# VA/DoD Clinical Practice Guidelines

# Assessment and Management of Patients at Risk for Suicide

## Provider Summary

Version 3.0 | 2024

# VA/DoD CLINICAL PRACTICE GUIDELINE FOR ASSESSMENT AND MANAGEMENT OF PATIENTS AT RISK FOR SUICIDE

**Department of Veterans Affairs**

**Department of Defense**

## Provider Summary

### QUALIFYING STATEMENTS

The Department of Veterans Affairs (VA) and the Department of Defense (DoD) guidelines are based on the best information available at the time of publication. The guidelines are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This clinical practice guideline (CPG) is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when providers consider the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Therefore, every health care professional using these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation with a patient-centered approach.

These guidelines are not intended to represent VA or DoD policies. Further, inclusion of recommendations for specific testing, therapeutic interventions, or both within these guidelines does not guarantee coverage of civilian sector care.

**Version 3.0 – April 2024**

# Table of Contents

**Introduction** ... **1**

**Recommendations** ... **1**

**Algorithm** ... **5**

Module A: Identification of Patients at Acute Risk for Suicide ... 6

Module B: Comprehensive Suicide Risk Assessment by Provider ... 7

Module C: Management of Patients at Acute Risk for Suicide ... 8

**Highlighted Features of this Guideline** ... **14**

**Routine Care for Suicide Prevention** ... **16**

A. Suicide Risk Identification ... 16

*a. Acute Warning Signs ... 17*

*b. Suicide Risk Screening Using Validated Tools ... 17*

*c. Predictive Analytics ... 17*

B. Suicide Risk Assessment and Risk Stratification ... 18

*a. Suicide Risk Stratification ... 18*

C. Suicide Risk Management ... 19

*a. Safety Planning and Crisis Response Planning ... 19*

*b. Lethal Means Safety ... 20*

*c. Post-Acute Care ... 20*

*d. Care Management ... 20*

D. Postvention ... 21

E. Additional Steps for Management of Military Service Members ... 22

*a. Command Consultation (Department of Defense) ... 22*

**Scope of the CPG** ... **23**

**Methods** ... **23**

**Guideline Development Team** ... **25**

**Patient-centered Care** ... **26**

**Shared Decision Making** ... **27**

**References** ... **28**

## Introduction

The VA and DoD Evidence-Based Practice Work Group (EBPWG) was established and first chartered in 2004, with a mission to advise the VA/DoD Health Executive Committee "on the use of clinical and epidemiological evidence to improve the health of the population . . ." across the Veterans Health Administration (VHA) and Defense Health Agency (DHA), by facilitating the development of CPG for the VA and DoD populations.(1) Development and update of VA/DoD CPGs is funded by VA Evidence Based Practice, Office of Quality and Patient Safety. The system-wide goal of evidence-based CPGs is to improve patient health and wellbeing.

In 2019, VA and DoD published a CPG for The Assessment and Management of Patients at Risk for Suicide (2019 VA/DoD Suicide Risk CPG), which was based on evidence reviewed through April 10, 2018. Since the release of that CPG, the evidence base on suicide risk has expanded. Consequently, the EBPWG initiated the update of the 2019 VA/DoD Suicide Risk CPG in 2022. This updated CPG's use of Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach reflects a more rigorous application of the methodology than previous iterations.(2) Therefore, the strength of some recommendations might have been modified because of the confidence in the quality of the supporting evidence (see Evidence Quality and Recommendation Strength in the full text version of the Suicide Risk CPG).

This CPG provides an evidence-based framework for evaluating and managing care for adult patients at risk for suicide toward improving clinical outcomes. Successful implementation of this CPG will

- Assess the patient's condition and collaborate with the patient, family, and caregivers to determine optimal management of patient care;
- Emphasize the use of patient-centered care and shared decision making;
- Minimize preventable complications and morbidity; and
- Optimize individual health outcomes and quality of life (QoL).

The full VA/DoD Suicide Risk CPG, as well as additional toolkit materials including a pocket card and provider summary, can be found at: https://www.healthquality.va.gov/index.asp.

## Recommendations

The evidence-based clinical practice recommendations listed in Table 1 were developed using a systematic approach considering four domains as per the GRADE approach (see Summary of Guideline Development Methodology in the full text version of the Suicide Risk CPG). These domains include confidence in the quality of the evidence, balance of desirable and undesirable outcomes (i.e., benefits and harms), patient values and preferences, and other implications (e.g., resource use, equity, acceptability).

**Table 1. Evidence-based Clinical Practice Recommendations with Strength and Category**

| Topic | Sub-topic | # | Recommendation | Strength[a] | Category[b] |
|---|---|---|---|---|---|
| *Screening and Assessment* | *Screening* | 1. | There is insufficient evidence to recommend for or against suicide risk screening programs to reduce the risk of suicide or suicide attempts. | Neither for nor against | Reviewed, New-added |
| | | 2. | When selecting a screening tool, we suggest the use of a validated measure to identify patients at risk for suicide-related behavior. Tools with evidence and support of use, by population, include the following.<br>• General population<br>♦ Columbia Suicide Severity Rating Scale Screener<br>♦ Suicide Cognition Scale – Revised<br>♦ Patient Health Questionnaire-9<br>• Populations at increased risk<br>♦ Beck Suicide Intent Scale/Beck Scale for Suicidal Ideation<br>♦ Columbia Suicide Severity Rating Scale Screener | Weak for | Reviewed, New-replaced |
| | *Assessment* | 3. | When performing a suicide risk assessment, we suggest including, but not limited to, factors (see Table 6) within the following domains.<br>• Self-directed violence, thoughts, and behaviors<br>• Current psychiatric conditions and current or past mental/behavioral health treatment<br>• Psychiatric symptoms<br>• Social determinants of health and adverse life events<br>• Availability of lethal means<br>• Physical health conditions<br>• Demographic characteristics | Weak for | Reviewed, Amended |
| | | 4. | While risk stratification is an expected component of routine care, there is insufficient evidence to recommend for or against the use of a specific tool or method to determine the level of suicide risk. | Neither for nor against | Reviewed, New-added |
| *Risk Management and Treatment* | *Non-pharmacologic Interventions* | 5. | We suggest cognitive behavioral therapy–based psychotherapy focused on suicide prevention to reduce the risk of suicide attempts in patients with a history of suicidal behavior within the past six months. | Weak for | Reviewed, New-replaced |
| | | 6. | We suggest offering cognitive behavioral therapy (including problem solving–based psychotherapies) focused on suicide prevention to reduce suicidal ideation for patients with a history of self-directed violence. | Weak for | Reviewed, New-replaced |
| | | 7. | There is insufficient evidence to recommend for or against completing a crisis response plan or safety planning intervention to reduce the risk of suicide attempts in patients with recent suicidal ideation, a lifetime history of suicide attempts, or both. | Neither for nor against | Reviewed, New-replaced |

| Topic | Sub-topic | # | Recommendation | Strength[a] | Category[b] |
|---|---|---|---|---|---|
| ***Risk Management and Treatment (cont.)*** | ***Non-pharmacologic Interventions (cont.)*** | 8. | There is insufficient evidence to recommend for or against Collaborative Assessment and Management of Suicidality to reduce suicidal ideation. | Neither for nor against | Reviewed, New-added |
| | | 9. | There is insufficient evidence to recommend for or against offering dialectical behavior therapy to reduce suicidal ideation and the risk of suicide attempts or suicide. | Neither for nor against | Reviewed, New-replaced |
| | | 10. | There is insufficient evidence to recommend for or against peer-to-peer programs to reduce suicidal ideation. | Neither for nor against | Reviewed, New-added |
| | ***Pharmacologic and Other Somatic Treatments*** | 11. | We suggest clozapine to reduce the risk of suicide attempts for patients with schizophrenia or schizoaffective disorder and either suicidal ideation or a history of suicide attempt(s). | Weak for | Reviewed, Amended |
| | | 12. | We suggest offering ketamine infusion as an adjunctive treatment for short-term reduction in suicidal ideation in patients with the presence of suicidal ideation and major depressive disorder. | Weak for | Reviewed, Not changed |
| | | 13. | There is insufficient evidence to recommend for or against ketamine infusions or esketamine to reduce the risk of suicide or suicide attempts. | Neither for nor against | Reviewed, New-added |
| | | 14. | There is insufficient evidence to recommend for or against lithium to reduce the risk of suicide or suicide attempts for patients with mood disorders. | Neither for nor against | Reviewed, New-replaced |
| | | 15. | There is insufficient evidence to recommend for or against repetitive transcranial magnetic stimulation to reduce the risk of suicide or suicide attempts. | Neither for nor against | Reviewed, New-added |
| | ***Post-Acute Care*** | 16. | We suggest sending patients periodic caring communications (e.g., postal mail, text messages), in addition to usual care, for 12 months following hospitalization related to suicide risk to reduce the risk of suicide attempts. | Weak for | Reviewed, New-replaced |
| | | 17. | There is insufficient evidence to recommend for or against offering brief contact interventions (e.g., telephonic interventions, crisis cards, World Health Organization Brief Intervention and Contact treatment modality) in addition to usual care following discharge from the emergency department to reduce the risk of suicide attempts. | Neither for nor against | Reviewed, New-replaced |
| | ***Technology-Based Modalities*** | 18. | We suggest the use of self-guided digital interventions (app or web) that include, but are not limited to, cognitive behavioral–based therapeutic content for short-term reduction in suicidal ideation. | Weak for | Reviewed, New-replaced |
| | | 19. | There is insufficient evidence to recommend for or against the use of standalone or adjunctive technology-based tools (e.g., mobile and web apps, automated telephone-based) to reduce the risk of suicide attempts or suicide. | Neither for nor against | Reviewed, New-replaced |

| Topic | Sub-topic | # | Recommendation | Strength[a] | Category[b] |
|---|---|---|---|---|---|
| Risk Management and Treatment (cont.) | *Community-Based Interventions* | 20. | We suggest multi-component community interventions to reduce the risk of suicide. Common components include but are not limited to: training on mental/behavioral health topics and/or suicide risk factors; local networking and/or community facilitation; and providing mental/behavioral health and/or suicide prevention materials. | Weak for | Reviewed, New-replaced |
| | | 21. | We suggest reducing access to lethal means to reduce the risk of suicide by firearms, jumping, or medication overdose. | Weak for | Reviewed, New-replaced |
| | | 22. | There is insufficient evidence to recommend for or against the use of targeted messaging to at-risk populations to reduce suicidal ideation and improve help-seeking behavior. | Neither for nor against | Reviewed, New-added |
| | | 23. | There is insufficient evidence to recommend for or against standalone gatekeeper training to reduce the risk of suicide. | Neither for nor against | Reviewed, Amended |
| | | 24. | There is insufficient evidence to recommend for or against crisis lines to reduce suicidal ideation or the risk of suicide attempts or suicide. | Neither for nor against | Reviewed, New-added |

[a] For additional information, see Determining Recommendation Strength and Direction in the full text version of the Suicide Risk CPG.

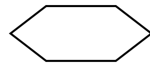
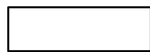
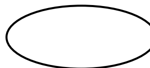
[b] For additional information, see Recommendation Categorization in the full text version of the Suicide Risk CPG.

## Algorithm

This CPG's algorithm is designed to facilitate understanding of the clinical pathway and decision-making process used in managing patients at risk for suicide. This algorithm format represents a simplified flow of the management of patients at risk for suicide and helps foster efficient decision making by providers. It includes

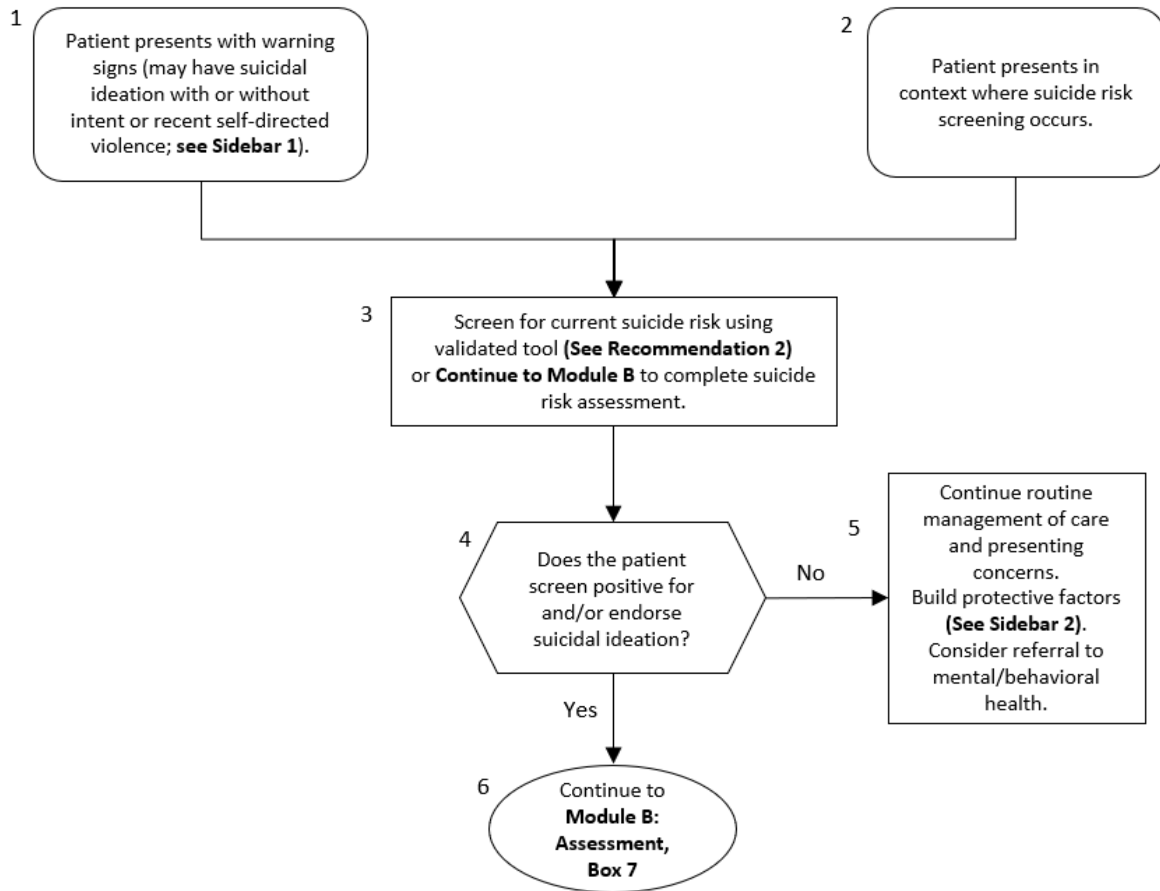
- Steps of care in an ordered sequence,
- Decisions to be considered,
- Decision criteria recommended, and
- Actions to be taken.

The algorithm is a step-by-step decision tree. Standardized symbols display each step, and arrows connect the numbered boxes indicating the order in which the steps should be followed.(3) Sidebars 1–5 provide more detailed information to assist in defining and interpreting elements in the boxes.

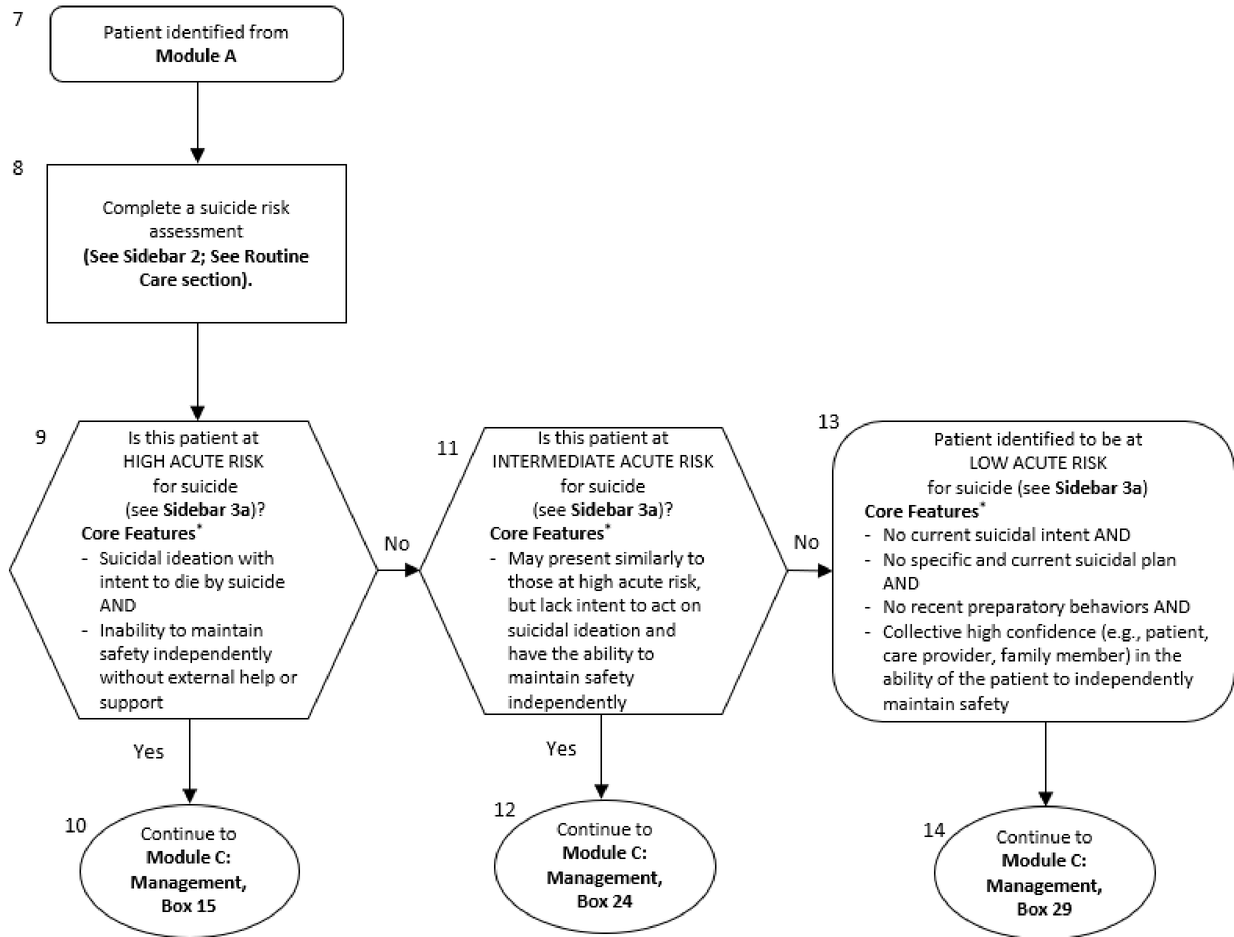
| Shape | Description |
| --- | --- |
| | Rounded rectangles represent a clinical state or condition. |
|  | Hexagons represent a decision point in the process of care, formulated as a question that can be answered "Yes" or "No." |
|  | Rectangles represent an action in the process of care. |
|  | Ovals represent a link to another section within the algorithm. |

Appendix H in the full text version of the Suicide Risk CPG contains alternative text descriptions of the algorithms.

## Module A: Identification of Patients at Acute Risk for Suicide

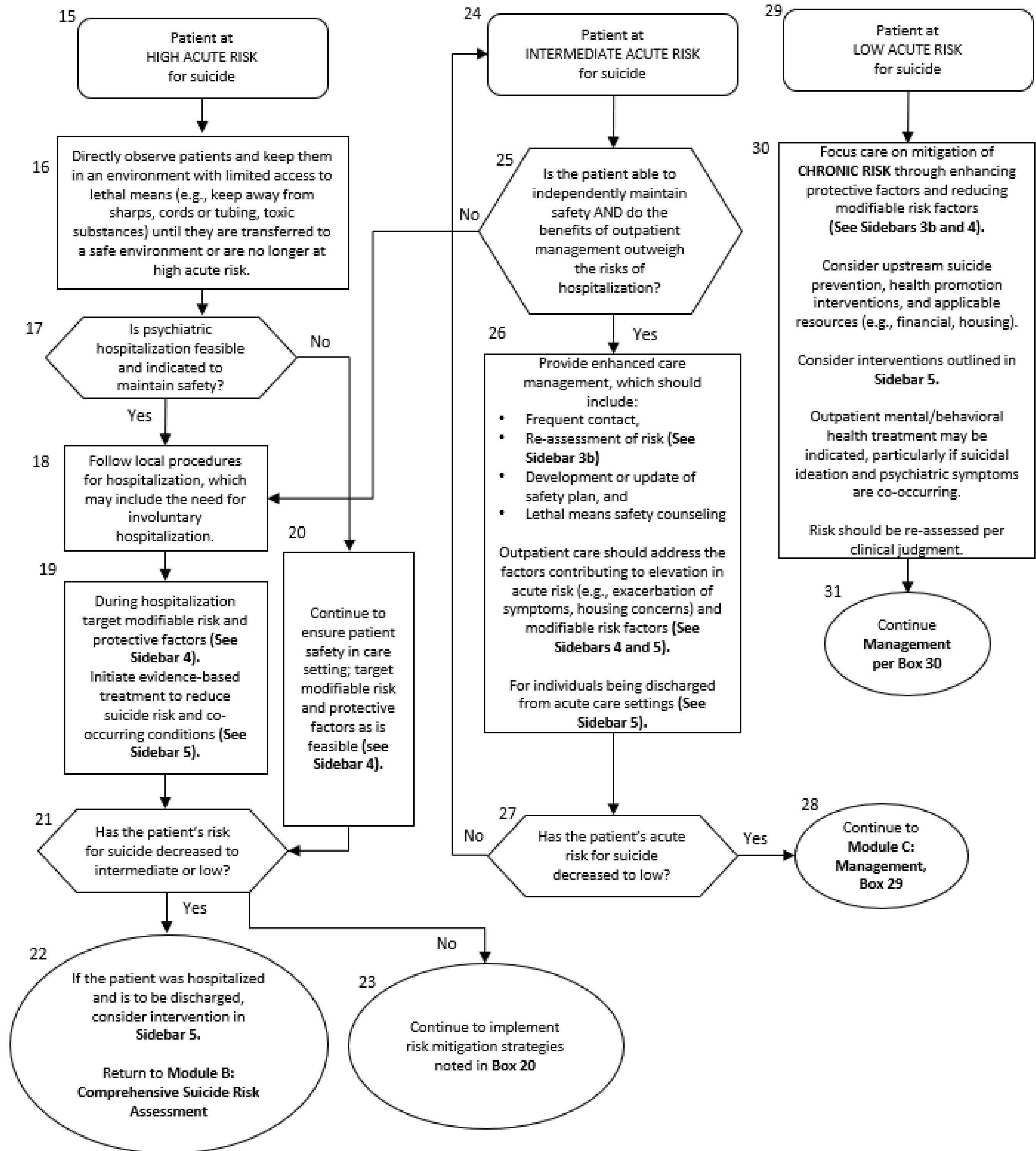


## Module B: Comprehensive Suicide Risk Assessment by Provider




* 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/

## Module C: Management of Patients at Acute Risk for Suicide



### Sidebar 1. Suicide Warning Signs

A warning sign is a person-specific thought, feeling, physical sensation, behavior, or any combination of the foregoing that indicates the presence of acute risk.

Direct warning signs might include the following.

- Suicide related communication (e.g., suicide note, mention of wishing to die)
- Preparation for suicide (e.g., giving items away)
- Seeking access or recent use of lethal means

Indirect warning signs might include the following.

- Substance use: uses substances increasingly or excessively
- Hopelessness: feels that nothing can be done to improve the situation
- Purposelessness: feels no sense of purpose, no reason for living
- Anger: exhibits rage, seeks revenge
- Recklessness: engages impulsively in risky behavior
- Feeling trapped: experiences feelings of being trapped with no way out
- Social withdrawal: withdraws from family, friends, society
- Anxiety: feels agitated or irritable, wants to "jump out of my skin"
- 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 following domains.

- Self-directed violence (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

We also suggest including protective factors, such as the following.

- Access to mental/behavioral health care
- Sense of connectedness
- Problem-solving skills
- Sense of spirituality
- Mission or purpose
- Physical health
- Employment
- Social and emotional wellbeing

| Sidebar 3a. Essential Features from Risk Stratification Table – Acute Risk[1] | | |
|---|---|---|
| **Level of Risk** | **Core Features** | **Action*** |
| **High Acute Risk** | • Suicidal ideation with intent to die by suicide *and*<br>• Inability to maintain safety independently without external help or support<br>Patients will often have a plan for suicide and access to lethal means. They might be experiencing an exacerbation of mental/behavioral health conditions (e.g., MDD episode, acute psychosis, recent or current recurrence of drug use, increased BPD symptomatology), psychosocial stressors (e.g., job loss, relationship dissolution, recurrence of alcohol use), or both. They might have also recently engaged in suicidal SDV (e.g., suicide attempt, preparatory behaviors). | Patients typically require psychiatric hospitalization (either voluntary or involuntary) to maintain safety and aggressively target modifiable factors.<br>Patients must be directly observed on a secure unit and be kept in an environment with limited access to lethal means (e.g., kept away from sharps, cords, tubing, toxic substances).<br>During hospitalization, co-occurring psychiatric symptoms should also be addressed. |
| **Intermediate Acute Risk** | • Suicidal ideation *and*<br>• Ability to maintain safety, independent of external help or support<br>Patients might present similarly to those at high acute risk, sharing many of the features. The only difference might be a lack of intent, based on an identified reason for living (e.g., children), and ability to abide by a safety plan and maintain their own safety. Preparatory behaviors are likely to be absent. | Consider voluntary psychiatric hospitalization if related factors driving risk are responsive to inpatient treatment (e.g., acute psychosis).<br>Outpatient management should include the following.<br>• Frequent contact<br>• Reassessment of risk<br>• Development or update of safety plan<br>• LMS counseling<br>Outpatient care should address the factors contributing to elevation in acute risk (e.g., financial stress, exacerbation of symptoms). |

[1] 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/

| Sidebar 3a. Essential Features from Risk Stratification Table – Acute Risk[1] | | |
|---|---|---|
| **Low Acute Risk** | • Possible suicidal ideation but no current suicidal intent *and*<br>• No specific and current suicidal plan *and*<br>• No recent preparatory behaviors *and*<br>• Collective high confidence (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety<br><br>Patients might have suicidal ideation, but it will be with little or no intent or specific current plan. If a plan is present, the plan is general, vague, or both and without associated preparatory behaviors (e.g., "One of these days, I might just end it."). Patients are likely to be capable of engaging appropriate coping strategies and willing and able to use a safety plan in a crisis situation. | Care should focus on mitigation of chronic risk through enhancing protective factors and reducing modifiable risk factors.<br><br>Consider upstream suicide prevention, health promotion interventions, and applicable resources (e.g., financial, housing).<br><br>Outpatient mental/behavioral health treatment might be indicated, particularly if suicidal ideation and psychiatric symptoms are co-occurring. Risk should be reassessed per clinical judgment. |

* Action taken should also address patient's chronic risk level (see Sidebar 3b).

Abbreviations: BPD: borderline personality disorder; LMS: lethal means safety; MDD: major depressive disorder; SDV: self-directed violence

| Sidebar 3b. Essential Features from Risk Stratification Table – Chronic Risk[2] | | |
|---|---|---|
| **Level of Risk** | **Core Features** | **Action** |
| **High Chronic Risk** | • Chronic medical condition<br>• Chronic mental/behavioral health conditions<br>• Chronic pain<br>• Chronic suicidal ideation<br>• History of prior suicide attempt or attempts<br>• History of SUD<br>• Limited ability to identify reasons for living<br>• Limited coping skills<br>• Unstable psychosocial status (e.g., unstable housing, erratic relationships, marginal employment)<br>These patients are considered at chronic risk for becoming acutely suicidal, often in the context of psychosocial stressors (e.g., loss of relationship, job loss, relapse on drugs). | Patients typically require the following.<br>• Routine mental/behavioral health follow-up<br>• Well-developed safety plan and LMS counseling<br>• Routine suicide risk assessment<br>• Coping skills building<br>• Management of co-occurring psychiatric symptoms |
| **Intermediate Chronic Risk** | Patients might feature similar chronicity as those at high chronic risk with respect to psychiatric, substance use, medical, and chronic pain conditions.<br>Protective factors, coping skills, reasons for living, and relative psychosocial stability suggest enhanced ability to endure future crisis without engaging in suicidal SDV. | Patients typically require the following.<br>• Routine mental/behavioral health care to optimize psychiatric condition and maintain or enhance coping skills and protective factors<br>• Well-developed safety plan and LMS counseling<br>• Management of co-occurring psychiatric symptoms |

[2] 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/

| Sidebar 3b. Essential Features from Risk Stratification Table – Chronic Risk[2] | | |
|---|---|---|
| **Level of Risk** | **Core Features** | **Action** |
| **Low Chronic Risk** | Patients might range from those with no or little in the way of mental/behavioral health or substance use problems, to patients with significant mental illness that is associated with relatively abundant strengths/resources.<br>Stressors have typically been endured without suicidal ideation emerging.<br>The following factors will generally be missing.<br>• History of SDV<br>• Chronic suicidal ideation<br>• Tendency toward being highly impulsive<br>• Risky behaviors<br>• Limited psychosocial functioning | Patients are appropriate for mental/behavioral health care as needed. Some might be managed in primary care settings; others might require mental/behavioral health follow-up to continue successful treatments. |

Abbreviations: LMS: lethal means safety; SDV: self-directed violence; SUD: substance use disorder

| Sidebar 4. Modifiable Risk Factors |
|---|
| • Modifiable risk factors, such as insomnia, have the potential to be changed.<br>• Such risk factors can often be reduced by certain interventions, such as prescribing antidepressant medication for depression, engaging in LMS counseling, or decreasing isolation by strengthening social support. |

Abbreviations: LMS: lethal means safety

### Sidebar 5. Evidence-Based Interventions to Reduce Suicidal Ideation, Suicidal Behavior, or Both

**Non-pharmacologic Treatments** (see Recommendations 5-6, 18)

- 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 11-12)

- 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 21)

- Periodic caring communications (following hospitalization for suicide risk)
- Reduced access to lethal means

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

## Highlighted Features of this Guideline

This document is an update to the 2019 VA/DoD Management of Suicide Risk CPG[3], and contains the following significant revisions:

- Updated Algorithm;
- Reviewed studies focused on specific outcomes to include critical outcomes of suicide attempt and suicide death;
- Added eight new recommendations; 12 reviewed and replaced, 3 amended, and 1 no change;
- Used more rigorous application of GRADE methodology;
- Updated Routine Care for Suicide Prevention section; and
- Updated Research Priorities section.

The body of research on suicide risk management, suicide prevention, intervention, and postvention continues to grow. This CPG includes updated recommendations on the following key topics.

1. Universal screening: The 2019 Suicide Risk CPG offered no specific recommendation regarding universal screening programs. The 2024 Suicide Risk CPG states that there is insufficient evidence to recommend for or against suicide risk screening programs to reduce the risk of suicide or suicide attempts (see Recommendation 1 in the full text version of the Suicide Risk CPG).
2. Selection of screening tool: The 2019 Suicide Risk CPG suggested (categorized as *Weak for*) the use of a validated screening tool (2019 Recommendation 1) and highlighted the Patient Health Questionnaire-9 (PHQ-9) item 9 (2019 Recommendation 2). In the 2024 Suicide Risk CPG, the Work Group has included additional validated screening tools for the general population versus screening for an at-risk population and has removed reference to the PHQ-9 Item 9 (see Recommendation 2 in the full text version of the Suicide Risk CPG).
3. Dialectal behavior therapy: The 2019 Suicide Risk CPG suggested (categorized as *Weak for*) the use of dialectical behavior therapy (DBT) for patients with borderline personality disorder (BPD) (2019 Recommendation 7); the 2024 Suicide Risk CPG recommendation is categorized as *Neither for nor against* for a broader patient population (see Recommendation 9 in the full text version of the Suicide Risk CPG).
4. Ketamine infusion: The 2024 Suicide Risk CPG Work Group changed the strength of the recommendation on the use of ketamine infusion (and now esketamine) for suicide risk management from a *Weak for* recommendation (2019

[3] See the 2019 VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide. Available at: https://www.healthquality.va.gov/

Recommendation 10) to a *Neither for nor against* recommendation (see Recommendation 13 in the full text version of the Suicide Risk CPG).

5. Lithium: The 2024 Suicide Risk CPG Work Group changed the lithium recommendation for suicide risk management from a *Weak for* recommendation (2019 Recommendation 11) to a *Neither for nor against* recommendation (see Recommendation 14 in the full text version of the Suicide Risk CPG).

As noted above, the methodology used in developing this CPG has been updated since the prior versions and reflects a more precise application of the methodology than used in previous iterations, which are detailed in Appendix A in the full text version of the Suicide Risk CPG. It is important to note that the recommendation strength downgrades from *Weak for* to *Neither for nor against* recommendations do not imply that providers should avoid these options, rather that the data from the current systematic evidence review is insufficient to make a recommendation when using the more rigorous methodology.

The 2024 Suicide Risk CPG Work Group focused largely on developing new and updated recommendations based on the systematic evidence review conducted for the priority areas addressed by the key questions (KQ) (see Summary of Guideline Development Methodology in the full text version of the Suicide Risk CPG). The 2019 Suicide Risk CPG included recommendations carried forward from the 2013 Suicide Risk CPG. In addition to the new and updated recommendations, the Work Group considered, without a complete review of the relevant evidence, the current applicability of these other recommendations included in the previous 2019 Suicide Risk CPG, subject to evolving practice in today's environment.

The 2024 Suicide Risk CPG systematic evidence review was based on a set of defined KQs related to specific topic areas of suicide risk. As part of the CPG process, the 2024 Suicide Risk Work Group considered the 2019 Suicide Risk CPG's recommendations. Several 2019 Suicide Risk CPG recommendations were not covered by a 2019 KQ and were based on evidence from the 2013 Suicide Risk CPG's systematic evidence review (i.e., were carried forward from the 2013 CPG). Because the 2024 Suicide Risk CPG used an updated GRADE methodology, the 2024 Suicide Risk CPG Work Group felt it was important to review the 2019 Suicide Risk CPG recommendations carried forward from the 2013 Suicide Risk CPG. Because the 2013 Suicide Risk CPG systematic evidence review was unavailable to the 2024 Suicide Risk CPG Work Group and its evidence was not reevaluated using the more precise GRADE methodology, this set of recommendations was deleted unless the topic was covered by a 2019 or 2024 KQ. This action resulted in a consistent methodology across recommendations within the 2024 Suicide Risk CPG.

As such, the 2024 Suicide Risk CPG Work Group considered the strength of the evidence cited for each recommendation in the 2019 Suicide Risk CPG, as well as the intervention's harms and benefits, patients' values and preferences, and other

implications, where possible. The Work Group referred to the available evidence as summarized in the body of the 2019 Suicide Risk CPG but did not systematically reassess all the evidence. In some limited instances (such as the 2019 Suicide Risk CPG recommendations carried forward from the 2013 Suicide Risk CPG), relevant peer-reviewed literature published since the 2019 Suicide Risk CPG was considered, along with the original evidence base for the specific recommendation. The CPG Work Group recognizes that although there are sometimes practical reasons for synthesizing findings from a previous systematic evidence review, previous recommendations, or recent peer-reviewed publications into an updated CPG, doing so does not involve an original, comprehensive systematic evidence review and might introduce bias.

# Routine Care for Suicide Prevention

The recommendations included in this CPG address only some aspects of care for patients at risk for suicide. Some aspects of routine care have insufficient evidence to support a recommendation. In many cases, studies assessing the efficacy of these components of routine care do not exist; however, the components have been established over the years as strong practices and are often supported by regulatory and accrediting agencies that establish practice for routine care. Providers should consider information provided in this section as they implement routine suicide prevention care.

Because of growing evidence that most patients who die by suicide received health care outside mental/behavioral health in the 12 months before their death, integrating suicide prevention across all aspects of care is critical. This approach ensures that every health care encounter is an opportunity to influence suicide prevention outcomes. The complexities of suicide necessitate the integration of expertise from various health domains, such as primary care, emergency medicine, pharmacy, nursing, and more, each of which encounters patients at different, often critical, junctions of their health care journey. Underscoring that suicide prevention is not an exclusive responsibility of mental/behavioral health professionals, but rather an overarching duty incumbent on all health care disciplines, is paramount.

## A. Suicide Risk Identification

The significance of suicide risk identification has been underscored and largely institutionalized by accrediting bodies such as The Joint Commission (TJC) and the Commission on Accreditation of Rehabilitation Facilities (CARF).(4, 5) These entities have established frameworks wherein the identification and monitoring of suicide risk is not merely a recommended practice but is embedded as an essential component of routine care. The standard of care acknowledges the dynamic nature of suicide risk and mental/behavioral health trajectories, which dictate that a systematic, ongoing approach to suicide risk identification be adopted as part of routine care. This practice is defined

by proactive suicide risk identification, which leads to further assessment and implementation of individualized risk mitigation strategies.

### a. Acute Warning Signs

Patients at risk for suicide might be identified via the presence of acute warning signs for suicide. Warning signs are specific to the patient (i.e., changes in thoughts, feelings, behaviors) that represent an acute increase in risk and often signal that the patient might engage in suicidal behavior in the immediate future (i.e., minutes to days). Patient specific warning signs can be assessed by asking patients to describe thoughts, feelings, and behaviors experienced before the most recent exacerbation of suicidal ideation or behavior. Module A contains additional guidance regarding how to follow up with a patient who presents with current warning signs.

See Sidebar 1 for examples of direct and indirect warning signs.

### b. Suicide Risk Screening Using Validated Tools

Suicide risk screening represents one of the crucial steps by which patients at risk for suicide are identified, and it is an essential element of routine care for suicide prevention. Standardized suicide risk screening, using validated screening tools, facilitates a proactive approach to suicide prevention within health care settings. Accrediting bodies such as TJC and CARF mandate the implementation of suicide risk screening as a standard procedure for patients with mental/behavioral health needs, fostering an approach by which to identify suicide risk across health care systems.(4, 5)

See Recommendation 2 in the full text version of the Suicide Risk CPG for additional information regarding screening tools.

### c. Predictive Analytics

The availability of large health care datasets and advanced statistical computing enables the development of predictive models of suicide and suicide-related behavior. These approaches can improve classification accuracy over subjective clinical judgment or the reliance on single risk factor determinations.(6)

Suicide prediction models, in their current state, yield good overall classification accuracy (most patients will not die by suicide and most of them are correctly classified as such) but are poor at accurately predicting future suicide events (among those classified as *at risk*, current algorithms will be correct only about 1% of the time). The literature on this topic already suggests that this finding is consistent across the military, VA, and civilian health care systems and is directly related to, and limited by, the suicide mortality rate in the population of interest.(7)

The application of suicide prediction models is new, and the critical, ethical, and practical concerns are only starting to be addressed. Importantly, it is yet to be established what interventions should be provided to those who are classified as being at risk for suicide,

especially if the majority of the cases being classified as at risk represent false positive identifications.(8) Clinical implementation of suicide prediction models must be well designed and highly intentional to avoid unintended consequences, including potential stigmatization of patients at risk for suicide, particularly if patients are labeled based on a predictive model. For example, among patients in the military, suicide prediction models might raise concerns about how the information will be used and the potential impact it might have on a patient's military career and social network. In other cases, machine learning and other predictive analytics methods can amplify existing biases within data sets, which can lead to discrimination based on variables such as race, age, or socioeconomic status (SES).

Most suicide prediction models have yet to be tested within a clinical context to evaluate the effects on the primary outcome of suicide prevention or the secondary outcomes of care processes, patient outcomes other than suicide death, and health care costs.

An exception, although yet untested via an RCT, is VHA's Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) program, which was implemented as standard care in the VHA in 2017.(9) Implementation of REACH VET includes outreach and reassessment of care for newly identified patients. Clinical judgment and patient input are incorporated into clinical decision making regarding changes to care. In an historical comparison, REACH VET was not associated with a reduction in the suicide mortality rate among patients identified as at high risk for suicide. It was associated with greater treatment engagement, new safety plan documentation, and fewer mental/behavioral health admissions, ED visits, and suicide attempts.(10)

## B. Suicide Risk Assessment and Risk Stratification

Once suicide risk is identified by the above described means, a suicide risk assessment should be conducted. The Joint Commission requires that suicide risk assessment includes evaluation of the following areas: suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Documentation of risk stratification and a risk mitigation plan is also required.(4) In addition to these key aspects, suicide risk assessment should yield a person-specific conceptualization of what is driving suicide risk as well as what factors are mitigating risk (i.e., protective factors, which are characteristics associated with a lower probability of negative health outcomes).

### *a. Suicide Risk Stratification*

As noted in Recommendation 4 and required by TJC, suicide risk stratification is considered to be a component of routine care for patients identified as at risk.(4) The Algorithm, Sidebar 3a, and Sidebar 3b provide guidance regarding how to stratify risk by both temporality and severity according to Therapeutic Risk Management Risk Stratification. Risk stratification serves as a lens through which health care professionals can view and comprehend the dynamic and varied severity of suicide risk as well as establishing a standardized pathway that guides clinical decision making and intervention

planning. Distinguishing among high, intermediate, and low (severity) risk categories for both acute and chronic risk (temporality) can help health care providers tailor interventions and allocate resources in a manner consistent with the patient's immediate and long-term needs. The tiered approach offered in the Algorithm, Sidebar 3a, and Sidebar 3b ensures that the spectrum of care provided enables health care professionals to navigate the dynamic nature of suicide risk proactively.

## C. Suicide Risk Management

Routine care for suicide prevention encompasses identification and assessment of risk but is also defined by the implementation of structured, evidence-based interventions and persistent support mechanisms by which risk is mitigated. According to accrediting bodies such as TJC and the CARF, suicide risk management is an essential component of routine care for suicide prevention.(4, 5)

Treatment should directly target suicidal thoughts and behaviors.(11) Additionally, specific treatment decisions should be evidence informed and driven by shared decision making principles.(12) See Recommendations 5–19 in the full text version of the Suicide Risk CPG for additional information regarding risk management strategies.

### *a. Safety Planning and Crisis Response Planning*

The Safety Planning Intervention (SPI) and Crisis Response Planning (CRP) both involve the development of step-by-step instructions to use for patients before or during a suicidal crisis. See Table 2 for comparison of the components of CRP versus SPI. Information regarding SPI, rather than CRP, is included in the Algorithm and associated Sidebars because SPI is consistent with the standard of care in both VA and DoD. Additionally, SPI has long been recognized as an important aspect of routine care for suicide prevention by accrediting organizations such as the TJC and CARF.(4, 5) Providers are encouraged to conduct SPI with any patient they believe would benefit from this risk mitigation strategy, particularly with patients who are at intermediate or high, acute, or chronic suicide risk based on Therapeutic Risk Management Risk Stratification (see Sidebar 3a and Sidebar 3b).

**Table 2. Components of CRP versus SPI (13, 14)**

| Crisis Response Planning | Safety Planning Intervention |
|---|---|
| Semi-structured interview of recent suicidal ideation and chronic history of suicide attempts | Conducting a semi-structured interview of a recent suicidal crisis |
| Unstructured conversation about recent stressors and current complaints using supportive listening techniques | Recognizing warning signs of an impending suicidal crisis |
| Collaborative identification of clear signs of crisis (behavioral, cognitive, affective, or physical) | Recognizing how an increase and a decrease in suicidal risk provides an opportunity to engage in coping strategies |

| Crisis Response Planning | Safety Planning Intervention |
| --- | --- |
| Self-management skill identification, including things that patients can do on their own to distract themselves or feel less stressed | Employing internal coping strategies—without contacting another person—for distraction from suicidal thoughts |
| Collaborative identification of social support, including friends, caregivers, and family members who have helped in the past and whom they would feel comfortable contacting in crisis | Using social contacts and social settings as a means of distraction from suicidal thoughts |
| Review of crisis resources, including medical providers, other professionals, and the suicide prevention lifeline (988) | Contacting mental/behavioral health professionals or agencies, including crisis intervention services (e.g., the Veteran/Military Crisis Line: 988) |
| Referral to treatment, including follow-up appointments and other referrals, as needed | Limiting access to lethal means: Consider prescribing naloxone for patients at risk for opioid overdose (see VA/DoD Use of Opioids in the Management of Chronic Pain CPG)[4] |

Abbreviations: CPG: clinical practice guideline; DoD: Department of Defense; VA: Department of Veterans Affairs

### b. Lethal Means Safety

Lethal means safety (LMS) is an intentional, collaborative, and voluntary practice to reduce one's suicide risk by limiting access to lethal means (i.e., objects that can be used to inflict self-directed violence [SDV]). Increasing the time and distance between someone with suicidal intent and lethal means can reduce suicide risk.(15) Lethal means safety is considered part of routine care for patients identified as at risk for suicide. Providers are encouraged to discuss LMS with any patient they believe would benefit from this risk mitigation strategy, particularly with patients who are at intermediate or high, acute, or chronic suicide risk (post-psychiatric hospitalization) based on Therapeutic Risk Management Risk Stratification (see Sidebar 3a and Sidebar 3b).

### c. Post-Acute Care

The period following acute care intervention and subsequent discharge is a timeframe in which patients are at elevated risk for suicide.(16) Structured post-acute care that provides ongoing support during this vulnerable period of transition is an important aspect of routine care and suicide risk management. Consistent post-discharge engagement offers a safety net of support but also ensures that emerging crises or hurdles in the recovery trajectory are swiftly identified and addressed.

See Recommendation 16 and Recommendation 17 in the full text version of the Suicide Risk CPG for additional information regarding specific post-acute care interventions.

### d. Care Management

Care management plays an important role in suicide prevention because it can directly impact factors (e.g., social determinants of health) that increase suicide risk

4 See the 2022 VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain. Available at: https://www.healthquality.va.gov/

(e.g., finances, housing). A multifaceted process involving a wide range of activities, care management often spans many disciplines, including nursing, social work, case management, and other professions involved in a care management service. The care management process frequently involves identifying and assessing patient needs; developing plans; providing needed services; monitoring and evaluating provided services; and advocating for the comprehensive needs of patients, their families, and caregivers.

## D. Postvention

Suicide postvention involves the provision of immediate and ongoing support to individuals impacted by a suicide loss. Being exposed to the death of a loved one, friend, or coworker by suicide increases the risk of suicide and other negative mental/behavioral health sequelae in survivors.(17) As such, postvention is an additional suicide prevention strategy. Losing a patient to suicide can impact one's professional identity, relationships with coworkers, and clinical work.(18) The 2012 National Strategy for Suicide Prevention states that "helping those who have been bereaved by suicide is a direct form of suicide prevention with a population known to be at risk."(19)

A 2019 SR identified 11 research studies related to the effectiveness of interventions for people bereaved by suicide.(20) Although no studies reported on suicidal behavior as an outcome, three reported on suicidal ideation. One of these demonstrated a statistically significant reduction in suicidal ideation among participants who completed complicated grief therapy. Additional studies demonstrated positive impacts on grief and psychosocial outcomes. These interventions "include supportive, therapeutic, and education approaches, involve the social environment of the bereaved, and comprise a series of sessions led by trained facilitators."(20)

Multiple resources exist to support individuals who have lost a Service member or Veteran to suicide. Any reference to or inclusion of external resources does not constitute an endorsement by VA, DoD, or the United States. Exemplars include the following.

- The Tragedy Assistance Program for Survivors (TAPS) is a nonprofit organization providing comprehensive resources for individuals grieving the loss of a military Service member or Veteran.
- VA's Uniting for Suicide Postvention program provides tools and support to suicide loss survivors.(21)
- Consultation through VA's Suicide Risk Management Consultation Program[5] is also available to individuals directly impacted by Veteran suicide loss as well as to those interested in developing postvention processes in their Veteran-serving organization.

[5] See the SRM program website for more information: https://www.mirecc.va.gov/visn19/consult/.

## E. Additional Steps for Management of Military Service Members

### *a. Command Consultation (Department of Defense)*

Military commanders play a crucial role in building a mission-ready force by promoting the resilience and health of the Service members under their command. Command consultation is an important aspect of the treatment of mental/behavioral health conditions and is a relevant part of military treatment planning. Command involvement in the care of their Service members is always considered in the context of balancing responsibilities for their health and wellbeing and their mission's success.

Department of Defense Instructions (DoDI) provide a foundation for military health care providers regarding mental/behavioral evaluation and command interaction requirements to balance patient confidentiality against mission demands. For example, DoDI 6490.08, "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members," and DoDI 6490.04, "Mental Health Evaluations of Members of the Military Services," establish policy for health care providers for determining command notification and referral, evaluation, treatment, and medical and command management of Service members who might request or require assessment for mental/behavioral health concerns, respectively.(22, 23) Commanders need to know certain information to make decisions related to military operational and risk management. In disclosure to commands, providers disclose a minimum amount of information to the commander about the Service member in accordance with policy—typically limited to sharing only enough information with the commander to satisfy the purpose of the disclosure.

Providers delivering care in DoD are encouraged to always consider potential command involvement when developing plans for intervention and support for the Service member. Interaction between the provider and the commander should aim to be cooperative in a manner that protects confidentiality, with the intent of building partnerships, enabling and encouraging members to feel comfortable in obtaining care while furthering the mission's successful accomplishment. When requested by Service members or providers, commanders are strongly encouraged to share with treating providers information that they believe might be pertinent to the health and welfare of their Service members or mission accomplishment. Regardless, interaction between the provider and the commander should occur in a manner that protects confidentiality.

Health care providers can notify commanders with or without a Service member's permission in the case of exigent circumstances, which are those where the need to prevent serious harm to an individual or essential military function clearly outweighs the need for confidentiality of information obtained by a health care provider. Exigent circumstances are defined as harm to self, harm to others, harm to mission, inpatient care, acute medical conditions interfering with duty, problematic substance abuse

treatment, command-directed mental/behavioral health evaluations, treatment of personnel in sensitive positions, or circumstances when execution of the military mission outweighs the interest served by avoiding notification. Voluntary care for SUD itself does not require command notification. For policy related to commander notification of patient disclosures related to harm by others, providers should consult with policy reporting and notification requirements[6] and, when necessary, also follow forensic health care response policy.

## Scope of the CPG

This CPG is based on published clinical evidence and related information available through March 15, 2023. It is intended to provide general guidance on best evidence-based practices (see Appendix A in the full text version of the Suicide Risk CPG for additional information on the evidence review methodology). Although the CPG is intended to improve the quality of care and clinical outcomes (see Introduction), it is not intended to define a standard of care (i.e., mandated or strictly required care).

This CPG is intended for use by VA, DoD, and community providers and others involved in the health care team assessing and managing adult patients at risk for suicide.

The patient population of interest for this CPG is adult patients at risk for suicide who may receive care in the VA or DoD health care delivery systems, or VA and DoD adult beneficiaries who receive care from community-based providers. Recommendations in this CPG are applicable for any adult patients of VA or DoD, inclusive of all care locations (VA, DoD, or community-based care).

## Methods

The Work Group used the GRADE approach to craft each recommendation and determine its strength. Per the GRADE approach, recommendations must be evidence based and cannot be made based on expert opinion alone. The GRADE approach uses the following four domains to inform the strength of each recommendation (see Determining Recommendation Strength and Direction).(24)

1. Confidence in the quality of the evidence
2. Balance of desirable and undesirable outcomes
3. Patient values and preferences
4. Other considerations, as appropriate (e.g., resource use, equity, acceptability, feasibility, subgroup considerations)

Using these four domains, the Work Group determined the relative strength of each recommendation (*Strong* or *Weak*). The strength of a recommendation is defined as the

[6] See the Sexual Assault Prevention and Response Office and Family Advocacy Office policy: https://www.sapr.mil/.

extent to which one can be confident that the desirable effects of an intervention outweigh its undesirable effects and is based on the framework above, which incorporates the four domains.(25) A *Strong* recommendation generally indicates *High* or *Moderate* confidence in the quality of the available evidence, a clear difference in magnitude between the benefits and harms of an intervention, similar patient values and preferences, and understood influence of other implications (e.g., resource use, feasibility).

In some instances, insufficient evidence exists on which to base a recommendation for or against a particular therapy, preventive measure, or other intervention. For example, the systematic evidence review might have found little or no relevant evidence, inconclusive evidence, or conflicting evidence for the intervention. The manner in which this finding is expressed in the CPG might vary. In such instances, the Work Group might include among its set of recommendations a statement of insufficient evidence for an intervention that might be in common practice although it is unsupported by clinical evidence and particularly if other risks of continuing its use might exist (e.g., high opportunity cost, misallocation of resources). In other cases, the Work Group might decide to exclude this type of statement about an intervention. For example, the Work Group might remain silent where an absence of evidence occurs for a rarely used intervention. In other cases, an intervention might have a favorable balance of benefits and harms but might be a standard of care for which no recent evidence has been generated.

Using these elements, the Work Group determines the strength and direction of each recommendation and formulates the recommendation with the general corresponding text (see Table 3).

**Table 3. Strength and Direction of Recommendations and General Corresponding Text**

| Recommendation Strength and Direction | General Corresponding Text |
|---|---|
| Strong for | We recommend … |
| Weak for | We suggest … |
| Neither for nor against | There is insufficient evidence to recommend for or against … |
| Weak against | We suggest against … |
| Strong against | We recommend against … |

# Guideline Development Team

**Table 4. Guideline Work Group and Guideline Development Team**

| Organization | Names* |
|---|---|
| ***Department of Veterans Affairs*** | **Lisa A. Brenner, PhD, ABPP (Champion)** |
| | **Nazanin Bahraini, PhD (Champion)** |
| | Bridget Matarazzo, PsyD |
| | Candice Bodie, LCSW |
| | Edgar Villarreal, PhD |
| | Joseph Constans, PhD |
| | Matthew A. Fuller, PharmD, FASHP, BCPP |
| | Ronald Nardi, MSN, PMHCNS-BC, APRN |
| | Stephanie Gamble, PhD |
| | Steven K. Dobscha, MD |
| ***Department of Defense*** | **Kate McGraw, PhD (Champion)** |
| | **Kenneth Richter Jr., DO, CPE, FAPA (Champion)** |
| | **Scott Williams, MD, FACP, FAASM, DFAPA (Champion)** |
| | **Vincent Capaldi, ScM, MD, DFAPA, FAASM, FACP (Champion)** |
| | Adrienne Manasco, PsyD |
| | Eric J. Serpico, DO |
| | Derek J. Smolenski, PhD, MPH |
| | Jennifer Tucker, PhD |
| | Kendra Parker-Pitts, MD |
| | Svetlana Kahle, PsyD |
| | Vanessa Kirkwood, PharmD |
| ***VA Evidence Based Practice, Office of Quality and Patient Safety Veterans Health Administration*** | James Sall, PhD, FNP-BC |
| | Jennifer Ballard-Hernandez, DNP, RN, FNP-BC |
| | René Sutton, BS, HCA, FAC-COR II |
| | Sarah Davis-Arnold, MSN, RN, NPD-BC, RCIS, EBP-C |
| ***Clinical Quality Improvement Program Defense Health Agency*** | Elaine Stuffel, MHA, BSN, RN |
| | Cynthia F. Villarreal, BSN, RN |
| | Isabella Alvarez, MA, BSN, RN |
| | Lynn Young, BSN, RN, CIC |
| | Gwen Holland, MSN, RN |

| Organization | Names* |
|---|---|
| ***The Lewin Group*** | Jennifer Weil, PhD |
| | Charles Zachariades, MSc |
| | Savannah Lantz, MPH, RN |
| | Katherine McCracken, BA |
| | Kristen Godwin, MPH |
| ***ECRI*** | Stacey Uhl, MS |
| | James Reston, PhD, MPH |
| | Rebecca Rishar, MSLS |
| | Kelley Tipton, MPH |
| | Emilio Berdiel, MPH |
| | Aggee Loblack, MPH |
| | Taylor Phillips, MPH |
| | Jesse Wagner, MA |
| ***Sigma Health Consulting*** | Frances M. Murphy, MD, MPH |
| | James G. Smirniotopoulos, MD |
| ***Duty First Consulting*** | Kate Johnson, BS |
| | Rachel Piccolino, BA |
| | Anita Ramanathan, BA |
| | Jake Fausnacht, BS |

*Additional contributor contact information is available in Appendix F in the full text version of the Suicide Risk CPG.

## Patient-centered Care

Intended to consider patient needs and preferences, guideline recommendations represent a whole/holistic health approach to care that is patient-centered, culturally appropriate, and available to people with limited literacy skills and physical, sensory, or learning disabilities. VA/DoD CPGs encourage providers to use a patient-centered, whole/holistic health approach (i.e., individualized treatment based on patient needs, characteristics, and preferences). This approach aims to treat the particular condition while also optimizing the individual's overall health and wellbeing.

Regardless of the care setting, all patients should have access to individualized evidence-based care. Patient-centered care can decrease patient anxiety, increase trust in providers, and improve treatment adherence.(26, 27) A whole/holistic health approach (https://www.va.gov/wholehealth/) empowers and equips individuals to meet their personal health and wellbeing goals. Good communication is essential and should be supported by evidence-based information tailored to each patient's needs. An

empathetic and non-judgmental approach facilitates discussions sensitive to gender, culture, ethnicity, and other differences.

## Shared Decision Making

This CPG encourages providers to practice shared decision making, a process in which providers, patients, and patient care partners (e.g., family, friends, caregivers) consider clinical evidence of benefits and risks as well as patient values and preferences to make decisions regarding the patient's treatment.(28) Shared decision making is emphasized in *Crossing the Quality Chasm,* an Institute of Medicine (IOM), now NAM, report in 2001 (29) and is inherent within the whole/holistic health approach. Providers must be adept at presenting information to their patients regarding individual treatments, expected risks, expected outcomes, and levels or settings of care or both, especially where patient heterogeneity in weighing risks and benefits might exist. The VHA and DHA have embraced shared decision making. Providers are encouraged to use shared decision making to individualize treatment goals and plans based on patient capabilities, needs, and preferences.

## References

1. U.S. Department of Veterans Affairs/Department of Defense Health Executive Committee (HEC). Evidence Based Practice Work Group Charter [updated January 9, 2017]. Available from: www.healthquality.va.gov/documents/EvidenceBasedPracticeWGCharter123020161.pdf.
2. Guyatt GH, Oxman AD, Kunz R, Atkins D, Brozek J, Vist G, et al. GRADE guidelines: 2. Framing the question and deciding on important outcomes. Journal of clinical epidemiology. 2011;64(4):395-400. Epub 2011/01/05. doi: 10.1016/j.jclinepi.2010.09.012. PubMed PMID: 21194891.
3. Society for Medical Decision Making Committee on Standardization of Clinical Algorithms. Proposal for clinical algorithm standards. Medical decision making : an international journal of the Society for Medical Decision Making. 1992;12(2):149-54. Epub 1992/04/01. PubMed PMID: 1573982.
4. The Joint Commission. R3 Report Issue 18: National Patient Safety Goal for suicide prevention. The Joint Commission, 2018 Contract No.: Issue 18.
5. Quality Practice Notice—September 2016; Suicide Prevention in CARF-Accredited Organizations: Advancing Clinical and Service Workforce Preparedness. 2016.
6. Walkup JT, Townsend L, Crystal S, Olfson M. A systematic review of validated methods for identifying suicide or suicidal ideation using administrative or claims data. Pharmacoepidemiology and drug safety. 2012;21 Suppl 1:174-82. Epub 2012/01/25. doi: 10.1002/pds.2335. PubMed PMID: 22262604.
7. Belsher BE, Smolenski DJ, Pruitt LD, Bush NE, Beech EH, Workman DE, et al. Prediction Models for Suicide Attempts and Deaths: A Systematic Review and Simulation. JAMA Psychiatry. 2019. Epub 2019/03/14. doi: 10.1001/jamapsychiatry.2019.0174. PubMed PMID: 30865249.
8. Nelson HD, Denneson LM, Low AR, Bauer BW, O'Neil M, Kansagara D, et al. Suicide Risk Assessment and Prevention: A Systematic Review Focusing on Veterans. Psychiatric services (Washington, DC). 2017;68(10):1003-15. Epub 2017/06/16. doi: 10.1176/appi.ps.201600384. PubMed PMID: 28617209.
9. Matarazzo BB, Eagan A, Landes SJ, Mina LK, Clark K, Gerard GR, et al. The Veterans Health Administration REACH VET Program: Suicide Predictive Modeling in Practice. Psychiatric services (Washington, DC). 2023;74(2):206-9. Epub 2022/08/31. doi: 10.1176/appi.ps.202100629. PubMed PMID: 36039552.
10. McCarthy JF, Cooper SA, Dent KR, Eagan AE, Matarazzo BB, Hannemann CM, et al. Evaluation of the Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment Suicide Risk Modeling Clinical Program in the Veterans Health Administration. JAMA Netw Open. 2021;4(10):e2129900. Epub 2021/10/19. doi: 10.1001/jamanetworkopen.2021.29900. PubMed PMID: 34661661; PubMed Central PMCID: PMCPMC8524305 Dr Trafton reported being employed by and serving on the board of directors of the Institute for Brain Potential. No other disclosures were reported.

11. Hogan MF, Grumet JG. Suicide Prevention: An Emerging Priority For Health Care. Health Aff (Millwood). 2016;35(6):1084-90. Epub 2016/06/09. doi: 10.1377/hlthaff.2015.1672. PubMed PMID: 27269026.
12. Rocky Mountain MIRECC (Mental Illness Research E, and Clinical Center) for Suicide Prevention. Evidence-Based Psychotherapy Shared Decision-Making Toolkit for Mental Health Providers. In: Rocky Mountain MIRECC (Mental Illness Research E, and Clinical Center) for Suicide Prevention, editor.
13. Bryan CJ. Managing suicide risk in primary care: Springer Publishing Company; 2010.
14. Stanley B, Brown G. Safety planning intervention: Brief instructions. Washington, DC: United States Department of Veterans Affairs. 2008.
15. Barber CW, Miller MJ. Reducing a suicidal person's access to lethal means of suicide: a research agenda. American journal of preventive medicine. 2014;47(3 Suppl 2):S264-72. Epub 2014/08/26. doi: 10.1016/j.amepre.2014.05.028. PubMed PMID: 25145749.
16. Forte A, Buscajoni A, Fiorillo A, Pompili M, Baldessarini RJ. Suicidal Risk Following Hospital Discharge: A Review. Harvard review of psychiatry. 2019;27(4):209-16. Epub 2019/07/06. doi: 10.1097/hrp.0000000000000222. PubMed PMID: 31274577.
17. National Action Alliance for Suicide Prevention, Survivors of Suicide Loss Task Force. Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines. 2015.
18. Séguin M, Bordeleau V, Drouin MS, Castelli-Dransart DA, Giasson F. Professionals' reactions following a patient's suicide: review and future investigation. Arch Suicide Res. 2014;18(4):340-62. Epub 2014/05/23. doi: 10.1080/13811118.2013.833151. PubMed PMID: 24846577.
19. Office of the Surgeon General, National Action Alliance for Suicide Prevention. 2012 National strategy for suicide prevention: goals and objectives for action: a report of the US Surgeon General and of the National Action Alliance for Suicide Prevention. 2012.
20. Andriessen K, Krysinska K, Hill NTM, Reifels L, Robinson J, Reavley N, et al. Effectiveness of interventions for people bereaved through suicide: a systematic review of controlled studies of grief, psychosocial and suicide-related outcomes. BMC Psychiatry. 2019;19(1): 49. Epub 2019/02/01. doi: 10.1186/s12888-019-2020-z. PubMed PMID: 30700267; PubMed Central PMCID: PMCPMC6354344.
21. U.S. Department of Veterans Affairs, Rocky Mountain Mental Illness Research Education and Clinical Center. Uniting for Suicide Postvention - About USPV 2023 [01 May 2023]. Available from: https://www.mirecc.va.gov/visn19/postvention/about.asp.
22. DoD Instruction, 6490.08, Command Notification Requirements to Dispel Stigmas in Providing Mental Health Care to Service Members, 6490.08 (2023).
23. DoD Instruction, 6490.04, Mental Health Evaluations of Members of the Military Services, 6490.04 (2020).
24. Andrews JC, Schunemann HJ, Oxman AD, Pottie K, Meerpohl JJ, Coello PA, et al. GRADE guidelines: 15. Going from evidence to recommendation-determinants of a recommendation's direction and strength. Journal of clinical epidemiology. 2013;66(7):726-35. Epub 2013/04/11. doi: 10.1016/j.jclinepi.2013.02.003. PubMed PMID: 23570745.

25. Andrews J, Guyatt G, Oxman AD, Alderson P, Dahm P, Falck-Ytter Y, et al. GRADE guidelines: 14. Going from evidence to recommendations: the significance and presentation of recommendations. Journal of clinical epidemiology. 2013;66(7):719-25. Epub 2013/01/15. doi: 10.1016/j.jclinepi.2012.03.013. PubMed PMID: 23312392.
26. Robinson JH, Callister LC, Berry JA, Dearing KA. Patient-centered care and adherence: definitions and applications to improve outcomes. Journal of the American Academy of Nurse Practitioners. 2008;20(12):600-7. Epub 2009/01/06. doi: 10.1111/j.1745-7599.2008.00360.x. PubMed PMID: 19120591.
27. Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, et al. The impact of patient-centered care on outcomes. J Fam Pract. 2000;49(9):796-804. Epub 2000/10/14. PubMed PMID: 11032203.
28. National Learning Consortium. Shared Decision Making 2013. Available from: https://www.healthit.gov/sites/default/files/nlc_shared_decision_making_fact_sheet.pdf.
29. Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington DC: National Academies Press, 2001.

Access to the full guideline and additional resources is available at:
https://www.healthquality.va.gov/.