Improving Suicide Risk Assessment Skills

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CPE Information

- Target Audience: Pharmacists and Pharmacist Technicians

- ACPE#: 0202-0000-18-229-L04-P/T

- Activity Type: Knowledge-based
This presentation will review the evidence-based practice of suicide prevention. We will review the epidemiology of suicidal behavior and present a recovery model for the management of patients at risk. We will discuss the performance of suicide risk assessment and understand the importance of suicide risk stratification in clinical care. We will describe the criteria that inform decisions to hospitalize and discharge patients with suicidal ideation.
Learning Objectives

- Appraise the scope & quality of available evidence to date for the bio-psycho-social factors related to Suicide and Suicide Prevention so that providers can select appropriate treatments.

- Develop improved skills in Suicide Risk Assessment by learning how to perform Suicide Risk Stratification to determine the appropriate setting of care to best manage the acute risk of suicide.

- Understand the evidence base for suicide-focused medication to reduce risk of suicide attempt in your patient.
Agenda

- Intro & Agenda
- Background & Scope of the problem of suicide
- Suicide Risk Stratification
- Exercise
- Acute Management of Safety
- Exercise
- Psychopharmacological Treatments to reduce Suicide Risk
- Q&A
The views and opinions expressed in this presentation are those of the presenter and the working group, and do not necessarily reflect the official policy or position of the Henry Jackson Foundation, the Uniformed Services University, the Department of the Defense, nor the US Government.
Self-Assessment Questions

1. Which statement is true?
   
   A. The overall rate of suicide is over 20 percent higher in veterans than the matched civilian population and is higher in both males and females than in their civilian counterparts.
   
   B. The overall rate of suicide is over 40 percent higher in veterans than the matched civilian population and is higher in both males and females than in their civilian counterparts.
   
   C. The overall rate of suicide is over 20 percent higher in veterans than the matched civilian population and is higher females than in their civilian counterparts.

2. Which statement is NOT true?
   
   A. Formulation of the level of suicide risk should be based on a comprehensive and structured clinical evaluation that is aimed to assess suicidal thoughts, intent and behavior and information about risk and protective factors obtained to estimating the level of risk.
   
   B. A Behavioral Health provider may use a standardized assessment to inform the comprehensive clinical evaluation.
   
   C. Assessment of risk for suicide can be based on a single assessment instrument alone and can replace a clinical evaluation.

3. Which statement is NOT true?
   
   A. When clinically possible, include limiting access to medications that carry risk for suicide, at least during the periods when patient is at high acute and intermediate risk for suicide.
   
   B. This may include prescribing limited quantities, supplying the medication in blister packaging, printed warnings about the dangers of overdose.
   
   C. This may include ensuring that currently prescribed medications are actively controlled by a responsible party.
Background & Scope of the Problem
VA/DoD Clinical Practice Guideline for Suicide Prevention
# The CPG Working Group

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---|---|---
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Definitions

**Suicide:** Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.

**Suicidal Self-Directed Violence (Suicide attempt):** A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior.

**Non-Suicidal Self Directed Violence:** 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.

- Cutting without intent to die
- Overdose without intent to die

**Suicidal intent:** There is past or present evidence 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. Extent of expectation to carry out the plan and the belief that the plan/act to will be lethal

**Suicidal ideation or thoughts:** Thoughts of engaging in suicide-related behavior. Various degrees of frequency, intensity, and duration
<table>
<thead>
<tr>
<th>Suicide Methods</th>
<th>Number</th>
<th>Rate</th>
<th>Percent of Total</th>
<th>Number</th>
<th>Rate</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firearm suicides (1st)</td>
<td>21,334</td>
<td>6.7</td>
<td>49.9%</td>
<td>All but Firearms</td>
<td>21,439</td>
<td>6.7</td>
</tr>
<tr>
<td>Suffocation/Hanging (2nd)</td>
<td>11,407</td>
<td>3.6</td>
<td>26.7%</td>
<td>Poisoning (3rd)</td>
<td>6,808</td>
<td>2.1</td>
</tr>
<tr>
<td>Cut/pierce (5th)</td>
<td>740</td>
<td>0.2</td>
<td>1.7%</td>
<td>Drowning (7th)</td>
<td>372</td>
<td>0.1</td>
</tr>
</tbody>
</table>
Suicide Rates (per 100,000)

Figure 1. Suicide Rates Among VHA Users by Sex and Fiscal Year

Dept of Veterans Affairs Suicide Data Report 2012
<table>
<thead>
<tr>
<th>Component and Service</th>
<th>2014 Count</th>
<th>2014 Rate</th>
<th>2015 Count</th>
<th>2015 Rate</th>
<th>2016 Count</th>
<th>2016 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active, all Services</td>
<td>276</td>
<td>20.4</td>
<td>266</td>
<td>20.2</td>
<td>275</td>
<td>21.1</td>
</tr>
<tr>
<td>Air Force</td>
<td>62</td>
<td>19.1</td>
<td>64</td>
<td>20.5</td>
<td>61</td>
<td>19.4</td>
</tr>
<tr>
<td>Army</td>
<td>126</td>
<td>24.6</td>
<td>120</td>
<td>24.4</td>
<td>127</td>
<td>26.7</td>
</tr>
<tr>
<td>Marine Corps</td>
<td>34</td>
<td>17.9</td>
<td>39</td>
<td>21.2</td>
<td>37</td>
<td>20.1</td>
</tr>
<tr>
<td>Navy</td>
<td>54</td>
<td>16.6</td>
<td>43</td>
<td>13.1</td>
<td>50</td>
<td>15.3</td>
</tr>
<tr>
<td>Reserve, all Services</td>
<td>79</td>
<td>21.6</td>
<td>90</td>
<td>24.7</td>
<td>80</td>
<td>22.0</td>
</tr>
<tr>
<td>Air Force</td>
<td>10</td>
<td>---</td>
<td>10</td>
<td>---</td>
<td>10</td>
<td>---</td>
</tr>
<tr>
<td>Army</td>
<td>42</td>
<td>21.4</td>
<td>55</td>
<td>27.7</td>
<td>41</td>
<td>20.6</td>
</tr>
<tr>
<td>Marine Corps</td>
<td>12</td>
<td>---</td>
<td>11</td>
<td>---</td>
<td>19</td>
<td>---</td>
</tr>
<tr>
<td>Navy</td>
<td>15</td>
<td>---</td>
<td>14</td>
<td>---</td>
<td>10</td>
<td>---</td>
</tr>
<tr>
<td>Guard, Air Force and Army</td>
<td>91</td>
<td>19.8</td>
<td>125</td>
<td>27.5</td>
<td>123</td>
<td>27.3</td>
</tr>
<tr>
<td>Air Guard</td>
<td>14</td>
<td>---</td>
<td>21</td>
<td>19.9</td>
<td>14</td>
<td>---</td>
</tr>
<tr>
<td>Army Guard</td>
<td>77</td>
<td>21.8</td>
<td>104</td>
<td>29.8</td>
<td>109</td>
<td>31.6</td>
</tr>
</tbody>
</table>

1Unadjusted rate per 100,000 Service members. Rates for subgroups with fewer than 20 suicides are not reported because of statistical instability.
2Rates for the Reserve and National Guard Components of the SELRES include all Service members irrespective of duty status.
In 2014, 20 Veterans died by suicide each day. Six of the 20 were users of VHA services.

The burden of suicide resulting from firearm injuries remains high. In 2014, about 67 percent of all Veteran deaths by suicide were the result of firearm injuries.

After adjusting for differences in age and gender, risk for suicide was 21 percent higher among Veterans when compared with U.S. civilian adults. (2014)

After adjusting for differences in age, risk for suicide was 18 percent higher among male Veterans when compared with U.S. civilian adult males. (2014)

After adjusting for differences in age, risk for suicide was 2.4 times higher among female Veterans when compared with U.S. civilian adult females. (2014)
80% of attempters seek VA Care in past month

Figure 12: Prevalence of Non-Fatal Events by Time since Last Service Use

Main Finding: Among those at risk, the first four weeks following service require intensive monitoring and case management.

Dept of Veterans Affairs Suicide Data Report 2012
Ways Pharmacists and Pharmacy Technicians Can Assist in Suicide Prevention

- Identify at risk patients
- Monitor medication use and mental health
- Collaborate with the health care team
- Refer to suicide prevention resources
  - National Suicide Prevention Lifeline (NSPL 1-800-273-8255)
- Be encouraging and empathetic

Resource:
Suicide Risk Stratification
Suicide Risk Assessment Review

Figure 2. Literature Flow Chart

16,426 records identified from database searches after removal of duplicates

95 additional records identified through other sources

16,521 records screened

15,743 records excluded at abstract level

778 full-text articles assessed for eligibility

732 full-text articles excluded
- 22 non-English language
- 72 ineligible country
- 110 ineligible outcome
- 49 did not evaluate risk factors or assessments
- 191 ineligible publication type
- 129 ineligible systematic review due to limitations in quality
- 10 ineligible nonsystematic regulatory agency analysis
- 26 did not account for major potential confounders
- 123 primary articles about risk, not a Veteran or military population

44 studies reported in 46 publications included in qualitative synthesis
- 30 observational studies
- 14 systematic reviews reported in 16 publications

* Modified from the PRISMA flow diagram.™

Factors Indicating Risk for Suicide

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warning signs</td>
<td>Warning signs are those 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; and may be experienced in the absence of risk factors.</td>
</tr>
<tr>
<td>Acute Factors</td>
<td>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.</td>
</tr>
<tr>
<td>Chronic Factors</td>
<td>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. Risk factors may be associated with a person contemplating suicide at one point in time over the long term.</td>
</tr>
<tr>
<td>Protective Factors</td>
<td>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 events.</td>
</tr>
</tbody>
</table>
# Risk Factors

<table>
<thead>
<tr>
<th>High</th>
<th>Behavioral</th>
<th>Biological</th>
<th>Psychological</th>
<th>Social</th>
<th>Military-Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>Preparation &amp; Rehearsal Behaviors</td>
<td>Agitation Insomnia Intoxication/Withdrawal Pain Functional limitation Medication-Induced New Major Illness Start/Stop/Change Antidepressant (~ 90 days)</td>
<td>Impulsivity Self loathing Perceived burdensomeness Hopelessness Anxiety (panic) Dysphoria Suicide bereavement</td>
<td>Stressful Life Events: Loss of status/respect/rank (Public humiliation, being bullied or abused, failure work/task) Loss of Relationship (divorce, separation) Loss of loved one (grief) Recent change in level of care (d/c from inpatient psychiatry) Other events (e.g., fired, arrested, evicted, assaulted)</td>
<td>Adverse deployment experience Administrative separation from service/unit Perceived sense of injustice or betrayal (unit/command) Career threatening change in fitness for duty Disciplinary actions (UCMJ, NJP) Reduction in rank</td>
</tr>
<tr>
<td>Chronic</td>
<td>History of NSSDV Access to firearms Access to other lethal means for suicide (e.g., medication stockpile)</td>
<td>Chronic pain Function limitation History of Traumatic Brain Injury (TBI) Terminal disease HIV/AIDS Worsening of chronic illness</td>
<td>Affective disorder Personality disorder Schizophrenia Anxiety disorder (Panic, PTSD) Substance use disorder Eating disorder</td>
<td>Financial Problems Unemployment, Underemployment Unstable housing, homeless Excessive debt, poor finances Legal Problems DUI/DWI Lawsuit Criminal offence and incarceration Social Support Poor relationships Geographic isolation Barriers to MH care</td>
<td>Deployment to a combat theater Transferring duty station Command/leadership stress, isolation from unit</td>
</tr>
<tr>
<td>Non-Mod</td>
<td>Prior suicide attempts</td>
<td>Gender (Male) Age (&lt;29 or &gt;45) Race (Caucasian) Family history Suicide/mental disorder</td>
<td>Prior suicide attempt Prior psychiatric hospitalization for SI Hx of Child maltreatment Sexual Assault</td>
<td>Marital status (separate, widowed) Lower Education level Same sex orientation (LGBT) Cultural or religious beliefs</td>
<td></td>
</tr>
</tbody>
</table>
Protective Factors

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 a sense of the importance of health and wellness
Recovery-Oriented Practice Model

Recovery / Return to Baseline

Clinical State & Vulnerability for Suicide (Affective, Motivational, Cognitive, Behavioral)

Suicide Attempt or Completion

Risk Factors

Precipitating Factors

Recovery-Oriented Practice Model

Wellness

Illness

Monitoring & Relapse Prevention

Assessment Intervention Treatment

Postvention Response
- Patient (if survived)
- Family / Support System / Unit
- First Responders
- Clinical Providers

Protective Factors

Means Restriction
Suicide Risk Assessment Instruments

RECOMMENDATIONS

1. Formulation of the level of suicide risk should be based on a comprehensive and structured clinical evaluation that is aimed to assess suicidal thoughts, intent and behavior and information about risk and protective factors obtained to estimating the level of risk.

2. Behavioral Health provider may use a standardized assessment to inform the comprehensive clinical evaluation and:
   - Estimate the level of risk
   - Supports clinical decision-making
   - Determines the level of intervention and indication for referral
   - Allow monitoring of risk level over time
   - Serves as the foundation for clinical documentation
   - Facilitates consistent data collection for process improvement

3. Assessment of risk for suicide should not be based on any single assessment instrument alone and cannot replace a clinical evaluation. The absolute risk for suicide cannot be predicted with certainty.

4. There is insufficient evidence to recommend any specific measurement scale to determine suicide risk. [I ]
# Risk Stratification of Suicide Risk

## Table A-1. Determine Level of Risk and Appropriate action

<table>
<thead>
<tr>
<th>Risk of Suicide Attempt</th>
<th>Indicators of Suicide Risk</th>
<th>Contributing Factors †</th>
<th>Initial Action Based on Level of Risk</th>
</tr>
</thead>
</table>
| **High Acute Risk**     | - Persistent suicidal **ideation** or thoughts  
- Strong **intention** to act or plan  
- Not able to control **impulse**  
- **Recent suicide attempt** or preparatory behavior †† | - Acute state of mental disorder or acute psychiatric symptoms  
- Acute **precipitating** event(s)  
- Inadequate **protective factors** | - 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** | - 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 ††  
- **Limited protective factor** | - 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**       | - 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**  
- **Limited risk factors** | - Consider consultation with Behavioral Health to determine:  
  - Need for referral  
  - Treatment  
  - Treat presenting problems  
  - Address safety issues  
  - Document care and rational for action |

Table A-1. Determine Level of Risk and Appropriate action
Columbia Suicide Severity Screener

**COLUMBIA-SUICIDE SEVERITY RATING SCALE**

**Screen Version with Triage Points**

<table>
<thead>
<tr>
<th>SUICIDE IDEATION DEFINITIONS AND PROMPTS:</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask questions that are bolded and underlined.</strong></td>
<td>YES</td>
</tr>
<tr>
<td><strong>Ask Questions 1 and 2</strong></td>
<td></td>
</tr>
<tr>
<td>1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.</td>
<td></td>
</tr>
<tr>
<td><em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td></td>
</tr>
<tr>
<td>2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide. &quot;I've thought about killing myself&quot; without general thoughts of ways to kill oneself/associated methods/intent or plan.&quot;</td>
<td></td>
</tr>
<tr>
<td><em>Have you actually had any thoughts of killing yourself?</em></td>
<td></td>
</tr>
<tr>
<td>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</td>
<td></td>
</tr>
<tr>
<td><strong>3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):</strong> Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. &quot;I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it.&quot;</td>
<td></td>
</tr>
<tr>
<td><em>Have you been thinking about how you might kill yourself?</em></td>
<td></td>
</tr>
<tr>
<td>4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to &quot;I have the thoughts but I definitely will not do anything about them.&quot;</td>
<td></td>
</tr>
<tr>
<td><em>Have you had these thoughts and had some intention of acting on them?</em></td>
<td></td>
</tr>
<tr>
<td>5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.</td>
<td></td>
</tr>
<tr>
<td><em>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</em></td>
<td></td>
</tr>
</tbody>
</table>
| 6) Suicide Behavior Question "Have you ever done anything, started to do anything, or prepared to do anything to end your life?" 
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. |  |  |
| If YES, ask: *How long ago did you do any of these?* 
Over a year ago? Between three months and a year ago? Within the last three months? |  |  |

**1-5 rating for suicidal ideation, of increasing severity (from a wish to die to an active thought of killing oneself with plan and intent)**

**Scoring:**
- 0 Low Risk – Routine Care
- 1-2 Mild Risk – Routine MH Referral
- 3 Moderate Risk – Consider Safety Precautions and MH Consult
- 4-5 Serious Risk – Emergent Action

**Suicide Behavior History**
- < 1 wk ago – ACUTE
- 1wk-3mos – CONCERN
- >3mos - DISCRETIONARY
Clinical Assessment of the Patient with Suicide Risk

1. Medical history to rule out life-threatening conditions
2. Psychiatric history
3. Suicidal behavior history (previous attempts)
4. Substance use history
5. Psychosocial history to include history of life stressors, impulsivity, aggression and relationships
6. Family psychiatric history to include history of suicide
7. Physical examination
8. Mental status examination (MSE)
9. Relevant laboratory tests
10. Drug inventory, including over-the-counter (OTC) drugs and supplements
Acute Management: To Hospitalize or not...
RECOMMENDATIONS

1. Consider hospitalization for patients at high risk for suicide who need crisis intervention, intensive structure and supervision to ensure safety, management of complex diagnosis, delivery of intensive therapeutic procedures.

2. The inpatient psychiatric hospital setting is particularly suitable for the treatment of acute rather than chronic suicidality.

3. Individualized treatment plan should be determined to meet the patient’s needs and aimed to allow as much self-control and autonomy as possible, balanced against the risk level.

4. Although suicidality may persist, the treatment goal is to transition the patient toward a less restrictive environment based on clinical improvement and the assessment that the suicide risk has been reduced.
Risk of Suicide After Discharge

~25% of all post-d/c suicides occur in the first week!

Gunnell et al. BMJ. 2008 Nov 18;337:a2278

Hoyer et al. JAD. 2004 Mar 78:3 209-217
Criteria for Transition to Less Restrictive Settings

RECOMMENDATIONS
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).
Safety Planning
RECOMMENDATIONS

Consider ways to restrict access to lethal means that Service members/Veterans could use to take their own lives. This includes, among others, restriction of access to firearms and ammunition, safer prescribing and dispensing of medications to prevent intentional overdoses, and modifying the environment of care in clinical settings to prevent fatal hangings.

1. Provide education about actions to reduce associated risks and measured to limit the availability of means with emphasis on more lethal methods available to the patient:
   a. **Fire Arms**: For patients at highest risk, exercise extreme diligence to ensure firearms are made inaccessible to the patient. For all patients at intermediate to high risk of suicide, discuss the possibility of safe storage of firearms with the patient, command, and family. (e.g., lock firearms up, use trigger locks or store firearms at the military armory, at a friend’s home, or local police station. Store ammunition separately.)
   b. **Medications**: When clinically possible, include limiting access to medications that carry risk for suicide, at least during the periods when patient is at imminent or high risk for suicide. This may include prescribing limited quantities, supplying the medication in blister packaging, providing printed warnings about the dangers of overdose, or ensuring that currently prescribed medications are actively controlled by a responsible party.
Means Restriction

RECOMMENDATIONS

1. Consider ways to restrict access to lethal means that service members/veterans could use to take their own lives. This includes the restriction of access by:
   - Securing firearms and ammunition,
   - Limit supply of medications prescribed
   - Use of blister packs for lethal medications to prevent intentional overdoses,
   - Environment of Care interventions on Inpatient Psychiatric Units
Why do Means Matter?

48% said 10 minutes or less. Most people who become suicidal have struggled with ongoing, underlying problems. But the movement from suicidal idea to attempt can be rapid.

Lethality

83-90% fatal

10-17% nonfatal, treated in hospital ER

1-2% fatal

98% nonfatal, treated in hospital ER

Firearms

Cutting or Poisoning
Main Finding: The percentage of all suicides resulting from suffocation and firearms increased among female Veterans who used VHA services.

Dept of Veterans Affairs Suicide Data Report 2016
# Medications Associated with Suicide

<table>
<thead>
<tr>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alemtuzumab</td>
</tr>
<tr>
<td>Amitriptyline Hydrochloride</td>
</tr>
<tr>
<td>Amoxapine</td>
</tr>
<tr>
<td>Apremilast</td>
</tr>
<tr>
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Ways Pharmacists and Pharmacy Technicians can assist in Suicide Prevention

- Identify at risk patients
- Monitor medication use and mental health
- Collaborate with the health care team
- Refer to suicide prevention resources
  - National Suicide Prevention Lifeline (NSPL 1-800-273-8255,
- Be encouraging and empathetic

Resource:
Summary

- Assess Risk of Suicide
  - Risk stratification should inform treatment recommendations
- Determine appropriate level of care
  - High Risk – Consider Hospitalization & Initiate Suicide-Focused Treatment
  - Intermediate Risk – Treat MH Condition as appropriate
  - Low Risk – Treatment as usual
- Treatment Plan
  - Suicide-focused therapies for HIGH Risk
  - Treat underlying conditions effectively
- Continuity of care with warm handoffs
  - Discharge HIGH Risk patients to lower level of care with SAFETY PLAN
- Follow-up regularly until fully recovered
  - 1 year for high risk
  - 6 mos for intermediate risk
- Monitor for relapse prevention
Self Assessment Questions

1. Which statement is true?
   A. The overall rate of suicide is over 20 percent higher in veterans than the matched civilian population and is higher in both males and females than in their civilian counterparts.
   B. The overall rate of suicide is over 40 percent higher in veterans than the matched civilian population and is higher in both males and females than in their civilian counterparts.
   C. The overall rate of suicide is over 20 percent higher in veterans than the matched civilian population and is higher females than in their civilian counterparts.

2. Which statement is NOT true?
   A. Formulation of the level of suicide risk should be based on a comprehensive and structured clinical evaluation that is aimed to assess suicidal thoughts, intent and behavior and information about risk and protective factors obtained to estimating the level of risk.
   B. A Behavioral Health provider may use a standardized assessment to inform the comprehensive clinical evaluation.
   C. Assessment of risk for suicide can be based on a single assessment instrument alone and can replace a clinical evaluation.

3. Which statement is NOT true?
   A. When clinically possible, include limiting access to medications that carry risk for suicide, at least during the periods when patient is at high acute and intermediate risk for suicide.
   B. This may include prescribing limited quantities, supplying the medication in blister packaging, printed warnings about the dangers of overdose.
   C. This may include ensuring that currently prescribed medications are actively controlled by a responsible party.
1. Which statement is true?

A. *The overall rate of suicide is over 20 percent higher in veterans than the matched civilian population and is higher in both males and females than in their civilian counterparts.*

B. The overall rate of suicide is over 40 percent higher in veterans than the matched civilian population and is higher in both males and females than in their civilian counterparts.

C. The overall rate of suicide is over 20 percent higher in veterans than the matched civilian population and is higher females than in their civilian counterparts.

2. Which statement is NOT true?

A. Formulation of the level of suicide risk should be based on a comprehensive and structured clinical evaluation that is aimed to assess suicidal thoughts, intent and behavior and information about risk and protective factors obtained to estimating the level of risk.

B. A Behavioral Health provider may use a standardized assessment to inform the comprehensive clinical evaluation.

C. **Assessment of risk for suicide can be based on a single assessment instrument alone and can replace a clinical evaluation.**

3. Which statement is NOT true?

A. *When clinically possible, include limiting access to medications that carry risk for suicide, at least during the periods when patient is at high acute and intermediate risk for suicide.*

B. This may include prescribing limited quantities, supplying the medication in blister packaging, printed warnings about the dangers of overdose.

C. This may include ensuring that currently prescribed medications are actively controlled by a responsible party.
Closing Remarks

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