-SPECIFIC</th>
<th>PRE-EXISTING &amp; NON-MODIFIABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>– Disciplinary actions (UCMJ, NJP)</td>
<td>– Age (young &amp; elderly)</td>
</tr>
<tr>
<td>– Reduction in rank</td>
<td>– Gender (male)</td>
</tr>
<tr>
<td>– Career threatening change in fitness for duty</td>
<td>– Race (white)</td>
</tr>
<tr>
<td>– Perceived sense of injustice or betrayal (unit/command)</td>
<td>– Marital status (divorce, separate, widowed)</td>
</tr>
<tr>
<td>– Command/leadership stress, isolation from unit</td>
<td>– Family history of:</td>
</tr>
<tr>
<td>– Transferring duty station (PCS)</td>
<td>• Suicide/attempt</td>
</tr>
<tr>
<td>– Administrative separation from service/unit</td>
<td>• Mental illness (including SUD)</td>
</tr>
<tr>
<td>– Adverse deployment experience</td>
<td>– Child maltreatment trauma-physical/psychological/sexual</td>
</tr>
<tr>
<td>– Deployment to a combat theater</td>
<td>– Sexual trauma</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Risk for Suicide Attempt</th>
<th>Indicator for Suicide Risk</th>
<th>Contributing factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Acute Risk</strong></td>
<td>• Persistent suicidal ideation or thoughts&lt;br&gt;• Strong intention to act or plan&lt;br&gt;• Not able to control impulse OR&lt;br&gt;• Recent suicide attempt</td>
<td>• Acute state of psychiatric disorder or acute psychiatric symptoms&lt;br&gt;• Acute precipitating event(s)&lt;br&gt;• Inadequate protective factors</td>
</tr>
<tr>
<td><strong>Intermediate Acute Risk</strong></td>
<td>• Current suicidal ideation or thoughts&lt;br&gt;• No intention to act&lt;br&gt;• Able to control the impulse&lt;br&gt;• No recent attempt or preparatory behavior or rehearsal of act</td>
<td>• Existence of warning signs or risk factors †† AND&lt;br&gt;• Limited protective factor</td>
</tr>
<tr>
<td><strong>Low Acute Risk</strong></td>
<td>• Recent suicidal ideation or thoughts&lt;br&gt;• No intention to act&lt;br&gt;• Able to control the impulse&lt;br&gt;• No planning or rehearsing a suicide act&lt;br&gt;• No previous attempt</td>
<td>• Existence of protective factors AND&lt;br&gt;• Limited risk factors</td>
</tr>
<tr>
<td><strong>Undetermined Risk</strong></td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

†† 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)

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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 C: Management of High Risk for Suicide**

Person has current suicidal thoughts, ideation presumed to be at **high** to **intermediate** level of acute risk for suicide

- Complete psychosocial evaluation by a behavior health provider
- Document risk assessment

16️⃣ Are there indications for admission?

- **Y**: Hospitalize
  - Consider involuntary commitment if patient refuses
  - Stabilize psychiatric conditions
  - Monitor Safety
  - Consider initiating suicide-focused therapies

- **N**: Continue on Algorithm C

Can the patient be managed in less restrictive environment? **All** the following are met:
- **No current suicide intent**
- **Psychiatric symptoms are stable**
- **Able and willing to follow Safety Plan**

- **Y**: Refer to appropriate setting of care for treatment and follow-up

- **N**: Maintain person in the least restrictive setting of care that manages safety risks appropriately

19️⃣ Table 6

**Patient at high acute risk for suicide?**

- **Y**: Hospitalize
  - Consider involuntary commitment if patient refuses
  - Stabilize psychiatric conditions
  - Monitor Safety
  - Consider initiating suicide-focused therapies

- **N**: Continue monitoring patient status and reassess risk in follow-up contacts

**Patient is at intermediate acute risk for suicide** *(Current suicidal ideation, no intent or plan, no suicidal preparatory behavior or suicide attempt)*

- Treat mental health and medical conditions
- Discuss safety and restriction of access to lethal means
- Address psychosocial needs
- Encourage social support *(family/unit members, friends, command and community resources)*

- Continue monitoring patient status and reassess risk in follow-up contacts

**Table 7**

**Table 8**
Person at **high acute risk** for suicide managed in outpatient behavioral health specialty care

- Secure patient safety:
  - Provide patient and family education
  - Limit access to lethal means
  - Establish Safety Plan
  - Address psychosocial needs
  - Document rationale and treatment plan

- Reevaluate the current treatment plan
- Optimize the treatment of the underlying condition, to include adding evidence-based psychotherapy or modifying ongoing psychotherapy to address suicide risk
- Initiate suicide-focused psychotherapy (cognitive therapy for suicide prevention or problem-solving therapy) addressing the risk for suicide in non-psychotic patients with previous suicide attempt (if not addressed above)
- Consider problem-solving for patients without previous attempt
- Modify/Optimize pharmacotherapy of the underlying disorder to reduce suicide risk
- Review any prescribed or OTC medication to reduce the risk of suicide

- Continue treatment and monitoring in follow-up visits
- Reassess risk for suicide
- Address adherence to treatment and engagement in care

Patient discontinues or refuses care? 

**Y** 
- Manage according to facility requirements for relocating and reengaging

Table 8
Table 9
Table 10
Table 11

**N** 
- Continue routine care
- Periodically reassess risk for suicide and monitor for relapse

Patient's risk for suicide decreased to low or below?

**Y** 

**N** 
- Return to Algorithm B Assessing appropriate setting of care

Table 7
### TABLE 5 Appropriate Action in Primary Care

<table>
<thead>
<tr>
<th>Risk for Suicide Attempt</th>
<th>Initial Action Based on Level of Risk</th>
</tr>
</thead>
</table>
| **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

- **Risk Factors** → **Clinical State** → **Warning Signs** → **Suicide Attempt Or Suicide Death** → **Means Restriction** → **Assessment of Risk Treatment Safety plan & Support** → **Follow-up Monitoring & Relapse Prevention** → **Protective Factors** → **Recovery / Return to Baseline** → **Recovery** → **Wellness** → **Illness**
### 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
Cognitive therapy for suicide prevention
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
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
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

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>
<thead>
<tr>
<th>Behavior</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Self-Directed Violence (SDV)</td>
<td>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</td>
</tr>
<tr>
<td>Suicide</td>
<td>Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior</td>
</tr>
<tr>
<td>Suicide Attempt</td>
<td>A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior</td>
</tr>
<tr>
<td>Preparatory Behavior</td>
<td>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)</td>
</tr>
<tr>
<td>Suicidal Intent</td>
<td>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</td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td>Thoughts of engaging in suicide-related behavior. (Various degrees of frequency, intensity, and duration)</td>
</tr>
<tr>
<td>Interrupted By Self or Other</td>
<td>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</td>
</tr>
<tr>
<td>Physical Injury</td>
<td>A bodily injury resulting from the physical or toxic effects of a self-directed violent act interacting with the body</td>
</tr>
<tr>
<td>Non-Suicidal SDV Behavior</td>
<td>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</td>
</tr>
<tr>
<td>Non-Suicidal SDV Ideation</td>
<td>Self-reported thoughts regarding a person’s desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent</td>
</tr>
<tr>
<td>Undetermined SDV</td>
<td>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</td>
</tr>
</tbody>
</table>

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.