

## Assessment and Management of Patients at Risk for Suicide

### About the Guideline

- This guideline is an update to the 2013 guideline.
- The guideline was updated by a panel of multidisciplinary subject-matter experts known as the Champions (three clinical leaders) and the Work Group (clinical specialists from psychiatry, psychology, nursing, social work, pharmacy, psychotherapy, mental health, and preventive medicine/public health).
- Peer review and feedback were provided by American Psychiatric Association and Perelman School of Medicine, University of Pennsylvania.
- The guideline provides 22 evidence-based recommendations on the management of patients at risk for suicide.
- Algorithms are included to promote clinical decision-making processes.
- The guideline is intended for VA and DoD healthcare practitioners and others caring for individuals at risk for suicide.
- The intended outcomes of the guideline are to promote practitioner-patient collaboration in determining the best treatment methods, to emphasize patient-centered care, to optimize health outcomes, to improve quality of life, and to minimize preventable complications.

### Key Clinical Considerations

Become familiar with the recommendations in this guideline, especially if you work in an acute care setting.

- The guideline provides three algorithms to aid in the identification of risk for suicide, the clinical evaluation for suicide, and the management of patients at acute risk for suicide.
- Each algorithm includes steps of care, recommended examinations and observations, decisions to consider, and actions to be taken.
- Practitioners should use the algorithms to guide their clinical practice.

### Screening and Evaluation

#### Screening

- Screen individuals using a validated screening tool to identify suicidal risk.
- Patient Health Questionnaire-9 (PHQ-9) item 9 is the recommended universal screening instrument to identify suicide risk.

#### Evaluation

- A comprehensive evaluation is recommended to identify the following: risk factors for suicide ideation; current psychiatric conditions such as mood disorders and substance abuse,

hopelessness, agitation; prior suicide attempts; past medical history of psychiatric hospitalization; and access to firearms.

- The use of more than one assessment tool, such as clinical interviews or self-reported measures to evaluate suicide risk, is recommended.
- Practitioners are advised to use caution with risk stratification of suicidal patients when determining level of care. There is no consensus on one reliable tool to stratify patients at risk for suicide.

## **Risk Management and Treatment**

### Nonpharmacologic Treatment

- Cognitive behavioral therapy (CBT) is strongly recommended to reduce suicidal ideation and behavior, and to reduce the incidence of future self-directed violence.
- Dialectical behavior therapy (DBT) is suggested for the treatment of suicidal ideation and self-directed violence among individuals with borderline personality disorder.
- A crisis response plan is suggested for individuals with a history of suicidal ideation, self-directed violence, moderate to severe traumatic brain injury, and hopelessness.
- Problem-solving psychotherapies are suggested for individuals with a history of suicidal ideation and self-directed violence, and as treatment for hopelessness among individuals with moderate to severe traumatic brain injury at risk for suicide.

### Pharmacologic Treatment

- Ketamine adjunctive therapy is suggested for symptom improvement in patients with suicidal ideation and major depression. Infuse a single dose at 0.5 mg/kg within 24 hours for a moderate effect that continues for 1 week and even up to 6 weeks.
- Lithium maintenance therapy alone is suggested to reduce the risk of suicidal ideation in patients with bipolar disorder. Patients with unipolar disorder may benefit from a combination of lithium and another psychotropic agent.
- CloZAPine therapy is suggested to reduce the risk of death in patients with schizoaffective disorder or schizophrenia and a history of either suicidal ideation or suicide attempts.

### Post-Acute Care

- It is suggested that sending periodic caring communications (postcards, letters) within 12 to 24 months after psychiatric hospitalization for suicide attempt or suicidal ideation may lower the rates of recurrent suicide attempts, ideation, and death.
- Home health visits are recommended for patients who fail to engage in outpatient care following hospitalization for a suicide attempt.
- Individuals who present to the emergency department following a suicide attempt should be given the World Health Organization Brief Intervention and Contact (BIC) treatment modality in addition to standard care.

### Technology-Based Modalities

- There is insufficient evidence to recommend the use of technology-based behavioral health treatment modalities (compact disc, web-based, and virtual provider) for individuals with suicidal ideation.
- There is insufficient evidence to recommend the use of technology-based adjuncts (web or telephone applications) in routine suicide prevention treatment for individuals with suicidal ideation.

### **Other Management Modalities**

#### Population and Community-Based Interventions

- Reducing access to lethal means (such as firearms) to decrease suicide rates is suggested.
- There is insufficient evidence to recommend the use of community-based interventions targeting individuals at risk for suicide, suicide ideation, or suicide attempts.
- There is insufficient evidence to recommend the use of community-based interventions to reduce suicide rates at the population level.
- There is insufficient evidence to recommend gatekeeper training alone for the reduction of suicide rates at the population level.
- There is insufficient evidence to recommend buddy support programs to prevent suicide, suicide attempts, or suicidal ideation.

#### **Reference:**

Department of Veterans Affairs, and Department of Defense (2019). VA/DoD clinical practice guideline for the assessment and management of patients at risk for suicide: Version 2.0, 1-142. Retrieved February 27, 2023 from <https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf>