APPENDICES
AIR FORCE GUIDE FOR SUICIDE RISK ASSESSMENT, MANAGEMENT, AND TREATMENT

June 27, 2014

Revision of 2002 Air Force Guide for Managing Suicidal Behaviors

LIST OF APPENDICES

APPENDIX A: Required Suicide Risk Screening

Quick Guide to the Patient Health Questionnaire-9 (PHQ-9)

Overview: The PHQ-9 (Kroenke, Spitzer, & Williams, 2001) is a brief instrument for assessing depression. The first 9 questions assess symptoms of depression and the last question assesses patient functional impairment. Item 9 asks: "Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or hurting yourself in some way?" All items are on a 4-point Likert-type scale, ranging from "Not at all" to "Nearly every day."

Purpose: The PHQ-9 is used for screening, diagnosing, and monitoring severity of depressive symptoms that can be used in primary care or mental health settings. Item 9 serves as a screening question for suicidality.

Psychometric Properties: The PHQ-9 has excellent sensitivity and specificity for major depression (Kroenke et al., 2001).

Scoring and Interpreting the PHQ-9: Scores are calculated by giving a 0, 1, 2, or 3 to the response categories, "Not at all," "Several days," "More than half the days," and "Nearly every day," respectively. Depression severity is determined by summed scores and range from Minimal (for scores of 1-4), Mild (5-9), Moderate (10-14), Moderately Severe (15-19) to Severe (20-27). Criteria for the diagnoses assessed on each page are at the bottom of the page.

Recommendations

- Use the patient's response to item 9 as a basis for follow-up questions on suicide ideation and behavior.
- Use the overall depression score to help determine risk level and treatment approach.

How to Obtain the PHQ-9: The PHQ-9 is in the public domain and requires no permission to reproduce or distribute. It can be found at http://phqscreeners.com. The instrument and instruction manual are also available on the website. Air Force providers can reproduce the form and use it (with no associated costs) in the context of their clinical practice.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

APPENDIX B: Required Suicide Risk Assessment

Quick Guide to the Suicide Status Form (SSF-II-R, SSF-III)

Overview: Section A is a self-report measure of five psychological risk factors (psychological pain, stress, agitation, hopelessness, and self-hate), overall risk of suicide, internal and external factors, wish to live, and wish to die on Likert-type scales. In addition, the patient completes a ranked list of reasons for living and reasons for dying. Section B is completed by the clinician and assesses 14 additional risk factors and warning signs, including suicide planning, preparation, history, and current intent. Section C is a treatment plan, and Section D (completed post-session) features a mental status exam, preliminary DSM-IV-TR diagnosis, and determination of overall suicide risk. Except Section D, the SSF-III is completed collaboratively, with the therapist and patient seated side-by-side discussing responses to each item.

Purpose: The SSF was designed to be used as a part of the Collaborative Assessment and Management of Suicidality model (CAMS; Jobes, 2006), and has a version for ongoing tracking of suicidality and outcome assessment.

Psychometric Properties: The SSF has been psychometrically evaluated in samples of psychiatric inpatients and outpatients (Conrad et al., 2009; Jobes, Kahn-Greene, Greene, & Hustead, 1997). Factor analysis results have supported of the five psychological risk factors (psychological pain, stress, agitation, hopelessness, and self-hate) and overall risk of suicide. In addition, these items had good convergent and criterion-prediction validity. Test-retest reliability have ranged from acceptable to good, and internal consistency reliability alphas ranged from good to excellent (Conrad et al., 2009).

Scoring and Interpreting the SSF: Results from the collaboratively completed Section A and clinician-completed Section B are used to determine completion of Section C, which is the treatment plan. The clinician completes Section D (mental status exam, preliminary DSM-IV-TR diagnosis) and uses these items together with the Sections A and B to determine the patient's overall suicide risk level.

Recommendations

- ☐ Use the SSF for a comprehensive initial and ongoing assessment of suicide risk.
- ☐ Rapport building may be facilitated by the collaborative completion of Section A.

How to Obtain the SSF: The SSF-III copyright stipulates that in order to use the measure for research or clinical purposes, the user must purchase the book in which it appears:

Jobes, D. (2006). *Managing suicidal risk: A collaborative approach*. New York, NY: Guildford Press.

SSF-II-R is included in this Guide's appendices with permission granted from Dr. David Jobes at Catholic University of America. Air Force providers can reproduce the form and use it (with no associated costs) in the context of their clinical practice.

Suicide Status Form-SSF II-R (Initial Session)

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (*Patient*):

Rate and fill out each item according to how you feel right now.
Then rank in order of importance 1 to 5 (1=most important to 5=least important).

Rank	
____	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*): **Low pain: 1 2 3 4 5 :High pain** What I find most painful is: _____
____	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress: 1 2 3 4 5 :High stress** What I find most stressful is: _____
____	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*): **Low agitation: 1 2 3 4 5 :High agitation** I most need to take action when: _____
____	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness: 1 2 3 4 5 :High hopelessness** I am most hopeless about: _____
____	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate: 1 2 3 4 5 :High self-hate** What I hate most about myself is: _____
N/A	6) RATE OVERALL RISK OF SUICIDE: **Extremely low risk: 1 2 3 4 5 :Extremely high risk (will not kill self) (will kill self)**

1) How much is being suicidal related to thoughts and feelings about yourself? **Not at all: 1 2 3 4 5 : completely**
2) How much is being suicidal related to thoughts and feelings about others? **Not at all: 1 2 3 4 5 : completely**

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	**Rank**	REASONS FOR DYING

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much
I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: _____

_____

Suicide Status Form-II-R (Initial Session—page 2)

Section B (*Clinician*):

Y N Suicide plan: When: _____
Where: _____
How: _____ Y N Access to means
How: _____ Y N Access to means

Y N Suicide Preparation Describe: _____

Y N Suicide Rehearsal Describe: _____

Y N History of Suicidality
- Ideation Describe: _____
  - Frequency _____ per day _____ per week ____ per month
  - Duration _____ seconds _____ minutes ____ hours
- Single Attempt Describe: _____
- Multiple Attempts Describe: _____

Y N Current Intent Describe: _____

Y N Impulsivity Describe: _____

Y N Substance abuse Describe: _____

Y N Significant loss Describe: _____

Y N Interpersonal isolation Describe: _____

Y N Relationship problems Describe: _____

Y N Health problems Describe: _____

Y N Physical pain Describe: _____

Y N Legal problems Describe: _____

Y N Shame Describe: _____

Section C (*Clinician*): OUTPATIENT TREATMENT PLAN (Refer to Sections A & B)

Problem #	Problem Description	Goals and Objectives Evidence for Attainment	Interventions (Type and Frequency)	Estimated # Sessions
1	*Self-Harm Potential*	*Outpatient Safety*	***Crisis Response Plan:***	
2				
3				

YES ____ NO _____ Patient understands and commits to outpatient treatment plan?
YES ____ NO _____ Clear and imminent danger of suicide?

_____ _____

Patient Signature Date Clinician Signature Date

Section D (*Clinician Post-Session Evaluation*):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS:	ALERT DROWSY LETHARGIC STUPOROUS
	OTHER: _____
ORIENTED TO:	PERSON PLACE TIME REASON FOR EVALUATION
MOOD:	EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT:	FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE
THOUGHT CONTINUITY:	CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
	OTHER: _____
THOUGHT CONTENT:	WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
	OTHER: _____
ABSTRACTION:	WNL NOTABLY CONCRETE
	OTHER: _____
SPEECH:	WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
	OTHER: _____
MEMORY:	GROSSLY INTACT
	OTHER: _____
REALITY TESTING:	WNL
	OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

PRELIMINARY DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I _____

_____

Axis II _____

_____

Axis III _____

Axis IV _____

Axis V _____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

- ❑ **No Significant Risk**
- ❑ **Mild**
- ❑ **Moderate**
- ❑ **Severe**
- ❑ **Extreme**

Explanation:_____

_____

_____

_____

CASE NOTES (diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date):

_____

_____

_____

_____

Next Appointment Scheduled: _____ Treatment Modality: _____

_____ _____

Clinician Signature Date Supervisor Signature Date

Suicide Tracking Form

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (*Patient*):

Rate each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*):	**Low pain:**	**1**	**2**	**3**	**4**	**5**	**:High pain**
2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):	**Low stress:**	**1**	**2**	**3**	**4**	**5**	**:High stress**
3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*):	**Low agitation:**	**1**	**2**	**3**	**4**	**5**	**:High agitation**
4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):	**Low hopelessness:**	**1**	**2**	**3**	**4**	**5**	**:High hopelessness**
5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):	**Low self-hate:**	**1**	**2**	**3**	**4**	**5**	**:High self-hate**
6) RATE OVERALL RISK OF SUICIDE:	**Extremely low risk: (will not kill self)**	**1**	**2**	**3**	**4**	**5**	**:Extremely high risk (will kill self)**

Section B (*Clinician*):

Resolution of suicidality: ☐ 1st session ☐ 2nd session

Complete **Suicide Tracking Outcome Form after 3rd consecutive resolved session

Y __ N __ Suicidal Thoughts?
Y __ N __ Suicidal Feelings?
Y __ N __ Suicidal Behaviors?

Patient Status:

☐ Discontinued treatment ☐ No show ☐ Referral to: _____
☐ Hospitalization ☐ Cancelled ☐ Other: _____

TREATMENT PLAN UPDATE

Problem #	Problem Description	Goals and Objectives Evidence for Attainment	Interventions (Type and Frequency)	Estimated # Sessions
1	*Self-Harm Potential*	*Outpatient Safety*	***Crisis Response Plan:***	
2				
3				

_____ _____

Patient Signature Date Clinician Signature Date

Section C *(Clinician Post-Session Evaluation):*

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS:	ALERT DROWSY LETHARGIC STUPOROUS OTHER: _____
ORIENTED TO:	PERSON PLACE TIME REASON FOR EVALUATION
MOOD:	EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT:	FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE
THOUGHT CONTINUITY:	CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL OTHER: _____
THOUGHT CONTENT:	WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY OTHER: _____
ABSTRACTION:	WNL NOTABLY CONCRETE OTHER: _____
SPEECH:	WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT OTHER: _____
MEMORY:	GROSSLY INTACT OTHER: _____
REALITY TESTING:	WNL OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I _____

_____

Axis II _____

_____

Axis III _____

Axis IV _____

Axis V _____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

- ❑ **No Significant Risk**
- ❑ **Mild**
- ❑ **Moderate**
- ❑ **Severe**
- ❑ **Extreme**

Explanation:_____

_____

_____

_____

CASE NOTES (diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date):

_____

_____

_____

_____

Next Appointment Scheduled: _____ Treatment Modality: _____

_____ _____

Clinician Signature Date Supervisor Signature Date

Suicide Tracking Outcome Form

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (*Patient*):

Rate each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*):	**Low pain:**	**1**	**2**	**3**	**4**	**5**	**:High pain**
2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):	**Low stress:**	**1**	**2**	**3**	**4**	**5**	**:High stress**
3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*):	**Low agitation:**	**1**	**2**	**3**	**4**	**5**	**:High agitation**
4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):	**Low hopelessness:**	**1**	**2**	**3**	**4**	**5**	**:High hopelessness**
5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):	**Low self-hate:**	**1**	**2**	**3**	**4**	**5**	**:High self-hate**
6) RATE OVERALL RISK OF SUICIDE:	**Extremely low risk: (will not kill self)**	**1**	**2**	**3**	**4**	**5**	**:Extremely high risk (will kill self)**

Were there any aspects of your treatment that were particularly helpful to you? If so, please describe these. Be as specific as possible.

What have you learned from your clinical care that could help you if you became suicidal in the future?

Section B (*Clinician*):

Third consecutive session of resolved suicidality: ____ Yes ____ No (if no, continue Suicide Status tracking)

OUTCOME/DISPOSITION (Check all that apply):

___ Continuing outpatient psychotherapy ___ Inpatient hospitalization

___ Mutual termination ___ Patient chooses to discontinued treatment (unilaterally)

___ Referral to: _____

___ Other. Describe: _____

Next Appointment Scheduled (if applicable): _____

_____ _____

Patient Signature Date Clinician Signature Date

Section C (*Clinician Outcome Evaluation*):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS:	ALERT DROWSY LETHARGIC STUPOROUS
	OTHER: _____
ORIENTED TO:	PERSON PLACE TIME REASON FOR EVALUATION
MOOD:	EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT:	FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE
THOUGHT CONTINUITY:	CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
	OTHER: _____
THOUGHT CONTENT:	WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
	OTHER: _____
ABSTRACTION:	WNL NOTABLY CONCRETE
	OTHER: _____
SPEECH:	WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
	OTHER: _____
MEMORY:	GROSSLY INTACT
	OTHER: _____
REALITY TESTING:	WNL
	OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I _____

_____

Axis II _____

_____

Axis III _____

Axis IV _____

Axis V _____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

- ❑ **No Significant Risk** **Explanation: _____**
- ❑ **Mild**
- ❑ **Moderate** _____
- ❑ **Severe**
- ❑ **Extreme** _____

CASE NOTES (diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date):

_____

_____

_____

_____

_____

Next Appointment Scheduled: _____ Treatment Modality: _____

_____ _____

Clinician Signature Date Supervisor Signature Date

Suicide Status Form-SSF II-R (Initial Session)

Patient: Pat Doe Clinician: Adam Example Date: 12/3/2012 Time: 9:30am

Section A (*Patient*):

Rate and fill out each item according to how you feel right now.
Then rank in order of importance 1 to 5 (1=most important to 5=least important).

Rank	
1	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*): **Low pain: 1 2 3 (4) 5 :High pain** What I find most painful is: not being able to see my daughter
2	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress: 1 2 3 (4) 5 :High stress** What I find most stressful is: upcoming separation from the military
5	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*): **Low agitation: 1 (2) 3 4 5 :High agitation** I most need to take action when: I become angry
4	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness: 1 2 (3) 4 5 :High hopelessness** I am most hopeless about: the future
3	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate: 1 2 3 (4) 5 :High self-hate** What I hate most about myself is: that I'm a bad parent
N/A	6) RATE OVERALL RISK OF SUICIDE: **Extremely low risk: (will not kill self) 1 2 (3) 4 5 :Extremely high risk (will kill self)**

1) How much is being suicidal related to thoughts and feelings about yourself? **Not at all: 1 2 3 4 (5) : completely**
2) How much is being suicidal related to thoughts and feelings about others? **Not at all: (1) 2 3 4 5 : completely**

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING
1	Brother	2	No one cares about me
2	Things may get better	1	Less of a burden on family
3	daughter	2	Stop depression
		4	I don't like who I am

I wish to live to the following extent: Not at all: 0 1 2 3 4 (5) 6 7 8 : Very much
I wish to die to the following extent: Not at all: 0 1 2 3 (4) 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: having my daughter back in my life and being able to provide for her

Suicide Status Form-II-R (Initial Session—page 2)

Section B (*Clinician*):

(Y) N Suicide plan:
When: Undecided
Where: At home
How: hanging (Y) N Access to means
How: Y N Access to means

Y (N) Suicide Preparation Describe:

(Y) N Suicide Rehearsal Describe: squeezed throat while imagining hanging

(Y) N History of Suicidality

- Ideation Describe: during depressive episodes (4-5) in past
  - Frequency ____per day 2 per week ____per month
  - Duration seconds 20 minutes hours
- Single Attempt Describe: denies
- Multiple Attempts Describe: denies

(Y) N Current Intent Describe: expresses desire to end suffering

Y (N) Impulsivity Describe:

(Y) N Substance abuse Describe: binge drinks on weekends

(Y) N Significant loss Describe: upcoming separation from Air Force

(Y) N Interpersonal isolation Describe: no close friends

(Y) N Relationship problems Describe: estranged from daughter

Y (N) Health problems Describe:

Y (N) Physical pain Describe:

Y (N) Legal problems Describe:

Y (N) Shame Describe:

Section C (*Clinician*): OUTPATIENT TREATMENT PLAN (Refer to Sections A & B)

Problem #	Problem Description	Goals and Objectives Evidence for Attainment	Interventions (Type and Frequency)	Estimated # Sessions
1	*Self-Harm Potential*	*Outpatient Safety*	***Crisis Response Plan:*** Crisis Card Emergency Numbers	2x/wk for 6 wks
2	Depression	Decrease depression Decrease alcohol consumption	CBT Behavioral activation Medication consult	6 wks
3	Upcoming separation from the Air Force (2 months)	Find a job Increase social support	Vocational counseling Increase contact with others (family)	6 wks

YES X NO ____ Patient understands and commits to outpatient treatment plan?
YES ____ NO X Clear and imminent danger of suicide?

Patient Signature Date Clinician Signature Date

Section D (*Clinician Post-Session Evaluation*):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: (ALERT) DROWSY LETHARGIC STUPOROUS
OTHER: _____

ORIENTED TO: (PERSON) (PLACE) (TIME) (REASON FOR EVALUATION)

MOOD: EUTHYMIC ELEVATED (DYSPHORIC) AGITATED ANGRY

AFFECT: (FLAT) BLUNTED CONSTRICTED APPROPRIATE LABILE

THOUGHT CONTINUITY: (CLEAR & COHERENT) GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
OTHER: _____

THOUGHT CONTENT: (WNL) OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
OTHER: "constantly" thinking about death and dying

ABSTRACTION: (WNL) NOTABLY CONCRETE
OTHER: _____

SPEECH: (WNL) RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
OTHER: _____

MEMORY: (GROSSLY INTACT)
OTHER: _____

REALITY TESTING: (WNL)
OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

PRELIMINARY DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I MDD. Recurrent (296.33)

Axis II Deferred

Axis III None

Axis IV Threat of job loss, estrangement from daughter

Axis V 50

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

- ☐ **No Significant Risk**
- ☐ **Mild**
- ☑ **Moderate**
- ☐ **Severe**
- ☐ **Extreme**

Explanation: Pt is depressed, history of SI with current plan to hang; however Pt was engaged during treatment planning and committed to goals. Can be managed as outpt

CASE NOTES (diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date):
Pt is a 26 y.o. WM, active duty Air Force. Pt is currently depressed, socially isolated, and withdrawn. He has limited social support. Pt expressed concerns about upcoming separation from Air Force. He is committed to treatment plan and medication consult.

Next Appointment Scheduled: 12/10/2012 Treatment Modality: CBT, medication consult

Clinician Signature Date Supervisor Signature Date

Dr. Kasaan Holmes has provided this sample SSF.

APPENDIX C: Other Suicide Risk Screening and Assessment Instruments

Quick Guide to the Acquired Capability for Suicide Scale (ACSS)

Overview: The ACSS (Van Orden, Witte, Gordon, Bender, & Joiner, 2008) is a 20-item self-report questionnaire on which individuals rate each item on a 0 to 4 scale. Items include statements such as "Things that scare most people don't scare me." and "The sight of my own blood does not bother me."

Purpose: The ACSS was developed to assess an individual's fearlessness about lethal self-injury and perceived tolerance of pain.

Psychometric Properties: The total ACSS score has been shown to negatively correlate with fear of suicide and having courage to kill oneself (Bender, Gordon, & Joiner, 2007). The ACSS also has adequate internal consistency reliability (Van Orden et al., 2008).

Scoring and Interpreting the ACSS: Higher total scores indicate less fear of lethal self-injury and greater tolerance of pain.

Recommendations

- ☐ Use the ACSS to determine an individual's fearlessness about suicide and/or tolerance of pain.

How to Obtain the ACSS: The ACSS is provided for free by Kim Van Orden and Jessica Ribeiro at Thomas Joiner's Lab website: http://www.psy.fsu.edu/~joinerlab/. Air Force providers can reproduce the form and use it (with no associated costs) in the context of their clinical practice.

ACSS

Please read each item below and indicate to what extent you feel the statement describes you. Rate each statement using the scale below and indicate your responses on your answer sheet.

0	1	2	3	4
Not at all like me				Very much like me

_____ 1. Things that scare most people do not scare me.

_____ 2. The sight of my own blood does not bother me.

_____ 3. I avoid certain situations (e.g., certain sports) because of the possibility of injury.

_____ 4. I can tolerate a lot more pain than most people.

_____ 5. People describe me as fearless.

_____ 6.The sight of blood bothers me a great deal.

_____ 7. The fact that I am going to die does not affect me.

_____ 8. The pain involved in dying frightens me.

_____ 9. Killing animals in a science course would not bother me.

_____10. I am very much afraid to die.

_____11. It does not make me nervous when people talk about death.

_____12. The sight of a dead body is horrifying to me.

_____13. The prospect of my own death arouses anxiety in me.

_____14.I am not disturbed by death being the end of life as I know it.

_____15. I like watching the aggressive contact in sports games.

_____16. The best parts of hockey games are the fights.

_____17. When I see a fight, I stop to watch.

_____18. I prefer to shut my eyes during the violent parts of movies.

_____19. I am not at all afraid to die.

_____ 20. I could kill myself if I wanted to. (Even if you have never wanted to kill yourself, please answer this question.)

Quick Guide to the Beck Depression Inventory (BDI-II)

Overview: The BDI-II (Beck, Steer, & Brown, 1996) is a 21-item self-report instrument that assesses symptoms of depression on a 0 to 3 Likert-type scale. Individuals are asked to indicate which response of four for each item best represents how they have been feeling for the past two weeks, including the day of assessment. Higher scores indicate more severe depressive symptoms, with total scores greater than 22 being associated with increased risk of suicide (Brown et al., 2000). Item 9 assesses for suicidal ideation and intent.

Purpose: The purpose of the BDI-II is to measure the severity of an individual's current depression symptoms and may be used as an indicator of suicide risk.

Psychometric Properties: The BDI-II has good concurrent validity and internal consistency reliability (Beck, Steer, Ball, & Ranieri, 1996) and good internal consistency reliability (Beck, Steer, Ball, & Ranieri, 1996). A study on the predictive validity of the BDI-II indicated that patients with scores of 2 or above on the suicide item were 6.9 times more likely to commit suicide than patients who scored below 2 (Brown et al., 2000).

Scoring and Interpreting the BDI-II: Cutoff scores for the BDI are as follows: 0–13: minimal depression; 14–19: mild depression; 20–28: moderate depression; and 29–63: severe depression. Scores of 2 or 3 on item 9 indicate increased risk for suicide.

Recommendations

- Use the BDI-II for initial assessment of depression severity and ongoing monitoring.
- Scores ≥2 on Item 9 signal increased risk for suicide and should be addressed immediately.

How to Obtain the BDI-II: The BDI-II is a copyrighted instrument that is available through Pearson Assessment, http://pearsonassessments.com/pai/

Quick Guide to the Beck Hopelessness Scale (BHS)

Overview: The Beck Hopelessness Scale (BHS; Beck & Steer, 1988) is a self-report instrument with 20 true-false items that assesses the construct of hopelessness across three dimensions: (1) feelings about the future; (2) loss of motivation; and (3) expectations. The measure includes 20 true/false items with higher scores indicating more hopelessness. For each item, the more hopeless response (endorsing a pessimistic statement or denying an optimistic statement) is scored with 1 point.

Purpose: The purpose of the BHS is to measure an individual's feelings about the future and may be used as an indicator of suicide risk.

Psychometric Properties: The BHS has good internal consistency and test-retest reliability (Beck & Steer, 1988; Holden & Fekken, 1988) and good concurrent validity with ratings of hopelessness (Beck, Morris, & Lester, 1974) and pessimism (Beck & Steer, 1988). The BHS also has good predictive validity with psychiatric patients scoring >9 on the BHS at 11 times greater risk of dying by suicide than those scoring 8 or below (Beck, Brown, Berchick, Stewart, & Steer, 2006). The BHS is also sensitive to changes in depressive symptoms (Rush, Beck, Kovacs, Weissenberger, & Hollen, 1982).

Scoring and Interpreting the BHS: For each of the 20 items, a response that endorses a pessimistic statement or denies an optimistic statement is scored with 1 point. A response that is not pessimistic is scored with 0 points. The total BHS score ranges from 0 to 20. A cutoff score of >9 indicates increased risk for suicide.

Recommendations

- ☐ Use the BHS for initial assessment of hopelessness and to track treatment progress.
- ☐ Scores >9 signal increased risk and should be addressed clinically.

How to Obtain the BHS: The BHS is a copyrighted instrument that is available through Pearson Assessment, http://pearsonassessments.com/pai/

Quick Guide to the Columbia Suicide Severity Rating Scale (C-SSRS)

Overview: The C-SSRS (Posner et al., 2008) is a rater-administered or self-report assessment tool of suicidal risk. The Screen version has a minimum of 2 questions and a maximum of 6 questions. The full version of the C-SSRS, available in rater-administered and self-report form has four subscales: (1) severity of ideation; (2) intensity of ideation; (3) suicidal behavior; and (4) lethality of actual attempts. The Risk Assessment Version of the C-SSRS includes a risk factor checklist to assist with determining an individual's immediate risk of suicide. There are also population-specific versions of the C-SSRS (military, pediatric, etc.). Mental health training is not required to administer the scale, and is appropriate for use by all types of providers and gatekeepers. The screen version has been incorporated into the Army's Behavioral Health Data Portal in 2013, and this data portal has the capability to be utilized tri-service wide.

Purpose: C-SSRS was designed to provide definitions of suicide ideation and behavior, quantify the spectrum of ideation and behavior, distinguish suicidal behavior from nonsuicidal self-harm, and use information from multiple sources to determine the severity of an individual's suicide ideation and behaviors.

Psychometric Properties: An initial study (Posner et al., 2011) of the psychometric properties of the C-SSRS has been shown to have good internal consistency reliability. It also had good convergent and divergent validity with other suicide ideation and behavior scales. In addition, the ideation and behavior subscales were sensitive to change over time. Predictive validity results indicated that individuals with intent or intent with a plan at baseline had higher odds of attempting suicide. In another large-scale study of non-suicidal depressed adults, not only were intent and intent with specific plan predictive, all behavior responses added significantly to an individual's short-term likelihood of attempting suicide.

Scoring and Interpreting the C-SSRS: The first section determines the severity suicide ideation on a scale of 0-5, based on the highest level endorsed, which is used as a basis for completing section 2, in which the most severe ideation is assessed for frequency, duration, controllability, deterrents, and reasons on Likert-type scales (0-5 and1-5). History of attempts, interrupted attempts, self-interrupted/aborted attempts, preparatory behavior, and non-suicidal self-injurious behavior are assessed with yes/no questions. Finally, actual lethality of attempts is assessed on a 0-5 scale, and potential lethality is rated on a 0-2 scale. The C-SSRS has operationalized criteria for next steps (e.g., triggering referrals to mental health professionals), which can streamline triage, expedite care delivery to those at highest risk, and redirect scarce resources. Recommended thresholds that indicate current clinically significant risk are intent or intent with specific plan in the past month or any suicidal behavior in the past 3 months.

Recommendations

- ☐ Use the C-SSRS to help determine current risk for suicide and history of suicidality.
- ☐ May also be used to assess for nonsuicidal self-harm behaviors.

How to Obtain the C-SSRS: For more information and a free, one-hour training module for providers go to http://www.cssrs.columbia.edu/. The C-SSRS products are provided for free on this site and also several are included in this Guide's appendices with permissions granted from Dr. Kelly Posner at Columbia University. Air Force providers may reproduce the forms and use them (with no associated costs) in the context of their clinical practice.

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
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. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan*." ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*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.*" ***Have you been thinking about how you might kill yourself?***		
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 "*I have the thoughts but I definitely will not do anything about them*." ***Have you had these thoughts and had some intention of acting on them?***		
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. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
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?		

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

RISK ASSESSMENT VERSION

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

	Suicidal and Self-Injurious Behavior (Past 3 months)		**Clinical Status (Recent)**
☐	Actual suicide attempt ☐ Lifetime	☐	Hopelessness
☐	Interrupted attempt ☐ Lifetime	☐	Major depressive episode
☐	Aborted or Self-Interrupted attempt ☐ Lifetime	☐	Mixed affective episode
☐	Other preparatory acts to kill self ☐ Lifetime	☐	Command hallucinations to hurt self
☐	Self-injurious behavior without suicidal intent ☐ Lifetime	☐	Highly impulsive behavior
	Suicidal Ideation (Most Severe in Past Month)	☐	Substance abuse or dependence
☐	Wish to be dead	☐	Agitation or severe anxiety
☐	Suicidal thoughts	☐	Perceived burden on family or others
☐	Suicidal thoughts with method (but without specific plan or intent to act)	☐	Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
☐	Suicidal intent (without specific plan)	☐	Homicidal ideation
☐	Suicidal intent with specific plan	☐	Aggressive behavior towards others
	Activating Events (Recent)	☐	Method for suicide available (gun, pills, etc.)
☐	Recent loss or other significant negative event	☐	Refuses or feels unable to agree to safety plan
	Describe:	☐	Sexual abuse (lifetime)
		☐	Family history of suicide (lifetime)
☐	Pending incarceration or homelessness		**Protective Factors (Recent)**
☐	Current or pending isolation or feeling alone	☐	Identifies reasons for living
	Treatment History	☐	Responsibility to family or others; living with family
☐	Previous psychiatric diagnoses and treatments	☐	Supportive social network or family
☐	Hopeless or dissatisfied with treatment	☐	Fear of death or dying due to pain and suffering
☐	Noncompliant with treatment	☐	Belief that suicide is immoral; high spirituality
☐	Not receiving treatment	☐	Engaged in work or school
	Other Risk Factors:		**Other Protective Factors:**
☐		☐	

Describe any suicidal, self-injurious or aggressive behavior (include dates):

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject 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 (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"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."* ***Have you been thinking about how you might do this?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal. Lifetime - ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation*** Recent - ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation***	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** *(*Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes** ☐ **No** ☐ Total # of Attempts _____	**Yes** ☐ **No** ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of interrupted _____	**Yes** ☐ **No** ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Suicidal Behavior: Suicidal behavior was present during the assessment period?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Lifetime/Recent Version

Version 1/14/09

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice*, pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact posnerk@childpsych.columbia.edu

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

	Lifetime: Time He/She Felt Most Suicidal	Past 1 month
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
"Now, I'd like you to think about the time in your life when you were feeling the most suicidal. During that time…"		
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject 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 (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"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."* ***Have you been thinking about how you might do this?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐

INTENSITY OF IDEATION

	Most Severe	Most Severe
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal. Lifetime - ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation*** Recent - ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation***		
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** *(*Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes** ☐ **No** ☐ Total # of Attempts _____	**Yes** ☐ **No** ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of interrupted _____	**Yes** ☐ **No** ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Suicidal Behavior: Suicidal behavior was present during the assessment period?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

Additional Questions

	Yes	No
Legal Troubles ***Are you currently facing any legal troubles?*** *Within military structure or outside ***If yes, how have these circumstances impacted you/your family?*** Additional Information:	☐	☐
Financial Troubles ***Are you experiencing any financial troubles?*** If yes: ***Do these concerns feel overwhelming or unmanageable?*** ***Sometimes a person can feel that others close to them (e.g., family) would be better off financially if the person were no longer alive. Have you experienced this?*** ***Is this financial stress or hardship the worst crisis you have ever experienced?***	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
State of Service **(pre-deployment, post-deployment, etc)** Pre-deployment ___ Post-deployment ___ Multiple deployments ___ ***Are the thoughts/behaviors we talked about related to your _____?*** (e.g., pending deployment)	☐	☐
Marital or Relationship Stress ***Are you having any marital or relationship stress or problems?*** *Ask about domestic violence.	☐	☐
Drug or Alcohol Use ***Do you use drugs or alcohol?*** ***Do you have a history of drug or alcohol abuse?*** Additional Information:	☐ ☐	☐ ☐
Pain ***Are you experiencing pain – chronic or intermittent****?* Additional Information:	☐	☐

Quick Guide to the
M.I.N.I. International Neuropsychiatric Inverview 6.0 (M.I.N.I. 6.0)
Suidicality Subscale

Overview: The M.I.N.I. (English Version 6.0.0) is a brief, structured clinician-administered interview that assesses for Axis I disorders, including suicidality, depression, anxiety, PTSD, alcohol and substance abuse and dependence in addition to antisocial personality disorder (ASD) on Axis II. The assessment consists of multiple modules, each of which begin with a few screening questions to determine whether further assessment in the area is warranted. All questions (except height and weight) are answered "yes" or "no." The Suicidality Subscale is a 14-item subscale that assesses for suicide ideation, planning, intent, and behavior.

Purpose: The M.I.N.I. is a diagnostic tool for major Axis I disorders. The Suicidality Subscale is intended to determine current suicide risk level.

Psychometric Properties: Initial and follow-up validation studies have shown that the M.I.N.I. has good interrater and test-retest reliability and moderate convergent validity with other Axis I diagnostic instruments (Lecrubier et al., 1997; Sheehan et al., 1997; Sheehan et al., 1998). Specific to the M.I.N.I. Suicidal Scale, results from a prospective study (Roaldset, Linake, & Bjorkly, 2012) indicated that for patients screened using the MINI Suicidal Subscale at discharge from the hospital, their scores were a significant predictor of suicidal behavior at 12 months post-discharge.

Scoring and Interpreting the M.I.N.I.-Suicidality Subscale: The M.I.N.I. Suicidality Subscale items are assigned varying numbers of points for responses indicating elevated risk. The points are summed and risk level is determined as follows: 1-8 (low risk); 9-16 (moderate risk); ≥ 17 (high risk).

Recommendations

- ☐ Use the M.I.N.I. Suicidality Subscale to help determine patient level of risk.
- ☐ Use the other subscales to determine psychiatric diagnostic information.

How to Obtain the M.I.N.I.: The M.I.N.I. (6.0.0) is a copyrighted instrument that is available through Medical Outcomes System (https://medical-outcomes.com/index/mini). Pricing options are available for students and clinicians in private practice as well as organizations (e.g., government).

Quick Guide to the Outcome Questionnaire (OQ-45.2)

Overview: The OQ-45.2 (Lambert et al., 2004) is a 45-item instrument with a total score and three subscales that are used to assess and track patient functioning over the course of treatment. The three subscales assess symptom distress, social-role functioning, and interpersonal relationship satisfaction. Responses are on a 5 point Likert-type scale ranging from 0 (never) to 4 (always). The OQ-45.2 has a suicide ideation question (Item 8): "I have thoughts of ending my life." The patient's response to this question can be used as a screening item for suicide ideation, which the provider can then follow-up on by asking about planning, intent, and behaviors.

Purpose: The purpose of the OQ-45.2 is to measure and track patients' symptom-related suffering, interpersonal relationships, and social role functioning over the course of therapy.

Psychometric Properties: The OQ-45.2 has good concurrent validity with measures of depression, anxiety, and psychiatric functioning (Umphress, Lambert, Smart, Barlow, & Clouse, 1997), good internal consistency reliability and adequate test-retest reliability (Lambert et al., 1996; Lambert et al., 2004). Total scores on the OQ-45.2 scale have been reported to be reliable and valid in distinguishing between clinical and nonclinical subjects (Umphress et al., 1997).

Scoring and Interpreting the OQ-45: Total scores on the OQ-45.2 range from 0 to 180, with scores above 63 considered significant. Subjective distress scores range from 0 to 88; social role scores range from 0 to 36; and interpersonal relationship scores range from 0 to 44.

Recommendations

- Use the patient's response on item 8 as a basis for follow-up questions on suicide ideation and behavior and to help determine risk level. In an Air Force clinic study (Jobes, Wong, Conrad, Drozc, & Neal-Walden, 2005), a client was considered suicidal if at intake or any point in treatment he or she endorsed a 2, 3, or 4 on item #8.
- Use patient response to item to track suicide ideation over the course of therapy.
- Use scores on the symptom distress and interpersonal relationship subscale to assess impact of psychiatric and relational factors on risk level and to determine treatment approach.

How to Obtain the OQ-45: The OQ-45.2 is a copyrighted instrument that is available for a fee through OQ Measures: http://www.oqmeasures.com/

Quick Guide to the Scale for Suicide Ideation (SSI)

Overview: The SSI (Beck et al., 1979) is a 21-item clinician-administered instrument that assesses presence and severity of current and past suicide ideation. The patient responds to each item based on how he or she is feeling on the day of the interview, as well as on the identified "most severe point of illness." There are five screening items; if the patient endorses any active or passive wish to die by suicide, the 14 additional items are administered. The SSI also has items that assess means access and other specifics of suicide intent and capability, which can be qualitatively important for determining level of suicide risk and for safety planning and other interventions.

Purpose: The SSI is intended to assess the current and previous intensity of suicide ideation, planning, and behavior.

Psychometric Properties: The SSI has been shown to have good internal consistency (Beck et al., 1979; Beck et al., 1997) and interrater reliability (Beck et al., 1979; Beck, Brown, & Steer, 1997). The SSI also has good concurrent validity with suicide items on other scales (Beck et al., 1979; Beck et al., 1997). It also has good predictive validity. In a study by Brown et al. (2000), those who scored a 3 or higher on the SSI (current ideation) were approximately seven times more likely to die by suicide than those who scored less than 3. In a prospective study (Beck, Brown, Steer, Dahlsgaard, & Grisham, 1999), psychiatric patients with scores greater than 16 on SSI (worst ideation) were 14 times more likely to die by suicide than those who scored less than 16. The SSI was also shown to be sensitive to changes in levels of depression and hopelessness from pre- to post-treatment (Beck et al., 1979) and to change in suicide ideation in psychiatric patient hospitalized for suicide risk (Russ, Kashdan, Pollack, & Bajmakovic-Kacila, 1999).

Scoring and Interpreting the SSI: All items are scored on a 0 to 2 scale, with items 1 through 19 being summed for a total score of 0 to 38. The SSI also has items that assess means access and other specifics of suicide intent and capability, which can be qualitatively important for determining level of suicide risk and for safety planning and other interventions.

Recommendations

- ☐ The SSI may be used to screen for current suicidality, with a cutoff score of 3 or higher indicating elevated risk.
- ☐ The SSI-worst scores of 16 and higher indicate elevated risk.

How to Obtain the SSI: The SSI is a copyrighted instrument that is available through Pearson Assessment, http://pearsonassessments.com/pai/

Quick Guide to the Suicide Behaviors Questionnaire-Revised (SBQ-R)

Overview: The SBQ-R (Osman, Bagge, Gutierrez, Konick, & Kooper, 2001) is a 4-item self-report measure of dimensions of suicidality that consist of (1) lifetime suicide ideation and attempt; (2) frequency of suicide ideation over the past 12 months; (3) threat of suicide attempt; and (4) self-reported likelihood of future suicidal behavior.

Purpose: The SBQ-R was designed specifically as a screening tool for suicide risk in adolescents and adults.

Psychometric Properties: Results from a validation study (Osman et al., 2001) indicate that the SBQ-R had good sensitivity and specificity for adult general population and psychiatric inpatients. It also had good reliability and validity. A cutoff score of 8 accurately distinguished between adult psychiatric inpatients with recent ideation or attempts and control group.

Scoring and Interpreting the SBQ-R: Each response is given points, and each item is anchored differently. The total score can range from 3-18. For item 1, 1=1 point, 2=2 points; 3a or 3b=3 points; 4a or 4b=4 points. For item 2, Never=1 point; Rarely=2 points; Sometimes=3 points; Often=4 points; and Very Often=5 points. For item 3, 1=1 point; 2=2 points; 3a or 3b=3 points. For item 4, Never=0 points; No chance at all=1 point; Rather unlikely=2 points; Unlikely=3 points; Likely=4 points; Rather Likely=5 points; and Very Likely=6 points. In summary, item 1 responses can receive from 1 to 4 points, item 2 from 1 to 5 points, item 3 from 1 to 3 points, and item 4 from 0 to 6 points. Points are then summed to determine the total score.

Recommendations

- ☐ The authors of the SBQ-R recommend using both the total scores and the Item 1 scores in making clinical determinations of risk.

How to Obtain the SBQ-R: The SBQ-R copyright stipulates that in order to use the measure for research or clinical purposes, the user must purchase the book in which it appears:

Gutierrez, P. M., & Osman, A. (2008). *Adolescent suicide: An integrated approach to the assessment of risk and protective factors.* DeKalb, IL: Northern Illinois University Press.

APPENDIX D: Safety Planning Intervention

SAFETY PLAN

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____
4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4. Local Emergency Service _____
   Emergency Services Address_____
   Emergency Services Phone _____

Making the environment safe:

1. _____
2. _____

Adapted from Stanley, B. & Brown, G.K. (2011). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice. 19*, 256–264

SAFETY PLAN

Step 1: Warning signs:

1. Behavior: Isolation (don't check Facebook, don't go bowling)
2. Thought: "I have nothing to live for", "I want to kill myself"
3. Feeling: Depressed, worthless, like a failure

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. Watch movies (1. Good Will Hunting, 2. Gladiator)
2. Play Video Games (1. Racing, 2. Role Playing Games)
3. Work Out

Step 3: People and social settings that provide distraction:

1. Name Jimmy from home (EST) Phone 212-555-5555
2. Name Sam from the auto club Phone 410-555-5555
3. Place MWR Lounge (corner of Main and 2nd Street)
4. Place Church (0700-2200)

Step 4: People whom I can ask for help:

1. Name William (Brother) Phone 202-555-5555(c), 301-555-5555 (h)
2. Name Thomas (Best friend) Phone 818-555-5555
3. Name SGT Stian Phone 323-555-5555

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name Ms. Carr, MSW Phone 301-555-5555
   Clinician Pager or Emergency Contact # 301-555-5555 (clinic after hours)
2. Clinician Name Dr. Juner, MD Phone 301-555-5555
   Clinician Pager or Emergency Contact # 301-555-5555 (after hours answering machine)
3. Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4. Local Emergency Service Rundie Medical center (2 miles away)
   Emergency Services Address 2001 Medical Park, Rundie, AZ 85011
   Emergency Services Phone 911 Emergency, 602-555-5555 (Nurse advice line)

Making the environment safe:

1. Mom will take gun to William's house to store in safe
2. Maintain only a 2 weeks supply of medication at a time

Adapted from Stanley, B. & Brown, G.K. (2011). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice. 19*, 256–264

Note. Dr. Jaime Carreno has provided this sample safety plan.

APPENDIX E: Documentation

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)

Mental Health Record

Date/Time:

Type Visit: Intake
Any Special Duty Status: (fly, jump, PRP, weapons bearing)

Duration: XX minutes

S: **Pt ID/Chief Complaint:** Patient is a XX y/o, marital status, ethnicity, AD USAF, rank, gender, job. The patient has read and understands the limits of confidentiality. The patient voluntary presented for an individual intake to address XXXXX. This case is/is not deployment related.

Psychiatric Review of Symptoms: Patient denied current and past depressive episodes, denied current and past si/hi, suicide attempts, self-mutilation and violence, denied psychotic, manic, delusional, PTSD, panic, GAD, OCD, social phobia, and eating disorder symptoms.

History of Presenting Illness:

Occupational/military history:

Legal/financial information:

Social/Developmental History: (relationship history, exposure to trauma)

Spiritual/Religious Beliefs:

Medical History (including significant family history):

Past Psych:

Fam Psych:

Current medications/OTC/herbs/supplements: (for prescribing providers: meds reconciled in CHCS; hard copy given to patient)

Allergies:

Surgery:

ETOH:,

Tobacco:

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*	REGISTER NUMBER	WARD NO.
	N/A	N/A

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)

Illegal drug use:

Caffeine (including supplements):

O: **MSE:** Pt did not present in acute distress. Pt was appropriately groomed IAW military standards. Pt was alert and oriented x4. Eye contact was appropriate. No abnormalities in attention or concentration were noted. No abnormalities of movement present; psychomotor activity was normal. Speech was fluent and regular in rhythm, rate, volume, and tone. Thought processes were linear, logical, and goal-directed. There was no evidence of thought disorder. No auditory or visual hallucinations. Long and short term memory appeared to be intact. Insight, judgment, and impulse control were deemed to be within normal limits. Reported mood was "***XXXX***." Affect was full-ranging and appropriate to thought content and conversation. Pt denied ***past and current*** suicidal and homicidal ideation ***in plan, intent, and preparatory behavior*** both verbally and on the PHQ-9 (or other measure).

Vital Signs: *(if applicable)*
Abnormal Involuntary Movement Scale/Labs/Rads *(if applicable)*

Place results of measures here (*PHQ-9, and if applicable GAD- 7, PCL, AUDIT-C, etc***)**
(Results should include severity classification ranges; mild, moderate, severe etc.)

A: DSM Diagnoses:

(List reason for giving diagnosis)

Risk Assessment:
The member denied any suicide-related ideation and/or behaviors and intent/plan, denied thoughts about death and dying both in session and during the period since last appointment, or past 2 weeks if first session, (if suicidal ideation is present, document frequency, duration, intensity, cognitions, associated images, active versus passive), (if intent is present then discuss extent of wish to die, likelihood of acting on suicidal urges, reasons for dying, timeframe) (If suicide plan is present then discuss when where how availability and lethality of means, motivation, planning, rehearsal) denied suicidal behaviors (If suicide related behaviors are present discuss specifics of behavior, e.g. how many pills did you take? Or Did you load the gun)

Warning Signs: (possible warning signs, remove all that do not apply):
Higher-Level Warning Signs: threats of harming or killing self, seeking means, such as access to weapons, talking or writing about death, dying, or suicide, giving belongings away

Lower-Level Warning Signs: hopelessness, rage, anger, seeking revenge; acting reckless or engaging in risky activities; feeling trapped; increased alcohol or drug use; withdrawing from family, friends, society; anxiety, agitation, insomnia, hypersomnia; dramatic changes in mood; no perceived reason for living or sense of purpose

Current risk factors are: (*possible risk factors, remove all that do not apply):*
Psychiatric History and Current Status: History of suicide attempt; history of psychiatric inpatient care; history of non-suicidal self-injurious behaviors; depression or other mood disorders; personality disorders or traits; PTSD or anxiety disorders; sleep disorders; substance-use disorders; family history of suicide and /or psychiatric illness; psychotic disorders.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*	REGISTER NUMBER	WARD NO.
	N/A	N/A

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)

Psychological Characteristics: hopelessness; thwarted belongingness; perceived burdensomeness; acquired capability for suicide; impulsivity; problem-solving deficits; shame; guilt.
Psychosocial Stressors: Relationship problems; legal or financial problems; work related problems; lack of social support.
Physical Injury or Illness: TBI or other physical injury, chronic pain, other medical problems.
Other Risk Factors: access to lethal means; combat exposure; history of physical, emotional, mental and or sexual abuse; sexual orientation; mental health stigma and perceived barriers to care; recent local cluster of suicides (consider possible contagion)

Current Protective factors are: (*possible protective factors, remove all that do not apply):*
Psychiatric History and Status: compliance with psychiatric medication; engagement in evidenced-based treatment; motivation and readiness to change; insight about problems.
Psychological Characteristics: Problem solving and effective coping strategies; resilience; reasons for living; future orientation; perceived internal locus of control.
Psychosocial Factors: healthy intimate relationships; social support and community involvement.
Physical Injury or Illness: Medical compliance; able to access care as needed; support for help seeking.
Other Protective Factors: Restricted access to lethal means; religion/spirituality, crisis response or other related training.

Risk Level (choose one): Not currently at Clinically Significant Risk; Currently at Clinically Significant Risk, but not Imminent; Currently at Clinically Significant Risk, Imminent

HI log:
No indication at this time
OR
Indicated at this time (document Command, PCM, ED and MH provider notifications)

Hospitalization **is/is not** deemed necessary at this time as the patients **does/does not** present a clear or imminent danger to self or others. No indication for pursuing higher level of care-Out pt management is currently most appropriate and least restrictive level of care.

P: TREATMENT PLANNING:

Treatment Goals/Objectives: Discussed treatment plan with the pt.
Problems/Goals include:
Modality of treatment:
Target Outcome/Objective:

PLAN/DISPOSITION

1) Date/time of next session:
2) Homework for Next Session (if applicable):
3) Plan for next session (if applicable):
4) **Crisis Response Plan (*personalize for your patient or delete as appropriate*):** Reviewed emergency resources with the patient and the patient expressed understanding; including: If feeling suicidal, patient will call or present to the Mental Health Clinic during duty hours (xxx-xxxx); call or present to closest ED (phone number), call 911 or crisis hotline (1-800-273-TALK) after duty hours; or call chaplain (xxx-xxxx) or Command Post (xxx-xxxx) during or after duty hours.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*	REGISTER NUMBER	WARD NO.
	N/A	N/A

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)

5) Referrals/Consults:
6) Medication—prescribing providers only (discuss risks/benefits/side effects discussed)
    a. Patient advised to refrain from using alcohol while taking any psychotropic medication.
7) Labs—prescribing providers only: (ordered, reviewed) (if applicable)
8) Prevention Topics Discussed: Safety and Emergency Contact Information, Medication Compliance, Social support, Sleep, Stress Management, Alcohol use, Tobacco use, Caffeine use, Substance abuse, Nutrition, Exercise, Safety, Domestic Violence/Family Maltreatment, Sexual behaviors, Other, None
9) Pt voiced understanding of, and agreement with, plan and goals as annotated above.

Current Profile: Member **IS/IS NOT** cleared for mobility, PCS, TDY, and Deployment; other limitations
Disposition: No alterations to duty status or security clearance recommended at this time.
Prognosis: poor, fair, good, excellent, guarded

If applicable, Flt Surgeon contacted (name/date)
Place PRP stamp here if applicable

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*	REGISTER NUMBER	WARD NO.
	N/A	N/A

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)

Mental Health Record

Date/Time:

Type Visit:
Any Special Duty Status: (fly, jump, PRP, weapons bearing)

Duration: XX minutes

S: **Pt ID/Chief Complaint:** Patient is a XX y/o, marital status, ethnicity, AD USAF, rank, gender, job. The patient voluntary presented for a follow-up individual session to address XXXXX. This case is/is not deployment related.

Current Situation/Content of Session:

Current medications/OTC/herbs/supplements: (for prescribing providers: meds reconciled in CHCS; hard copy given to patient)

Allergies:

O: **MSE:** Pt did not present in acute distress. Pt was appropriately groomed IAW military standards. Pt was alert and oriented x4. Eye contact was appropriate. No abnormalities in attention or concentration were noted. No abnormalities of movement present; psychomotor activity was normal. Speech was fluent and regular in rhythm, rate, volume, and tone. Thought processes were linear, logical, and goal-directed. There was no evidence of thought disorder. No auditory or visual hallucinations. Long and short term memory appeared to be intact. Insight, judgment, and impulse control were deemed to be within normal limits. Reported mood was "***XXXX***." Affect was full-ranging and appropriate to thought content and conversation. Pt denied ***past and current*** suicidal and homicidal ideation ***in plan, intent, and preparatory behavior*** both verbally and on the PHQ-9 (or other measure).

Vital Signs: *(if applicable)*
Abnormal Involuntary Movement Scale/Labs/Rads *(if applicable)*

Place results of measures here (*PHQ-9, and if applicable GAD- 7, PCL, AUDIT-C, etc***)**
(Results should include severity classification ranges; mild, moderate, severe etc.)

A: DSM Diagnoses:

(List reason for giving diagnosis)

Risk Assessment:
The member denied any suicide-related ideation and/or behaviors and intent/plan, denied thoughts about death and dying both in session and during the period since last appointment, or past 2 weeks if first session, (if suicidal ideation is present, document frequency, duration, intensity, cognitions, associated images, active versus passive), (if intent is present then discuss extent of wish to die, likelihood of acting on suicidal urges, reasons for dying, timeframe) (If suicide plan is present then discuss when where how availability and lethality of means, motivation, planning, rehearsal) denied suicidal behaviors (If suicide related behaviors are present discuss specifics of behavior, e.g. how many pills did you take? Or Did you load the gun)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*	REGISTER NUMBER	WARD NO.
	N/A	N/A

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)

Warning Signs: (possible warning signs, remove all that do not apply):
Higher-Level Warning Signs: threats of harming or killing self, seeking means, such as access to weapons, talking or writing about death, dying, or suicide, giving belongings away

Lower-Level Warning Signs: hopelessness, rage, anger, seeking revenge; acting reckless or engaging in risky activities; feeling trapped; increased alcohol or drug use; withdrawing from family, friends, society; anxiety, agitation, insomnia, hypersomnia; dramatic changes in mood; no perceived reason for living or sense of purpose

Current risk factors are: (*possible risk factors, remove all that do not apply):*
Psychiatric History and Current Status: History of suicide attempt; history of psychiatric inpatient care; history of non-suicidal self-injurious behaviors; depression or other mood disorders; personality disorders or traits; PTSD or anxiety disorders; sleep disorders; substance-use disorders; family history of suicide and /or psychiatric illness; psychotic disorders.
Psychological Characteristics: hopelessness; thwarted belongingness; perceived burdensomeness; acquired capability for suicide; impulsivity; problem-solving deficits; shame; guilt.
Psychosocial Stressors: Relationship problems; legal or financial problems; work related problems; lack of social support.
Physical Injury or Illness: TBI or other physical injury, chronic pain, other medical problems.
Other Risk Factors: access to lethal means; combat exposure; history of physical, emotional, mental and or sexual abuse; sexual orientation; mental health stigma and perceived barriers to care; recent local cluster of suicides (consider possible contagion)

Current Protective factors are: (*possible protective factors, remove all that do not apply):*
Psychiatric History and Status: compliance with psychiatric medication; engagement in evidenced-based treatment; motivation and readiness to change; insight about problems.
Psychological Characteristics: Problem solving and effective coping strategies; resilience; reasons for living; future orientation; perceived internal locus of control.
Psychosocial Factors: healthy intimate relationships; social support and community involvement.
Physical Injury or Illness: Medical compliance; able to access care as needed; support for help seeking.
Other Protective Factors: Restricted access to lethal means; religion/spirituality, crisis response or other related training.

Risk Level (choose one): Not currently at Clinically Significant Risk; Currently at Clinically Significant Risk, but not Imminent; Currently at Clinically Significant Risk, Imminent

HI log:
No indication at this time
OR
Indicated at this time (document Command, PCM, ED and MH provider notifications)

Hospitalization **is/is not** deemed necessary at this time as the patients **does/does not** present a clear or imminent danger to self or others. No indication for pursuing higher level of care-Out pt management is currently most appropriate and least restrictive level of care.

P: TREATMENT PLANNING:

Treatment Goals/Objectives: Discussed treatment plan with the pt.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*	REGISTER NUMBER	WARD NO.
	N/A	N/A

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)

Problems/Goals include:
Modality of treatment:
Target Outcome/Objective:
Rating Scale for Progress/Status 1: Significantly Worse; 2: Somewhat Worse; 3: No change; 4: Somewhat improved; 5: Significantly Improved; 6: Objective/Goals achieved**:**

PLAN/DISPOSITION

1) Date/time of next session:
2) Homework for Next Session (if applicable):
3) Plan for next session (if applicable):
4) **Crisis Response Plan (*personalize for your patient or delete as appropriate*):** Reviewed emergency resources with the patient and the patient expressed understanding; including: If feeling suicidal, patient will call or present to the Mental Health Clinic during duty hours (xxx-xxxx); call or present to closest ED (phone number), call 911 or crisis hotline (1-800-273-TALK) after duty hours; or call chaplain (xxx-xxxx) or Command Post (xxx-xxxx) during or after duty hours.
5) Referrals/Consults:
6) Medication—prescribing providers only (discuss risks/benefits/side effects discussed)
   a. Patient advised to refrain from using alcohol while taking any psychotropic medication.
7) Labs—prescribing providers only: (ordered, reviewed) (if applicable)
8) Prevention Topics Discussed: Safety and Emergency Contact Information, Medication Compliance, Social support, Sleep, Stress Management, Alcohol use, Tobacco use, Caffeine use, Substance abuse, Nutrition, Exercise, Safety, Domestic Violence/Family Maltreatment, Sexual behaviors, Other, None
9) Pt voiced understanding of, and agreement with, plan and goals as annotated above.

Current Profile: Member **IS/IS NOT** cleared for mobility, PCS, TDY, and Deployment; other limitations
Disposition: No alterations to duty status or security clearance recommended at this time.
Prognosis: poor, fair, good, excellent, guarded

If applicable, Flt Surgeon contacted (name/date)
Place PRP stamp here if applicable

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*	REGISTER NUMBER	WARD NO.
	N/A	N/A

HIGH INTEREST LOG/HOSPITALIZATION CHECKLIST

Patient Name (last 4):	**SSN:**	**Squadron:**
CC:	**CCF:**	**PCM:**
CC Phone:	**CCF Phone:**	**PCM Phone:**
Primary MH Provider:		

Patient was placed on High Interest for the following reason(s):

- ☐ Suicidal ideation / attempt / gesture
- ☐ Homicidal ideation / intent
- ☐ Psychiatric hospitalization
- ☐ Risk for Psychological Decompensation
- ☐ Inpatient Alcohol or Drug program
- ☐ Intensive Outpatient Treatment
- ☐ Other: _____

	HOSPITALIZATION (if not applicable, leave blank)	**Date**	**Provider Initials**
1.	Notify CC/CCF (if AD)		
2.	Completed Involuntary Hospitalization Procedures – (if AD Emergency CDE)		
3.	Add patient to "HIGH INTEREST Log"		
4.	Inform MTF commanders of admission (MDG/CC, SGH)		
5.	Follow up at least weekly w/hospital for updates		
6.	Provider received and reviewed the discharge summary from the hospital		
7.	Patient was seen within one duty day after hospitalization discharge		

	ADDING/MANAGING PATIENT TO/ON HIL	**Date**	**Provider Initials**
1.	Patient notified he/she is entered on HIL		
2.	Completed Crisis Response Plan		
3.	Modify/Complete Treatment Plan to address safety		
4.	HIL Notifications:		
	Commander (AD only)		
	PCM/ED/PRP/Flight Med, MH providers, MH Technicians		
5.	DLC/Profile created in ASIMS. DLC expiration date (at least 90 days):		
6.	AHLTA BH1/BH2 High Interest List Flag Created		
7.	If suicide attempt: Met with SGH to review case, treatment plan, potential administrative actions (disqualifying diagnosis/MEB/CDE)		
8.	Completed DoDSER (if applicable) within 30 days		
9.	Conducted Treatment Team Meeting with CC/CCF/Patient		
10.	Added patient into LPSP (if applicable)		

	REMOVING PATIENT FROM HIL	**Date**	**Provider Initials**
1.	Patient has had at least 4 consecutive weeks of documented risk stability		
2.	Clinical justification for removal, discussed with peers and documented		
3.	Date patient was removed from the HIL		
4.	Patient notified he/she is removed from HIL		
5.	Command notified patient removed from HIL		
6.	PCM notified patient removed from HIL		
7.	AHLTA BH1/BH2 High Interest List Flag Removed		

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)

HIGH INTEREST TREATMENT TEAM MEETING

Date: _____ @ _____

DEPLOYMENT RELATED	☐ YES	☐ NO
FLYER	☐ YES	☐ NO
PRP/PSP	☐ YES	☐ NO
TS/SCI	☐ YES	☐ NO

S: HIGH INTEREST Treatment Team Meeting for patient entered on the Mental Health High Interest Log.
Members present: ☐ Patient ☐ Commander ☐ 1st Sgt ☐ PCM Rep ☐ Provider ☐ Other: _____

INFORMATION DISCUSSED OR PRESENTED:
Mental Health Provider discussed the following:

MH Provider Comments: _____

Squadron Comments: _____

Patient Comments/Concerns: (include ways patient would like to be supported by squadron) _____

O: MSE: Appropriate to situation and WNL/other: _____
Patient did/did not participate

A: DSM-IV-TR DIAGNOSIS:

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*	REGISTER NUMBER	WARD NO.
	N/A	N/A

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)

P: DISPOSITION / PLAN

Mental Health Actions:

- ☐ Discussed follow up appointments and No Show policy
- ☐ Enter LPSP date: _____
- ☐ Hospitalized @ _____
- ☐ Initiate MEB
- ☐ Consult with legal
- ☐ Referral: _____
- ☐ Other: _____
- ☐ DLC NO: □ Leave □ TDY □ PCS □ Firearm □ Deploy
- ☐ Name of MH provider and date of next MH appointment: _____
- ☐ Safety Plan: _____

Command Actions:

- ☐ No contact order
- ☐ Consult with legal
- ☐ Remove access to means
- ☐ Check-ins: Frequency _____ Method: _____ Person: _____
- ☐ Initiate CDE
- ☐ Duty Changes: _____

I have acknowledged and understand the above information as it was discussed. Please print and sign below:

Patient: _____ First Sergeant: _____

Commander: _____ PCM/Flt Med: _____

Mental Health Provider: _____ Other: _____

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*	REGISTER NUMBER	WARD NO.
	N/A	N/A

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)

Multidisciplinary Clinical Case Conference

Date: _____ @ _____

☐ **High Interest Meeting** ☐ **Multidisciplinary Case Management (MCM)**

Primary Provider: _____ **Date Added to HIL:** _____

Diagnoses: _____ **Last appt:** _____

Risk/Risk Level: _____ **Next appt:** _____

Duty Restrictions: _____ **Date of Initial TTM:** _____

Sensitive Duties: _____ **DLC/Profile Exp Date:** _____

Is a CDE warranted?	☐ Yes	☐ No	☐ N/A	Status: _____
Is a MEB warranted	☐ Yes	☐ No	☐ N/A	Status: _____
Was PCM contacted?	☐ Yes	☐ No		Date: _____
Was Command contacted?	☐ Yes	☐ No		Date: _____

Clinical Update (i.e., presenting problem, risk factors, clinical progress, and disposition)*If removing from HIL, ensure proper NOTIFICATIONS (PCM and CC) and JUSTIFICATIONS are documented in AHLTA. A minimum of 4 consecutive weeks of stability is required before removing from the HIL.

_____

_____

_____

_____

Comments from other Mental Health Providers present at the meeting:

_____

_____

_____

_____

Referral(s): In-Transition /Psychiatry / ADAPT / FAP / NPSP / HAWC / PCM / Psych Testing / Chaplain / Groups/Classes:_____ Other:_____

Providers from the following Flight Elements were present:

☐ ADAPT
☐ FAP
☐ Mental Health

Provider's Signature/Stamp _____

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*
Last, First, Middle
SSN:
Gender:
DOB:
Rank/Grade:
Unit:

REGISTER NUMBER	WARD NO.
N/A	**N/A**

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 11/2010)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
Page 1 of 1

SOAP Note Format

Documentation for suicidal patients must be clear and detailed. Given that a number of Air Force providers use the SOAP format as a structure for their clinical documentation, a brief summary on the SOAP strategy for suicidal patients is provided below. Please note that the information provided in this Appendix is to *guide* you through the documentation process and not to dictate what you should and should not include in the documentation. There is no single recipe for a "perfect" clinical note. Please use your clinical judgment about content and when needed, please consult with your colleagues and/or supervisors.

Subjective

- Statements made by the patient
- Chief complaint and/or presenting problems

Example: SrA Smith made the following statement at the onset of the session today: "I am so tired of living, wishing that I could just disappear."

Example: SrA Smith reports that his wife convinced him to seek treatment for his recent anger outbursts. SrA Smith explains that while his wife sees the anger at the surface, what is at the core of his difficulty is related to recent experiences (within the past month) of intrusive thoughts and images associated with his father's suicide.

Objective

- Clinical interview data
- Behavioral observations
- Mental status exam
- Information from Screening Measures and/or Assessment Tools
- Collateral information

Example: SrA Smith arrived to today's session on time, however, appeared fatigued and had difficulty concentrating. He became easily tearful as he described his symptoms over the past week (e.g., suicide ideation, thoughts about his father's suicide, irritability, decreased appetite, no pleasure in activities, sleep disturbances) and his perceptions about their impact on his wife and children. BDI score of 57 indicates severe depressive symptoms over the past week and response to item 9 is "I would like to kill myself." Consultation with command representative, Maj Jones indicated that the patient has missed 1 day of work over the past week and has in general isolated himself from social activities at the unit.

Assessment

- Interpretation of all available data
- Clinical conceptualization
- Diagnostic impressions

Example: Based on a clinical interview, the OQ-45, the BDI score, and consultation with Maj Jones, the results of this emergency commander directed evaluation indicate that SrA Smith is Currently at Imminent Risk. SrA Smith has had chronic suicide ideation since the age of 16, a total of 1 prior suicide attempt (method: overdose) which resulted in a 15-day psychiatric hospitalization at the age of 26, and a family history of suicide (father). Evaluation data indicate that SrA Smith is currently actively thinking about suicide (rated by patient as 10 on a scale of 1-10 with 10 indicating highest severity of suicidal thinking), has full intent (rated by patient as 9 on a scale of 1-10 with 10 indicating highest intent), and a well-formulated plan (personal firearm kept at home which he plans to use to shoot himself in the stomach).

Axis I: Major Depressive Disorder, Recurrent

Axis II: No Diagnosis

Axis III: Diabetes

Axis IV: Financial Problems; Recent Separation from Significant Other; Work-Related Stressors

Axis V: Current GAF = 9; Highest GAF Past Year = 65

Plan

- Implemented interventions
- Compliance/motivation of the patient and likelihood of engagement in plan
- Actions to be taken

Example: SrA Smith's Current Imminent Risk for suicide requires immediate admittance to inpatient behavioral health for emergency psychiatric evaluation and treatment. Brief consult with Dr. Brown confirmed decision to hospitalize. The patient was initially reluctant to be admitted for inpatient treatment, but recognized the severity of his depression and likelihood that he would attempt suicide if not hospitalized. After discussion and brief use of motivational interviewing techniques, patient agreed to inpatient care. Contacted inpatient behavioral health and requested immediate admittance. While waiting for transport to hospital, had patient complete Reasons for Living/Reasons for Dying and discussed how he could increase the number of items on his list of Reasons for Living. After transport picked up SrA Smith, placed patient on HIL and contacted Maj Jones to inform him of SrA Smith's hospitalization. Will follow-up with inpatient staff tomorrow re patient's likely duration of hospitalization.

Sample Caring Letter

Date

Dear [Name],

It has been a month since your stay at [SITE LOCATION; e.g., Walter Reed National Military Medical Center (WRNMMC)], and we are wishing you well.

We remember that you said that you enjoyed… [If available, a*dd personalized content such as hobbies/other activities learned about patient prior to hospital discharge and acknowledgment of communications from a reply]* We want you to know that we are thinking of you.

If you wish to contact us, we would be pleased to hear from you.

Best wishes,

Provider Name

Please note that the following resources are always available to you:

Military OneSource: www.militaryonesource.com **1-800-833-6622**
Many helpful resources for active duty and families.

Suicide Prevention Lifeline: www.suicidepreventionlifeline.org **1-800-273-TALK (8255)**
A crisis line for anyone (Press 1 for Military).

The Defense Centers of Excellence (DCoE) Outreach Center: **1-866-9660-1020**
or www.dcoe.health.mil/24-7help.aspx

DoD/VA Suicide Outreach: www.suicideoutreach.org

If you will be changing your contact information (email address, phone number, postal address), feel free to let us know so that we can stay in contact with you.

Note. Sample letter adapted from the Caring Letters Project led by Dr. David Luxton at the National Center for Telehealth and Technology |T2|. T2's Caring Letters Project is a 21st century, email-based version of the 1976 University of California, San Francisco study (Motto & Bostrom, 2001) that showed significantly reduced suicide rates among civilian patients who received brief caring letters from staff they met during treatment.

Sample Coping Card

MY CHECKLIST FOR BATTLING IMPULSIVE DECISIONS

- ✓ Pull out my coping card from my wallet.
- ❑ Focus on slowing down my breathing.
- ❑ Put some cold water on my face.
- ❑ Write down a list of pros and cons for decision.
- ❑ Write down the worst expected consequence in **bold**.
- ❑ Talk with my friend, _____.
- ❑ Consult with Dr. _____ during our weekly appointment.
- ❑ Make decision.
- ❑ Congratulate myself for taking time to consider all options.

APPENDIX F: Suicide Nomenclature

Self-Directed Violence Classification System*

Type	Sub-Type	Definition	Modifiers	Terms
Thoughts	Non-Suicidal Self-Directed Violence Ideation	Self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence Ideation in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).	N/A	•Non-Suicidal Self-Directed Violence Ideation
	Suicidal Ideation	Thoughts of engaging in suicide-related behavior. For example, intrusive thoughts of suicide without the wish to die would be classified as Suicidal Ideation, Without Intent.	•Suicidal Intent: -Without -Undetermined -With	•Suicidal Ideation, Without Suicidal Intent •Suicidal Ideation, With Undetermined Suicidal Intent •Suicidal Ideation, With Suicidal Intent
Behaviors	Preparatory	Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away). For example, hoarding medication for the purpose of overdosing would be classified as Suicidal Self-Directed Violence, Preparatory.	•Suicidal Intent: -Without -Undetermined -With	•Non-Suicidal Self-Directed Violence, Preparatory •Undetermined Self-Directed Violence, Preparatory •Suicidal Self-Directed Violence, Preparatory
	Non-Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).	•Injury: -Without -With -Fatal •Interrupted by Self or Other	•Non-Suicidal Self-Directed Violence, Without Injury •Non-Suicidal Self-Directed Violence, Without Injury, Interrupted by Self or Other •Non-Suicidal Self-Directed Violence, With Injury •Non-Suicidal Self-Directed Violence, With Injury, Interrupted by Self or Other •Non-Suicidal Self-Directed Violence, Fatal
	Undetermined Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based upon the available evidence. For example, the person is unable to admit positively to the intent to die (e.g., unconsciousness, incapacitation, intoxication, acute psychosis, disorientation, or death); **OR** the person is reluctant to admit positively to the intent to die for other or unknown reasons.	•Injury: -Without -With -Fatal •Interrupted by Self or Other	•Undetermined Self-Directed Violence, Without Injury •Undetermined Self-Directed Violence, Without Injury, Interrupted by Self or Other •Undetermined Self-Directed Violence, With Injury •Undetermined Self-Directed Violence, With Injury, Interrupted by Self or Other •Undetermined Self-Directed Violence, Fatal
	Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent. For example, a person with the wish to die cutting her wrists with a knife would be classified as Suicide Attempt, With Injury.	•Injury: -Without -With -Fatal •Interrupted by Self or Other	•Suicide Attempt, Without Injury •Suicide Attempt, Without Injury, Interrupted by Self or Other •Suicide Attempt, With Injury •Suicide Attempt, With Injury, Interrupted by Self or Other •Suicide

* Developed in collaboration with the Centers for Disease Control and Prevention

Self-Directed Violence Classification System*

Key Terms	***Self-Directed Violence:*** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. ***Suicidal Intent:*** There is past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and in the absence of suicidal behavior. ***Physical Injury:*** A (suspected) bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical, or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance. In some cases an injury results from an insufficiency of vital elements, such as oxygen. Acute poisonings and toxic effects, including overdoses of substances and wrong substances given or taken in error are included, as are adverse effects and complications of therapeutic, surgical and medical care. Psychological injury is excluded in this context. ***Interrupted By Self or Other:*** A person takes steps to injure self but is stopped by self/another person prior to fatal injury. The interruption may occur at any point. ***Suicide Attempt:*** A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior. ***Suicide:*** Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.

* Developed in collaboration with the Centers for Disease Control and Prevention

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Self-Directed Violence (SDV) Classification System
Clinical Tool

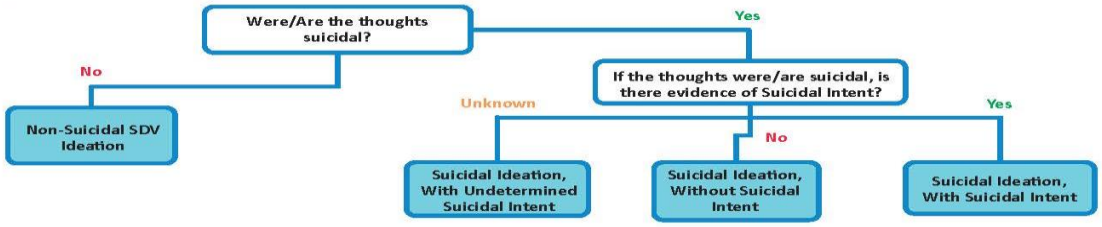
BEGIN WITH THESE 3 QUESTIONS:

1. Is there any indication that the person engaged in self-directed violent behavior that was lethal, preparatory, or potentially harmful? (Refer to Key Terms on reverse side)
   If NO, proceed to Question 2
   If YES, proceed to Question 3

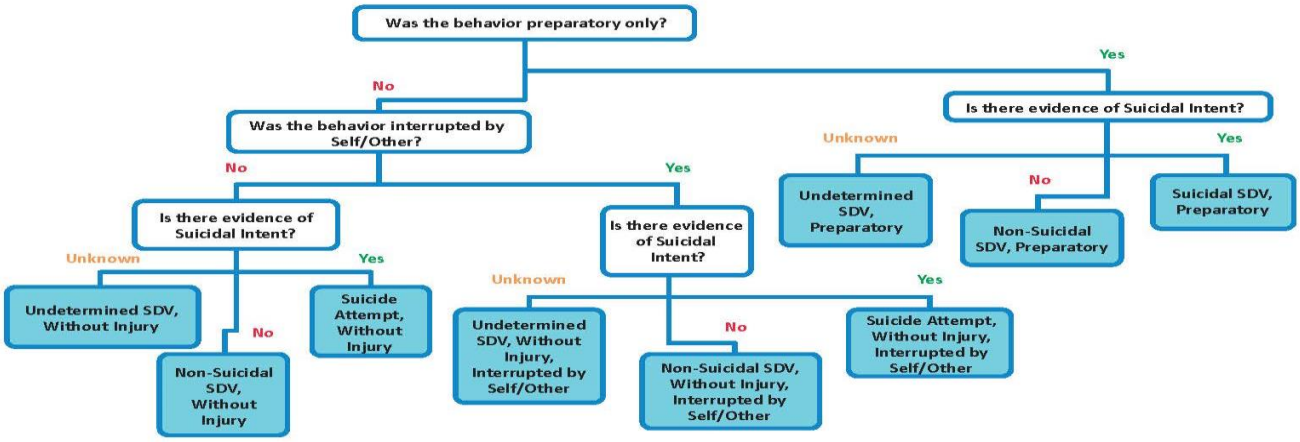
2. Is there any indication that the person had self-directed violence related thoughts?
   If NO to Questions 1 and 2, there is insufficient evidence to suggest self-directed violence → NO SDV TERM
   If YES, proceed to Decision Tree A

3. Did the behavior involve any injury or did it result in death?
   If NO, proceed to Decision Tree B
   If YES, proceed to Decision Tree C

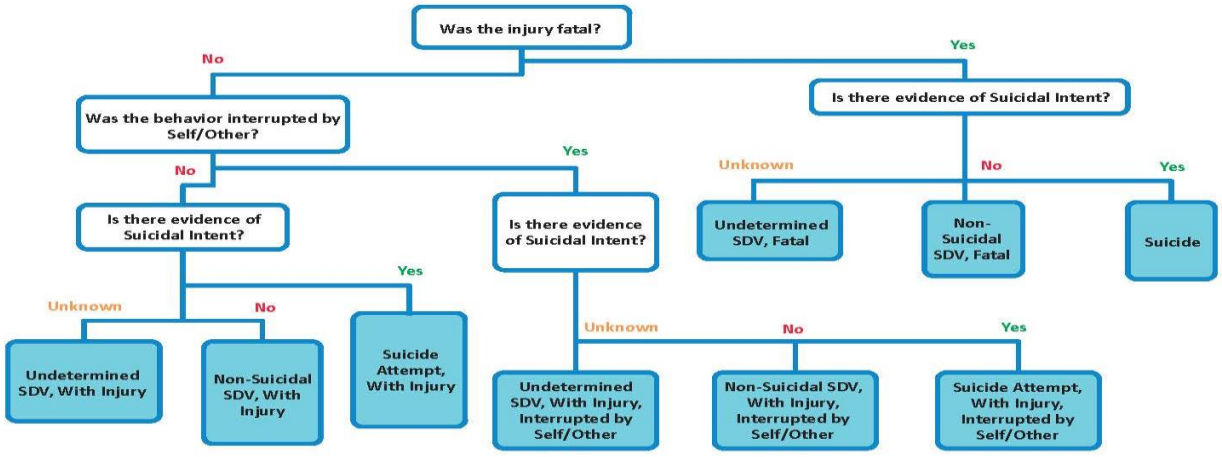
DECISION TREE A: THOUGHTS



DECISION TREE B: BEHAVIORS, WITHOUT INJURY



DECISION TREE C: BEHAVIORS, WITH INJURY



Self-Directed Violence (SDV) Classification System
Clinical Tool

Key Terms (Centers for Disease Control and Prevention)

Self-Directed Violence:	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.
Suicidal Intent:	There is past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and in the absence of suicidal behavior.
Preparatory Behavior:	Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away).
Physical Injury (paraphrased):	A bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical, or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance (e.g., bodily harm due to suffocation, poisoning or overdoses, lacerations, gunshot wounds, etc.). Refer to the Classification System for the Centers for Disease Control and Prevention definition.
Interrupted By Self or Other:	A person takes steps to injure self but is stopped by self/another person prior to fatal injury. The interruption may occur at any point.
Suicide Attempt:	A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior.
Suicide:	Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.

Reminder: Behaviors Trump Thoughts

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APPENDIX G: Applicable DoD and Air Force Instructions

Please note that currently, many of these instructions are under revision.

Air Force Instruction (AFI)

AF Instruction	Title
AFI 10-203	Duty Limiting Conditions
AFI 44-109	Mental Health, Confidentiality, and Military Law
AFI 44-119	Clinical Performance Improvement
AFI 44-153	Traumatic Stress Response
AFI 44-157	Medical Evaluation Boards (MEB) and Continued Military Service
AFI 44-172	Mental Health
AFI 48-123	Medical Examinations and Standards
AFI 90-505	Suicide Prevention Program

Department of Defense Instruction (DoDI)

DoD Instruction	Title
DoDI 1010.6	Rehabilitation and Referral Services for Alcohol and Drug Abusers
DoDI 1332.38	Physical Disability Evaluation
DoDI 5210.42	Nuclear Weapons Personnel Reliability Program
DoDI 6400.06	Domestic Abuse Involving DoD Military and Certain Affiliated Personnel
DoDI 6490.04	Mental Health Evaluations of Members of the Military Services
DoDI 6490.06	Counseling Services for DoD Military, Guard and Reserve, Certain Affiliated Personnel, and Their Family Members
DoDI 6490.08	Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members

APPENDIX H: Brief Overview of Suicide Prevention Literature

Suicide Risk and Protective Factors (Air Force)

A summary of the scientific literature on Air Force risk and protective factors for suicide-related ideation and behaviors is provided below.

Risk Factors

Bryan et al. (2011); Cross-Sectional (*N* = 348)	
Acquired Capability Deployment and/or Combat Exposure	Among combat deployed Airmen, all types of combat exposure independently contributed to acquired capability for suicide; very violent combat, with high levels of injury and death, compared with less violent combat was strongly associated with acquired capability.

Bryan et al. (2012); Cross-Sectional (*N1* = 348; *N2* = 214)	
Deployment and/or Combat Exposure	Combat exposure was not directly related to suicidality but directly associated with PTSD symptom severity; PTSD severity was associated with depression severity; depression symptom severity directly related to suicide risk.

Cox et al. (2011); Retrospective Records Review (*N* = 98)	
Hopelessness Perceived Burdensomeness Thwarted Belongingness	Among USAF suicide decedents who communicated about their distress either verbally or in suicide notes, hopelessness was one of the most frequently occurring risk indicators (35.7% of communications), followed by perceived burdensomeness (31.6%) and thwarted belongingness (29.6%).

Nademin et al. (2008); Matched Case Control (*N* = 182)	
Acquired Capability	Acquired capability significantly predicted suicidality in Airmen.

Snarr et al. (2010); Cross-Sectional (*N* = 52,780)	
Suicide Attempt History	3.8% reported suicide ideation within the past year; of those, 8.7% had made at least 1 suicide attempt during the past year.

Protective Factors

Langhinrichsen-Rohling et al. (2011); Cross-Sectional (*N* = 52,780)	
Religion – Spirituality Resilience & Coping Social Support	Religious involvement was a protective factor for men only. Personal coping was a protective factor for both sexes. Satisfaction with intimate relationships, spouse's preparedness for deployment, good workplace relationships, support from leadership, and workgroup cohesion were protective factors for both sexes. For mothers, satisfaction with the parent-child relationship reduced suicide ideation risk. At the community level, social support was protective for both men and women, and perceptions of community unity were protective for men.

Suicide Risk and Protective Factors
(Military, Veteran, and Selected Civilian)

A brief review of the scientific literature on military and Veteran suicide risk and protective factors is provided below. Literature on civilian data is presented for some risk factors that have not yet been investigated in military and/or Veteran samples, if the information is deemed helpful to AF providers.

Risk Factors

Barnes et al. (2012); Matched Case-Control (*N* = 92)	
TBI	Veterans with PTSD + mild TBI compared with those with PTSD alone showed no significant differences in suicide risk.

Bell et al. (2007); Cross-Sectional (*N* = 50)	
Deployment and/or Combat Exposure	Among Vietnam combat Veterans with PTSD, severity of combat exposure was not significantly related to suicide ideation.
PTSD	However, re-experiencing of trauma symptoms significantly predicted severity of suicide ideation.

Bell et al. (2010); Matched Case Control (*N* = 7,492)	
Injury, Pain, and/or Medical Problems	Soldiers hospitalized for an injury prior to suicide compared with controls were approximately twice as likely to die by suicide.
Substance-Related Disorders	Soldiers diagnosed with a mental disorder and with both injury- and alcohol-related hospitalizations compared with controls were approximately 6x more likely to die.

Black et al. (2011); Case Control (*N* = 4,377,478)	
Anxiety Disorders Axis II Traits or Diagnosis Mood Disorders PTSD Substance-Related Disorders	Suicide risk was higher for soldiers with the following conditions than those without a behavioral health diagnosis: -Anxiety Disorders -Axis II Diagnosis -Any Mood Disorder -PTSD -Substance-Related Disorder
Depression	Soldiers with a history of major depression had especially elevated risk.

Brenner et al. (2011); Retrospective Records Review (*N* = 160)	
PTSD TBI	For Veterans both with and without TBI, a history of PTSD was significantly associated with increased risk of suicide attempt.

Brenner et al. (2011); Case Control (*N* = 438,679)	
TBI	Veterans with a history of TBI compared to those without were approximately 1.5x more likely to die by suicide; comorbid psychiatric disorders did not account for increased risk.

Risk Factors

Bryan et al. (2011); Cross-Sectional (*N* = 161)	
Acquired Capability PTSD	Among combat-deployed personnel referred for TBI evaluation, PTSD re-experiencing symptoms were directly related to acquired capability for suicide. A significant relationship between PTSD re-experiencing symptoms and acquired capability for suicide beyond the effects of the confounding variables of sex and general mental health was found.

Bryan et al. (2012); Cross-Sectional (*N1* = 137; *N2* = 55)	
Acquired Capability Perceived Burdensomeness	Significant main and interaction effects for perceived burdensomeness and acquired capability, after controlling for gender, age, depression, PTSD, and TBI symptoms were found in the mild TBI sample. Significant main effect for perceived burdensomeness and a significant interaction between perceived burdensomeness and acquired capability were found for the self-referred sample.

Goldstein et al. (2012); Cross-Sectional (*N* = 3,595)	
Depression	Homeless Veterans with current depression compared with those without depression had an odds ratio of 14.5 for suicide ideation and 12.0 for suicide attempt within the past 30 days.

Griffith (2012); Retrospective Records Review (*N* = 4,546)	
Deployment and/or Combat Exposure PTSD	Among personnel returning from OIF/OEF, war experiences had no direct effect on postdeployment suicide ideation; war experience predicted PTSD symptoms, PTSD symptoms predicted negative mood, negative mood predicted suicidality.

Guerra et al. (2011); Cross-Sectional (*N* = 393)	
Depression PTSD	For OEF/OIF Veterans with PTSD, heightened depressive symptoms, specifically, cognitive-affective symptoms of major depressive disorder were associated with an increased risk of suicide ideation. Emotional numbing symptoms of PTSD were related to suicide ideation.

Haas et al. (2011); Review	
Sexual Orientation	Meta-analysis results indicate that gay men are about 4x more likely to have attempted suicide than heterosexual men and that lesbian and bisexual women are more than 2x more likely to have attempted suicide than heterosexual women.

Hartzenbuehler (2011); Cross-Sectional (*N* = 31,852)	
Sexual Orientation	Lesbian, gay, and bisexual (LGB) youth were significantly more likely than heterosexual youth to have attempted suicide in the past 12 months; risk of attempting suicide was 20% higher for LGB youth in unsupportive environments versus supportive environments.

Risk Factors

Ilgen et al. (2010); Retrospective Records Review (*N* = 260,254)	
Injury, Pain, and/or Medical Problems	Veterans with severe pain versus moderate/mild/no pain were 39% more likely to die by suicide, even after controlling for demographics and psychiatric diagnosis.

Ilgen et al. (2010); Retrospective Records Review (*N* = 3,291,891)	
Anxiety Disorders PTSD	For both male and female Veterans, there was an increased risk for suicide for those with PTSD and other anxiety disorders.
Mood Disorders	For male Veterans, the diagnosis with the greatest risk for suicide was bipolar disorder followed by depression. For female Veterans, there was an increased risk of suicide for those with a diagnosis of bipolar disorder or depression.
Substance-Related Disorders	For both male and female Veterans, there was an increased risk for suicide for those with substance use disorders.

Jakupcak et al. (2009); Retrospective Records Review (*N* = 435)	
PTSD	For OEF/OIF Veterans, (1) PTSD was significantly associated with suicide ideation after accounting for age, depression, and substance abuse; (2) those with PTSD versus those without were more than 4x likely to report suicide ideation; and (3) those screened + for PTSD versus those screened - were 5.7x more likely to report suicide ideation.

Jakupcak et al. (2011); Retrospective Records Review (*N* = 336)	
Hopelessness	For OEF/OIF Veterans, hopelessness and/or suicidal ideation were significantly more likely to occur among those with low social support, alcohol abuse, and depression.
PTSD	Patients with PTSD versus those without were significantly more likely to report hopelessness or suicidal ideation; satisfaction with social support was significantly less protective against suicide in the PTSD group.

Kline et al. (2011); Cross-Sectional (*N* = 1,165)	
	Among National Guard soldiers at 3 months post-deployment, the adjusted odds ratio for suicide ideation was:
Depression	2.9 for those with depression compared with those without.
PTSD	3.7 for those with PTSD compared with those without.
Substance Related Disorders	3.0 for those with alcohol dependence and 1.9 for illicit drug use compared with those without such problems.

Klonsky et al. (2010); Cross-Sectional (*N* = 1,836)	
Impulsivity	Among Army recruits in basic training, there was a significant difference in levels of impulsivity among soldiers who denied suicide ideation, who reported a history of ideation, and who reported a history of attempt, with those were never suicidal significantly lower than ideators and attempters. No significant difference in impulsivity between ideators and attempters.

Risk Factors

Lemaire et al. (2011); Cross-Sectional (*N* = 1,740)	
Depression	Among OEF/OIF Veterans, depressive disorder diagnosis was associated with suicide ideation. A prior suicide attempt significantly predicted suicide ideation.
Suicide Attempt History	
PTSD	Those with comorbid PTSD and depression had a higher risk for suicide ideation than did individuals with either PTSD or depression alone. The avoidance cluster of PTSD symptoms was associated with a higher risk of suicide ideation than either hyperarousal or re-experiencing symptoms.

Maguen et al. (2011); Cross-Sectional (*N* = 2,854)	
Deployment and/or Combat Exposure	In OIF Veterans: Depression and PTSD symptoms mediated the relationship between killing in combat and suicide ideation.
Depression	Post-deployment depression was associated with suicide ideation.
Suicide Attempt History	A prior suicide attempt significantly predicted post-deployment suicidal ideation and desire for self-harm.
PTSD	Post-deployment PTSD symptoms predicted self-harm desire.

Maguen et al. (2012); Cross-Sectional (*N* = 259)	
Deployment and/or Combat Exposure	Vietnam Veterans with killing experiences versus those without had approximately 2x the odds of suicide ideation.

Mahon et al. (2005); Retrospective Case-Control (*N* = 126)	
Access to Lethal Means	Among Irish Defence Forces, access to firearms was associated with death by suicide, but also opportunity to use lethal means (solitary duty) was significantly related to suicide.
Suicide Attempt History	Personnel who died by firearm suicide compared with those who died by non-suicide means were significantly likely to have a history of deliberate self-harm.

Mansfield et al. (2011); Cross-Sectional (*N* = 3,069)	
Deployment and/or Combat Exposure	Combat exposure was associated with suicide ideation and mediated by symptoms of PTSD and depression.
Depression PTSD	Depression was significantly related to suicide ideation and mediated the effect of PTSD on suicide ideation.
Substance-Related Disorders	Substance abuse moderated the effects of PTSD on depressive symptoms and suicide ideation.

Mitchell et al. (2012); Cross-Sectional (*N* = 1,716)	
Deployment & Combat Exposure	Among redeployed soldiers, exposure to combat was a significant risk factor for suicide ideation.

Risk Factors

Mrnak-Meyer et al. (2011); Clinical Trial (*N* = 269)	
Suicide Attempt History	Veterans with a history of suicide attempt and a dual diagnosis of substance dependence and major depressive disorder were approximately 3x more likely to be hospitalized for suicide ideation or behavior than were veterans with no history of suicide attempt during and after treatment.

Olson-Madden et al. (2012); Retrospective Records Review (*N* = 247)	
Substance-Related Disorders TBI	Among Veterans with comorbid TBI and substance use disorder, 43% reported at least 1 incident of suicide ideation (range from 0 to 15), and 14% made at least 1 suicide attempt (range from 0 to 13).

Perales et al. (2012); Retrospective Records (*N* = 995)	
Childhood Trauma	Among regular active duty Army soldiers who attempted suicide between 2005 and 2010, 64.7% had experienced childhood trauma; 14.1% experienced physical, sexual, or emotional abuse; 21.9% had experienced environmental trauma; and 31% had an unspecified trauma. Among soldiers who died by suicide, 43.3% had a history of childhood trauma. The most prevalent types of trauma for both decedents and attempters were abuse and family problems.

Pfeiffer et al. (2009); Retrospective Cohort (*N* = 887,859)	
Anxiety Disorders PTSD	Panic disorder, generalized anxiety disorder, and anxiety disorder not otherwise specified were significantly associated with increased odds of death by suicide among Veterans. Comorbid PTSD and depression were associated with significantly decreased odds of completed suicide, which the authors hypothesized was due to the higher levels of behavioral health services and income support for this group of patients.

Pietrzak et al. (2010); Cross-Sectional (*N* = 272)	
Deployment and/or Combat Exposure Depression Barriers to Care PTSD	A medium effect size for combat exposure was found for participants with suicide ideation compared with those without. OEF/OIF Veterans with suicide ideation were more likely to screen positive for depression and PTSD. There was a small effect size for mental health care stigma and barriers to care for OEF/OIF Veterans with suicide ideation compared with those with no suicide ideation.

Pollock et al. (2004); Prospective Cohort (*N* = 72)	
Problem Solving Deficits	Civilians with attempted suicide had problem solving deficits and a passive style compared with non-suicidal psychiatric controls.

Risk Factors

Pukay-Martin et al. (2012); Cross-Sectional (*n* = 164, *n* = 98)	
Depression PTSD	For Vietnam Veterans and OEF Veterans who reported stronger depression symptoms, there was a stronger relationship between PTSD symptoms and suicide ideation.

RAND (2010); Cross-Sectional (*N* = 208)	
Sexual Orientation	Among lesbian, gay, and bisexual active duty service members, 35% reported experiencing mental health problems because of Don't Ask, Don't Tell (DADT); 29% reported that they had been teased or mocked and 7% had been threatened or injured by another service member.

Richardson et al. (2012); Cross-Sectional (*N* = 250)	
PTSD	Among Veterans and actively serving Canadian Forces and Royal Canadian Mounted Police, PTSD symptoms were no longer significantly associated with suicide ideation after controlling for depression, alcohol use, and generalized anxiety.

Ribeiro et al. (2012); Cross-Sectional and Longitudinal (*N* = 311)	
Sleep	In a sample of military personnel, self-reported insomnia was associated with suicide ideation, even after controlling for depression, hopelessness, PTSD, anxiety symptoms, and alcohol/drug abuse. Self-reported insomnia symptoms uniquely predicted suicide attempts longitudinally when baseline insomnia symptoms, depressive symptoms, and hopelessness were controlled.

Skopp et al. (2011); Cross-Sectional (*N* = 5,187)	
Childhood Trauma	Among active duty service members seeking outpatient mental health services, childhood adversity was a significant predictor of suicide ideation, even after controlling for the following: legal, work, financial, relationship problems, psychiatric disorders. Those with prior suicide attempts versus those without had a significantly higher reporting of childhood adversity.

Skopp et al. (2012); Retrospective Case-Control (*N1* = 1,764; *N2* = 7,018)	
Mood Disorders TBI	Increased odds of suicide were associated with mood disorders, partner relational problems, family problems, but not with mild TBI, alcohol dependence, or PTSD. Psychiatric comorbidities increased odds of suicide.

Risk Factors

Zivin et al. (2007); Retrospective Cohort (*N* = 807,694)	
Mood Disorders PTSD Substance-Related Disorders	Veterans with comorbid depression and PTSD had lower rates of suicide than did those with depression alone; however, younger veterans with comorbid depression and PTSD had a higher rate of suicide than did older veterans with the same comorbid diagnoses. Veterans with comorbid depression and substance-related disorder had a higher rate of suicide than did those with depression diagnosis alone.

Protective Factors

Griffith (2012); Retrospective Records Review (*N* = 4,546)	
Social Support	Post-deployment social support was negatively associated with PTSD symptoms, negative mood, and suicidality.

Jakupcak et al. (2011); Retrospective Records Review (*N* = 336)	
Social Support	Married OIF/OEF Veterans compared with those unmarried were less likely to be at a higher suicide risk. Satisfaction with social support was protective for suicide risk for those with and without PTSD, but it was significantly less protective against suicide risk among Veterans with PTSD.

Lemaire et al. (2011); Cross-Sectional (*N* = 1,740)	
Social Support Training & Preparation	Current social support was protective against suicide ideation. Among OEF/OIF Veterans, training and preparation were protective against suicide ideation.

Mansfield et al. (2011); Cross-Sectional (*N* = 3,069)	
Resilience	Resilience had a significant protective effect on suicide ideation for Marines with a history of combat exposure.

Mihaljevic et al. (2011); Case Control (*N* = 25)	
Religion & Spirituality	There was a significant negative correlation between spiritual well-being and suicidality.

Mitchell et al. (2012); Cross-Sectional (*N* = 1,716)	
Social Support	Unit cohesion was a significant protective factor against suicide ideation. Soldiers with greater combat exposure and higher levels of unit cohesion had lower levels of suicide ideation and soldiers with higher levels of combat exposure and lower unit cohesion had higher suicide ideation.

Protective Factors

Pietrzak et al. (2010); Cross-Sectional (*N* = 272)	
Resilience	Among OEF/OIF Veterans, a sense of purpose and control were negatively associated with suicide ideation.
Social Support	Accessibility to friends/family was negatively associated with suicide ideation. A large effect size for post-deployment social support and medium effect sizes for unit support and leadership were found for those without suicide ideation.

Skopp et al. (2011); Cross-Sectional (*N* = 5,187)	
Social Support	Among active duty service members seeking outpatient mental health services, presence of an intimate partner was a protective factor against suicide ideation. Support from a military unit was found to be helpful as well.

Theoretical Models for Suicide

A brief overview of several theoretical perspectives on suicide is provided here in order to (1) enhance your understanding of why suicide occurs and (2) to provide you with a framework for conceptualizing patients with suicide-related ideation and/or behaviors. For a more comprehensive review of each of the models discussed below, please refer to the original cited sources.

Cognitive Perspective on Suicide

The cognitive perspective on suicide is based on the general principles of cognitive theory for depression and emotional disorders as proposed by Aaron Beck in 1967. According to Beck, some individuals may have a unique combination of biological, social, and/or psychological vulnerability factors for suicide. Over time, these individuals may develop a series of suicide-related cognitions in the form of automatic thoughts, associated images, and core beliefs which can subsequently lead them on a path toward suicide-related behaviors. Consequently, individual vulnerability factors, combined with suicide-related cognitions and behaviors, contribute to the formation, maintenance, and exacerbation of what Beck conceptually describes as a suicide-specific mode (Rudd, 2004). A mode refers to a state of mind that individuals can quickly shift into (Young et al., 2003), and this state of mind reflects integrated cognitive, affective, motivational, and behavioral life patterns or schemas (Rudd, Joiner, & Rajab, 2001).

For example, a service member may have his suicide-specific mode activated following exposure to specific internal (e.g., “I am weak because I can’t provide for my family.”) and/or external (e.g., drinking following an argument with spouse) stressors. He may experience the following automatic thought, “I can’t deal with this anymore and my family would be better off without me,” and as a result feel extreme levels of hopelessness and an internal sense of pressure to respond behaviorally to his negative thoughts. His response to this pressure is the thought that suicide is an immediate and final way to end his psychological pain. This perceived “solution” gives him a renewed sense of energy and motivation to end his psychological pain, and, combined with the physiological effects of alcohol in his system, the service member may act out on his suicide intent. Consider other instances (Ghahramanlou-Holloway, Cox, & Greene, 2012) in which a suicide mode (i.e., a rapid shift to a state of mind) can be activated when a person experiences loss-related (e.g., “I could not save my buddy.”) and/or hopeless-related (e.g., “Life is not worth living.”) cognitions, sad or angry affect (e.g., “Others need to understand my pain.”), passivity in seeking help (e.g., “No one can help me now.”), and/or increased impulsivity (e.g., “I have to act and end this misery now.”).

As stated, suicide-related cognitions occur in the form of automatic thoughts and associated images. These may form strong links with other automatic thoughts and associated images. For instance, a service member may experience the automatic thought, “My life is meaningless and such a waste” and, over time, this automatic thought connects with a suicide-related automatic thought of “Therefore, my family would be better off without me.” This service member may also repeatedly experience the image of holding a gun to her stomach – an image that may further activate the suicide mode each and every time. Moreover, suicide-related cognitions are directly related to one’s core beliefs. The core belief of “I am worthless” can easily become activated during times of distress or during times of intoxication such that the

service member feels paralyzed and hopeless about her future. Attentional fixation (Wenzel, Brown, & Beck, 2009) may occur during which time the service member cannot focus on anything else but death and destruction of oneself. An information processing bias further exacerbates the imminence of risk as the service member begins to pay more attention to negative information in her environment, to interpret ambiguous information in negative ways, and to experience overgeneralized memories about the past (Wenzel et al., 2009).

For patients without protective factors such as a strong social support network, the frequency, duration, and severity of the suicide-specific mode may increase over time. Those with a greater pre-existing risk profile and set of vulnerabilities, for example a prior suicide attempt, may require minimal internal and/or external triggers to re-activate their existing suicide-specific mode. Beck argues that once a suicide-specific mode has been activated, suicide appears as the *only* option and may even be considered by the individual as a rational course of action (Beck, 1976, p. 123). This highlights the rigidity of the suicidal person's thinking process and the complexities associated with the de-activation of the suicide-specific mode. An impaired ability to problem-solve effectively (Ellis, 1986; 2006) in individuals who attempt suicide can easily result in a state of arrested flight where they lose the ability to consider reasons for living, become hopeless, feel trapped, and view suicide as the only option (Ghahramanlou-Holloway, Brown, & Beck, 2008; Ghahramanlou et al., 2012). Understanding the suicide mode activation processes for each patient such that therapeutic strategies can assist with de-activation of the mode and the restructuring of cognitions that underlie it.

Interpersonal Psychological Theory

According to the interpersonal psychological theory of suicide behavior proposed by Thomas Joiner in 2005, in order to die by suicide, an individual must have a strong desire to take his or her own life and the capability to act on that desire. Joiner and colleagues (2009) explain that the most dangerous factors of suicidal desire are a sense of thwarted belongingness and perceived burdensomeness. Individuals with a sense of thwarted belongingness believe that no one cares for them or can relate to them, which in turn causes them to feel isolated or disconnected. The belief that no one can relate is of particular concern for military personnel, especially for those who may have difficulty re-integrating into family or civilian life following a deployment. A service member may feel that others who do not understand military culture or have not shared the very intense experiences of combat cannot truly understand him or her (Bryan & Anestis, 2011). The other component of suicidal desire, perceived burdensomeness, is a cognitive distortion in which individuals believe they do not contribute meaningfully to the world and that they are a liability to others. This causes them to believe it would be better for others if they were no longer alive. Individuals who have experienced an adverse life event may be more prone to believing themselves a burden to others.

Another key component of the interpersonal-psychological theory of suicide behavior, as described by Joiner (2005) is the acquired capability for suicide. Because the natural instinct for self-preservation is so strong, in order to acquire the capability for suicide, an individual must (1) increase his or her tolerance for pain and (2) habituate to the fear of death, both of which can occur through multiple exposures to painful and provocative events such as combat. Bryan and Cukrowicz (2011) found that exposure to all forms of combat predicted acquired capability for suicide, and that combat events with high levels of aggression and exposure to death and injury have a much stronger association with capability. This supports the theory that exposure to painful and provocative experience contribute to capability for suicide. However, combat experiences were not found to predict thwarted belongingness or perceived burdensomeness. Research has also indicated that PTSD re-experiencing symptoms associated with profoundly

painful and traumatic events (e.g., nightmares, flashbacks, upsetting memories) may contribute to acquired capability (Selby et al., 2007). Results of a study (Bryan & Anestis, 2011) of deployed military personnel indicated that the relationship between PTSD re-experiencing symptoms and acquired capability was significant even after controlling for sex and general mental health, indicating that experiencing intense flashbacks and/or recurrent nightmares about traumatic experiences significantly related to an acquired capability for suicide.

In a case-controlled psychological autopsy study, Nademin and colleagues (2008), compared data extracted from a subsample of Air Force suicide death investigation files to data collected from a living active duty Air Force sample in order to examine the utility of Joiner's (2005) interpersonal-psychological theory of suicide to discriminate between suicide cases and controls. The acquired capability to commit suicide subscale of the Interpersonal-Psychological Survey distinguished between these two groups. Brenner and colleagues (2008) have examined Joiner's theory through qualitative interviews with OEF/OIF Veterans seeking mental health services at the VA. Veterans in this study reported a sense of being a burden on family and friends, a loss of self, status, and purpose, as well feelings of disconnection from the civilian world. Combat experiences were described as a context for exposure to pain (acquired ability) and an increased tolerance for pain after deployment.

Research on Joiner's perspective has been accumulating. Two additional studies are noted here due to their relevance to the Air Force community. In the first study (Bryan, Morrow, Anestis, & Joiner, 2010), researchers found that active duty Air force personnel were higher on acquired capability than civilian clinical and nonclinical samples, indicating support for the idea that exposure to aggression, injury, and death contribute to capability. Although the Airmen were higher on acquired capability, they were lower on perceived burdensomeness than the civilian sample, which may indicate that military personnel may generally have less suicidal desire than civilian but greater capability of acting on desire for suicide. In the second study (Cox et al., 2011) reported on 237 suicide death investigation files reviewed by researchers at the Uniformed Services University of the Health Sciences. These files included 98 decedents who left suicide notes. Approximately 36% of the cases communicated hopelessness and 32% of cases communicated perceived burdensomeness in their suicide note but not verbally. Thwarted belongingness was most often (30% of cases) communicated both verbally and in the suicide note. Air Force mental health personnel are encouraged to ask questions that directly assess for these three important and well-supported constructs as proposed by Joiner in order to target treatment efforts on re-shaping these cognitive distortions.

Biosocial Perspective on Suicide

According to Marsha Linehan (1986, 1993), suicide-related behavior is evidence of a lack of coping skills for dealing with acute psychic pain. The biosocial perspective, most often applied to individuals who have borderline personality disorder, assumes many causal pathways to suicide behaviors, but focuses on four common pathways: (1) environmental, (2) cognitive, (3) emotional, and (4) behavioral.

Environmental causes may be adverse events, lack of social support, or having others model suicidal behavior (Brown, 2006). These environmental factors may trigger emotions and cognitions that lead to suicidal behaviors. Research (Gross, 1999) has indicated that some events can trigger emotional responses through neural pathways that bypass cognition. As discussed in a previous section, adverse life events are a risk factor for suicide. If an individual has inadequate problem solving skills, such events may cause him or her to be overwhelmed and act out in dependent or hostile ways that may cause others to withdraw social support.

When an individual remains without any sources of social support, he or she may not be able to reach out for help and support during a suicidal crisis. This may be particularly problematic in a culture that values strength and mental toughness and in which there is a perceived stigma against mental disorders. A final environmental factor is modeling of suicidal behavior. Research results on the phenomenon of suicide contagion are mixed; however if an individual is struggling emotionally and is exposed to suicidal behavior through the suicide of a peer, the model may influence the individual toward taking his or her own life. A case write-up (Carr, 2011) of the suicide of an OIF soldier revealed that after the suicide, other members of the company expressed suicidal ideation and mentioned the decedent as an influence in their thinking.

According to Linehan's theory (Brown, 2006), a prevalent cognitive cause of suicide is hopeless thinking. Specifically, individuals have no hope for positive events in their future and believe they will never be able to tolerate the intense negative emotions triggered by adverse life events. A number of studies (Lizardi et al, 2007; Wang, Lightsey, Pietruska, Uruk, & Wells, 2007) have shown that individuals with fewer reasons for living have higher hopelessness and suicide-related thoughts and behaviors. With regard to hopelessness about emotion regulation, results of one study indicated that intensity of emotional distress predicted suicide-related ideation and behavior more strongly than hopelessness. These cognitions are thought to contribute to an individual's poor problem-solving skills and failure to solve problems further contributes to hopeless thinking.

Furthermore, emotion dysregulation is a pathway of particular focus in Linehan's theory. Individuals who are especially reactive to emotional stimuli and have difficulty regulating their feelings experience emotion with intolerable intensity. When such individuals do not have adequate coping skills, they may often seek to control or escape pain through suicide. An inability to tolerate negative emotion may be due to an early environment in which an individual's feelings were scorned or otherwise invalidated, and as adults, the feelings are intensified by anxiety about having such emotions. Think of a service member who experiences problems with anger management post deployment. The service member's emotion regulation capabilities may have been shaped by early life experiences and subsequently affected by the experience of deployment such that negative emotions about others can no longer be effectively tolerated and managed.

Finally, a key component of the biosocial perspective is based on social learning theory, specifically that individuals learn from their early environment to disregard their own feelings and to be self-critical and punishing. The suicidal behaviors resulting from this self-hatred are then reinforced by others in an invalidating environment. All of these causal components interact to create a repetitive cycle of overwhelming emotions, self-punishing acts, and reinforcement from the environment. Working from this theory, Linehan (1993) developed dialectical behavior therapy (DBT) to address common causal factors of suicidal thoughts and actions. DBT is a type of cognitive-behavioral therapy that integrates mindfulness and acceptance strategies to help the patient move toward accepting that change is possible and to learn the coping skills necessary to begin to make changes.

Heritability and Neurobiological Perspectives on Suicide

A number of family and twin studies have shown modest heritability of suicide ideation and behavior. Results of two family studies (Qin, Agerbo, & Mortenson, 2003; Runeson & Asberg, 2003) show that a family history of suicide doubles the risk of suicide. For instance, children of parents who attempted suicide are six times more likely to attempt than children whose parents

did not attempt suicide (Brent et al., 2002). Concordance rates for suicide, based on a review of twin studies (Pedersen & Fiske, 2010) are estimated to range between 3% and 36% for monozygotic (MZ) twins and between 0% and 4% for dizygotic (DZ) twins. For suicide attempt, concordance rates ranged from 12% to 47% for MZ twins and between 0% and 25% for DZ twins, depending on the seriousness of the attempt with serious attempts carrying a lower concordance than all attempts. Concordance for suicide ideation ranged from 23% to 44% for MZ twins and from 9% to 31% for DZ twins.

With regard to neurobiological factors, a number of studies have indicated an association between dysfunctions in the serotonin and norepinephrine systems and suicide (Anisman et al., 2008; Gibb, McGeary, Beevers, & Miller, 2006; Lee & Kim, 2011; Mann & Currier, 2007; van Heeringen, 2003). Studies of the cerebrospinal fluid (CSF) for those who attempt suicide and those who die by suicide have indicated low levels of serotonin (Lester, 1995). Additionally, low levels of serotonin in the CSF of those who attempt predicted subsequent attempts (Asberg, 1997). These results support the rationale for pharmacologic treatment with selective serotonin reuptake inhibitors (SSRIs) and other serotonergic medications. Whereas serotonergic dysfunction is associated with trait-dependent risk factors such as suicide ideation and impulsivity, dysfunction of the hypothalamic-pituitary-adrenal axis (HPA) in suicide-related ideation and behaviors has been related to state-dependent factors such as alcohol use or adverse life events (Kim, 2011). Further, hyperactivation of the HPA in suicidal individuals has been reported (Pompili et al., 2010).

Research findings also support the theory that suicide-related behaviors result from the interaction between the neurobiological diathesis and triggering stressors such as one or more adverse life events (Mann, 2003; Mann & Currier, 2010). Given the considerable evidence that genes, environment, and possibly neurobiological alterations explain the origination and exacerbation of suicidal behaviors, Air Force mental health staff members are encouraged to carefully assess for the patient's family history of suicide, attempted suicide, and suicide ideation. Moreover, staff members are encouraged to learn as much as possible about the early life stressors faced by each suicidal patient and the possible neurobiological alterations that may be associated with future suicide risk (e.g., having resulted from traumatic brain injury).

Overview of Interventions for Suicide Prevention

This section provides a brief overview of interventions that specifically target suicide ideation and/or behaviors. These include Cognitive Behavior Therapy (CBT); Collaborative Assessment and Management of Suicide (CAMS); Dialectical Behavior Therapy (DBT); Interpersonal Psychotherapy (IPT); Motivational Interviewing to Address Suicide Ideation (MI-SI); Safety Planning Intervention (SPI); and the Caring Letters Project (CLP). While some of these approaches are supported by at least one well-powered randomized controlled trial (RCT), others are in the process of being evaluated for their efficacy but have shown early promise. One of the most pressing issues in the field of suicidology is the lack of empirical support for psychotherapeutic interventions offered to those engaging in suicide behavior (Linehan, 2008). The models of intervention presented below represent the best current science. While additional research is warranted to establish best practice guidelines and replication studies are needed to strengthen support for each modality, a foundational knowledge of each of these interventions is helpful to all mental health personnel who work with suicidal patients.

Please note that instructions on the clinical implementation of brief CBT, CAMS, MI, and SPI are included in this Guide. One of the primary objectives of this revised Guide is to provide AF mental health providers with an outline of a brief and targeted cognitive behavior therapy protocol for the prevention of suicide given that this intervention has shown efficacy (e.g., Brown et al., 2005). Providers must receive appropriate training and supervision before using treatments such as CBT for the prevention of suicide with patients. Given that clinical instructions for longer treatments such as DBT and IPT are beyond the scope of this Guide, providers interested in learning more about these interventions are encouraged to refer to selected readings and continuing education opportunities in Appendix K.

Cognitive Behavior Therapy (CBT)

A number of outpatient cognitive behavior RCTs have demonstrated a reduction in subsequent self-harm behavior after a suicide attempt (e.g., Salkovskis, Atha, & Storer, 1990; Stewart, Quinn, Plever, & Emmerson, 2009). The main goal of cognitive behavior therapy for suicidality is the prevention of a subsequent suicide attempt, while targeting negative automatic thoughts and core beliefs related to suicide. In a recent well-powered psychotherapy outcome study (Brown et al., 2005), 120 adults evaluated at the University of Pennsylvania's Hospital Emergency Department within 48 hours of their suicide attempt were randomized to receive cognitive therapy (N = 60) or usual care (N = 60). Follow-up assessments were performed at 1, 3, 6, 12, and 18 months. The primary outcome measure was the incidence of repeat suicide attempts. Secondary outcome measures included suicide ideation, hopelessness, and depression. From baseline to the 18-month assessment, 24.1% of the participants in the CBT group as compared to the 41.6% of the participants in the usual care group made at least 1 subsequent suicide attempt. While there were no significant between group differences on rates of suicide ideation at any assessment point, the severity of depression was significantly lower for the CBT group at 6-month, 12-month, and 18- month. Significantly reduced levels of hopelessness for the CBT group were observed at 6-months. Overall, the results of this RCT indicated that a relatively brief cognitive protocol (average of 9 hours of individual outpatient therapy) as presented here is effective in reducing the rate of suicide reattempt by 50% in adults who recently attempted suicide. The efficacy of this promising new intervention is currently

being tested in both outpatient (Rudd and colleagues – funded by DoD) and inpatient military settings (Ghahramanlou-Holloway and colleagues – funded by DoD).

Collaborative Assessment and Management of Suicidality (CAMS)

Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2006) is a treatment platform on which the therapist and patient work collaboratively to assess, track, manage, and plan treatment for patients presenting with suicide-related thoughts and behaviors. Studies examining the use of CAMS in both inpatient and outpatient settings have reported positive preliminary results. One study (Jobes, Wong, Conrad, Drozd, & Neal-Walden, 2005) was a non-randomized retrospective control comparison trial of CAMS with 56 suicidal USAF personnel that yielded supportive correlational data. Patients in the CAMS group resolved their suicidal ideation in significantly fewer sessions (mean = 7.35 sessions) than treatment as usual patients (TAU) (mean = 11.4 sessions). In the six months after initial mental health treatment, CAMS patients had significantly fewer emergency department and primary care medical appointments and spent fewer total minutes in these settings than TAU patients. Three published within-subjects studies of CAMS have shown similar rapid reductions of suicidal ideation on repeated measures with suicidal outpatients (Arkov et al., 2008; Jobes, Kahn-Greene, Greene, & Goeke-Morey, 2009; Nielsen, Alberdi, & Rosenbaum, 2011). Recent results from another study (Comtois et al., 2011), indicate potentially causal effectiveness of CAMS. In this study, 32 patients were randomly assigned to CAMS or enhanced care as usual (E-CAU) care in an outpatient setting. Results indicated that suicide ideation in CAMS patients decreased significantly from baseline to 12-month follow up and were significantly lower in suicide ideation than E-CAU patients at 12-month follow up. In addition, patient satisfaction ratings and treatment retention were significantly higher for CAMS patients than E-CAU patients and CAMS patients also reported increased levels of hope at the 12-month follow-up compared to E-CAU patients. The effectiveness of CAMS in an inpatient setting is currently being investigated (Ellis, Greene, Allen, Jobes, & Nordorff, 2012). Preliminary results show significant reductions in depression, hopelessness, suicide cognitions, and suicidal ideation. A recent open trial, case-focused, study conducted by Ellis and colleagues (2012) with 20 suicidal inpatients showed significant reductions in depression, hopelessness, suicide cognitions, and suicidal ideation over the course of CAMS care with large treatment effect sizes.

Dialectical Behavior Therapy (DBT)

Dialectical behavior therapy (DBT) is a comprehensive, empirically supported treatment that was initially developed by Marsha M. Linehan (1993). DBT focuses on managing the patient's multiple, severe problems, suicidal behavior, and extreme emotional sensitivity by providing structured, staged treatment and multiple sources of support for both the patient and the provider. A number of randomized controlled studies (see review by Lynch, Trost, Salsman, & Linehan, 2007) have indicated support for the efficacy of DBT in reducing suicidal and self-harm behaviors in individuals with Borderline Personality Disorder (BPD). DBT was first validated in an RCT with 44 female patients who met diagnostic criteria for BPD (Linehan, Armstrong, Suarez, Almon, & Heard, 1991). In recent years, DBT has been adapted for other psychiatric conditions featuring emotion dysregulation, including substance-related disorders and binge eating; other clinical populations (e.g., depressed suicidal adolescents); and a variety of settings (e.g., inpatient, forensic). Of particular relevance to military caregivers is a 2010 study (Harned, Jackson, Comtois, & Linehan, 2010) in which DBT was a precursor treatment for individuals with comorbid BPD and PTSD. One obstacle to treatment for many individuals with PTSD and BPD has been that the severity of their suicidality excludes them from participating in prolonged

exposure therapy (PE; Foa, Hembree, & Rothbaum, 2007). Harned and colleagues drew 51 participants from an RCT sample of women with BPD. Results showed that exclusionary behaviors for PE treatment for PTSD decreased significantly for participants with comorbid PTSD and BPD. Between pre- and post-treatment, imminent suicide risk was completely eliminated and the prevalence of self-injury decreased significantly, making them eligible for PE for the PTSD symptoms.

Interpersonal Psychotherapy (IPT)

Interpersonal psychotherapy (IPT) for suicidality was adapted from IPT for depression, which focuses on improving problematic relationships that contribute to an individual's depressive symptoms. To clarify: despite the similarity in names, IPT is *not* an outgrowth of Joiner's (2005) tripartite interpersonal-psychological theory of suicide covered in the theory section of this Guide. Rather, IPT is based on the premise that interpersonal difficulty is associated with depressive/suicidal symptoms (Weisman, Markowitz, & Klerman, 2000). The IPT model is based on the interpersonal triad, in which an interpersonal crisis acts as a stressor on the individual's ability to manage the crisis. Crisis management ability is affected by biopsychosocial vulnerabilities including genetic factors, temperament, attachment style, and personality. Finally, the individual's current relationship and general social support system serve as the context in which the interpersonal crisis and biopsychosocial factors interact, thus adding another factor contributing to psychological distress. IPT is a present-centered intervention that focuses on interpersonal problem areas, the use of the therapy relationship, and collaboration and goal consensus. Interpersonal problem areas may include, for example, interpersonal deficits, role dispute or confusion, grief, or role transition. One published RCT of IPT (Guthrie et al., 2001) specifically targeting suicidality investigated IPT with 119 adults who presented to the emergency department with deliberate self-poisoning. Participants were randomized to either usual care or IPT consisting of four 50-minute weekly sessions. Results indicated that at 6-month follow-up, participants in IPT had significantly lower suicide ideation and fewer subsequent incidents of self-harm than control participants. These results suggest that even a very truncated adaptation of IPT may be effective in decreasing suicide ideation and behavior. In another study (Heisel, Duberstein, Talbot, King, & Tu, 2009), IPT (16 sessions, each lasting 50-60 minutes) was modified for use with 12 older outpatients at increased risk for suicide. Results indicated that suicide ideation and death ideation decreased from pre-treatment to post-treatment. Participants also reported high satisfaction with the treatment. Although the study is limited by small sample size and lack of randomization, the results provide preliminary evidence of the potential for IPT as a treatment for suicidality.

Motivational Interviewing (MI)

Motivational interviewing (MI; Miller & Rollnick, 2002) is a brief intervention for resolving an individual's ambivalence about making changes and enhancing his or her motivation to change, with clear implications for engagement in the treatment process. Research studying Motivational Interviewing for Suicide Ideation (MI-SI), as a suicide prevention intervention, is in preliminary stages and has not been tested in a RCT (Britton, Conner, Maisto, 2012). However, as of 2009, more than 200 RCTs had been conducted using MI (Miller & Rose, 2009). Results of a 2005 meta-analysis (Hettema, Steele, & Miller) indicated that, across a variety of outcomes, MI increased engagement in treatment and improved treatment outcomes. In a study of MI use in Veterans with a history of alcohol abuse, MI was found to decrease hazardous alcohol use (Bien, Mille, & Boroughs, 1993), indicating MI may be an effective basis for suicide prevention interventions for Veteran and military populations. More recent research results (Britton et al.,

2012) provided evidence of MI's potential for use with suicidal individuals. The study investigated the use of a two-session MI for suicide ideation with the overall goal of shifting motivation away from suicide and toward recovery. Participants were 13 Veterans who were hospitalized with suicide ideation. Results indicated that participants were mostly satisfied to very satisfied with it. In addition, there were large effect sizes for reduction in suicide ideation from baseline to post-treatment and from post-treatment to 2-month follow-up. Finally, a large proportion of participants engaged in substance abuse programs or mental health treatment following MI-SI. Although the study was limited by small sample size and lack of randomization, these findings are promising for the use of MI-SI with Veterans and military personnel with suicide ideation.

Safety Planning Intervention (SPI)

The Safety Planning Intervention (SPI), a type of crisis response plan, is based on four evidence-based suicide risk-reduction strategies: (1) restricting means, (2) improving problem-solving and coping skills, (3) enhancing social support and use of emergency contacts, and (4) improving motivation to seek further treatment. Because SPI was developed as a stand-alone intervention quite recently, evidence on its effectiveness is limited. Nevertheless, several empirically validated treatment strategies developed for working with suicidal individuals include safety planning components (e.g., Brown et al., 2005; Jobes, 2006; Linehan, 1993). Anecdotal evidence from a VA psychiatric inpatient unit where the SPI has been adapted as a group intervention supports use of the SPI (Rings, Alexander, Silvers, & Gutierrez, 2012). Preliminary evidence (Knox, Stanley, Currier, Brenner, Ghahramanlou-Holloway, & Brown 2012) on a version of the SPI for veterans (SAFE VET) seeking care in VA emergency departments (*N* = 438), indicated that acceptance of SAFE VET is very high (93%). In addition, following the intervention, Veterans made significantly more mental health visits than prior to the intervention, suggesting that they were seeking mental health treatment. One key component is the intensive follow-up provided by the acute service coordinator. Currently, the SPI is being empirically evaluated in the context of a well-powered RCT at the Walter Reed National Military Medical Center.

Caring Letters Project (CLP)

The Caring Letters Project (CLP; Luxton, Kinn, June, Pierre, Reger, & Gahm, 2012) is a post-discharge intervention that involves sending brief written communication (emails, letters, or postcards) to recently discharged psychiatric patients who are at high risk for suicide. For the CLP, participants (*N* = 110; mainly active duty, Guard, Reserves, or retired) admitted for psychiatric hospitalization were sent a series of 13 emails or letters over a period of 2 years following their discharge from the hospital. The messages were brief and personal, referring to something about the patient that the research assistant had learned during their interaction, such as hobbies or films the patient liked. Also included in the content was contact information for behavioral health resources and crisis hotlines. Results from the feasibility study indicated that CLP can be implemented in a military treatment facility and that participants responded well to the intervention and that most preferred email to letters. In addition, fewer CLP patients were readmitted compared to patients who had usual care. Further results will be available once the study is complete. Previous research on post-discharge caring letters (Motto & Bostrom, 2007; *N* = 843) indicates that there were fewer suicides in the caring letters group than in the no-contact group for 2 years post-discharge but that the difference between the two conditions decreased over 5 years. There are two RCTs of a similar intervention (i.e., Postcards from the EDge; Carter, Clover, Whyte, Dawson, & D'Este, 2007; Hassanian-Moghaddam, Sarjami, Kolahi, & Carter, 2011). Results from the Carter et al. (2007) study indicate that participants in

the intervention group had significantly fewer repeat admissions than those in the control group. Results from the Hassanian-Moghaddan et al. (2011) study indicate that there was significant reduction in suicide ideation, any attempt, and number of attempts. Given these results combined with the feasibility of use in a military treatment facility, providers may want to consider using a CLP intervention to follow up with suicidal patients. A sample caring letter is provided in Appendix E.

Commonalities of Psychotherapy Treatments for Suicide Prevention

Given the diversity of treatment approaches to suicide prevention, you may question the commonalities of treatment that scientifically show promise for preventing suicide. Igor Weinberg and colleagues (2010) from Harvard University recently summarized these commonalities based on a review of 37 years of psychotherapy research on suicide prevention. Findings indicate that there are 6 common ingredients for the management of suicidal behaviors. First, there is an agreed-upon treatment framework between the provider and the patient. Second, the intervention pays close attention to emotions and how to best regulate intense emotions. Third, an active therapist is required because, especially in the earlier stages of treatment, suicidal individuals may not be the most motivated to engage in treatment. Fourth, suicide must be understood by some form of collaborative exploration or behavioral analysis. Fifth, treatment must focus on changing thoughts and behaviors that activate a suicidal state. Finally, there should be an agreed-upon strategy for managing a suicidal crisis.

Psychotherapeutic Approaches for Inpatient Psychiatric Care of Suicidal Patients

Even though psychiatric admission is the standard of care for individuals at imminent risk for suicide, the therapeutic impact of inpatient mental health care remains unknown. To date, no RCTs have examined whether hospitalizing individuals with a recent suicide attempt saves lives (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Notably, only 2 cognitive behavioral studies have evaluated an exclusively inpatient intervention for individuals recently hospitalized following a suicide attempt (Liberman & Eckman, 1981; Patsiokas & Clum, 1985). In the first study (Liberman & Eckman, 1981), 24 state-hospital patients with a recent suicide attempt were randomized to either insight-oriented psychotherapy (*N* = 12) or behavior therapy (*N* = 12). Treatment in both groups consisted of 4 hours daily of therapy over an 8-day period. Although both groups demonstrated significantly reduced levels of depression, suicide ideation, and subsequent suicide attempts, patients in the behavior therapy group demonstrated greater sustainability of improvements at the 9-month follow-up. In the second study (Patsiokas & Clum, 1985), 15 inpatients admitted for a suicide attempt were randomized to either a cognitive restructuring condition (*N* = 5; Beck et al. [1976] methods), a problem-solving condition (*N* = 5; D'Zurilla & Goldfried, 1971 methods), or a non-directive control condition (*N* = 5). Each patient was offered 10 individual therapy sessions over 3 weeks. Problem solving abilities improved most for those in the problem-solving condition, followed by those who received cognitive restructuring. Levels of hopelessness, suicide ideation, and intent improved for all participants regardless of treatment condition. Since the publication of these studies over two decades ago, the field of suicidology continues to lack an adequately powered study that examines the efficacy of an inpatient intervention for suicidal individuals.

A number of active projects are attempting to address the lack of targeted interventions for suicidal inpatients within the DoD and the VA. For instance, researchers at the Uniformed Services University of the Health Sciences in collaboration with other DoD and civilian subject matter experts are engaged in a multi-site study to examine the efficacy and effectiveness of a safety planning intervention (Stanley & Brown, 2008) delivered in inpatient and emergency

department (ED) settings. Additionally, the Collaborative Assessment and Management of Suicide (CAMS; Jobes, 2006) is being adapted for inpatient use. Finally, Post Admission Cognitive Therapy (PACT), the adapted intervention based on the efficacious outpatient cognitive therapy protocol (Brown et al., 2005), is currently under pilot and feasibility testing at military inpatient settings. PACT is offered in six 60-90 minutes individual therapy sessions over the course of preferably 3-4 consecutive days. The overall objective of PACT is to help patients process the suicide-related event that precipitated their psychiatric hospitalization, plan for safety, and learn skills (e.g., emotion regulation, relapse prevention, problem solving) to cope more effectively with their life stressors so that suicide is no longer viewed as the only solution. A full description of the inpatient model is provided in a recent edition of Cognitive Behavioral Practice (Ghahramanlou-Holloway et al., 2012).

Other Factors to Consider

Individuals who have died by suicide demonstrate a history of poor treatment outcomes when compared to controls. In a sample of 2,753 inpatients, Motto, Heilbron, and Juster (1985) found that negative or variable results of previous efforts to obtain help predicted suicide risk. Modestin, Schwarzenbach, and Wurmle (1992) found that therapist experience was the most significant psychotherapy factor contributing to different outcomes in a sample of suicide decedents compared to matched controls. Goldstein, Black, Nasrallah, and Winokur (1991) found that a favorable outcome at discharge was a protective factor for suicide in a prospective study of 1,906 inpatients with affective disorders. Additionally, Borg and Stahl (1982) reported that patient dropout from treatment was a risk factor for suicide. Dahlsgaard, Beck, and Brown (1998) investigated response to CT as a predictor of suicide in a group of psychiatric outpatients. In this matched cohort study, suicide decedents attended significantly fewer psychotherapy sessions and had a significantly higher rate of premature termination of therapy as well as significantly higher hopelessness as compared to controls. Non-responsiveness to psychotherapy as measured by the number of sessions attended, level of hopelessness, and premature termination served as important risk factors for suicide.

Summary

Even though a great deal of progress is currently being made in the field of suicide prevention, especially due to DoD funded intervention studies, we do not yet have a solid understanding of what types of interventions are the most helpful in preventing suicide and the mechanisms underlying some of our designed interventions. Conducting suicide prevention research is a significant challenge because of a number of issues. For instance, this type of research faces many regulatory requirements and can be burdensome to conduct. High drop-out rates for research participants are often observed given that suicidal individuals are very tough to fully engage in treatment. Most intervention studies for individuals with psychiatric disorders have excluded those who are suicidal – therefore, many of the psychotherapies that we currently use, (e.g., prolonged exposure for the treatment of PTSD) have not been empirically validated for individuals with suicide ideation and those who have attempted suicide. Integrating some of the best known practices in suicide prevention within your specific model of intervention is one way to deliver the best care to your suicidal patients.

APPENDIX I: USAF Suicide Data (SESS and DoDSER)

USAF Suicides: Demographic Information from SESS and DoDSERs

Variable	1999-2009 SESS (*N* = 376)		2010 DoDSER (*N* = 59)		2011 DoDSER (*N* = 50)	
	Count	%	Count	%	Count	%
GENDER						
Female	21	5.6	2	3.39	4	8.00
Male	355	94.4	57	96.61	46	92.00
RACE						
American Indian/Alaskan Native	-----	-----	1	1.69	2	4.00
Asian/Pacific Islander	13	3.5	1	1.69	1	2.00
Black/African American	48	12.8	8	13.56	8	16.00
Caucasian/White	286	76.1	46	77.97	34	68.00
Hispanic	17	4.5	-----	-----	-----	-----
Other/Unknown	12	3.2	1	1.69	5	10.00
MARITAL STATUS						
Divorced	59	15.7	6	10.17	3	6.00
Legally Separated	4	1.1	0	0.00	0	0.00
Married	189	50.3	34	57.63	30	60.00
Single (Never Married)	118	31.4	18	30.51	17	34.00
Widowed	-----	-----	0	0.00	0	0.00
Unknown	6	1.6	1	1.69	0	0.00
RANK						
Cadet/Midshipman	-----	-----	1	1.69	0	0.00
E1 – E3	91	24.2	-----	-----	-----	-----
E1 – E4	-----	-----	24	40.68	22	44.00
E4 – E6	205	54.5	-----	-----	-----	-----
E5 – E9	-----	-----	31	52.54	22	44.00
E7 – E9	37	9.8	-----	-----	-----	-----
O1 – O3	21	5.6	-----	-----	-----	-----
O4 – O7	22	5.9	-----	-----	-----	-----
Officer	-----	-----	3	5.08	6	12.00
Warrant Officer	-----	-----	0	0.00	0	0.00

Note. SESS information provided based on tables constructed for Capt Jeffery Martin's dissertation completed at Uniformed Services University. DoDSER 2010 and 2011 information is provided from published reports by T2.

USAF Suicides: Details from SESS and DoDSERs

Variable	1999-2009 SESS (*N* = 376)		2010 DoDSER (*N* = 59)		2011 DoDSER (*N* = 46)	
	Count	%	Count	%	Count	%
PRECIPITANT 72 HOURS PRIOR TO SUICIDE						
Argued with Significant Other	101	26.9	-----	-----	-----	-----
Alcohol Related Incident	15	4.0	-----	-----	-----	-----
Legal	19	5.1	-----	-----	-----	-----
Separation/Divorce	23	6.1	-----	-----	-----	-----
RISK FACTORS – PSYCHOPATHOLOGY						
Adjustment	38	10.1	-----	-----	-----	-----
Alcohol	101	26.9	-----	-----	-----	-----
Anxiety	43	11.4	9	15.25	5	10.87
Illegal Drugs	22	5.9	-----	-----	-----	-----
Mood	95	25.3	9	15.25	13	28.26
Personality	27	7.2	2	3.39	1	2.17
Psychotic	9	2.4	0	0.00	1	2.17
Rx Drugs	22	5.9	-----	-----	-----	-----
Substance Abuse	-----	-----	11	18.64	6	13.04
RISK FACTORS – OTHER						
Criminal Acts	78	20.7	-----	-----	-----	-----
Family Problems	99	26.3	-----	-----	-----	-----
Financial	110	29.3	-----	-----	-----	-----
Military Legal	110	29.3	-----	-----	-----	-----
Previous Event	41	10.9	-----	-----	-----	-----
Significant Other Problems	92	24.5	-----	-----	-----	-----
Spouse Problems	190	50.5	-----	-----	-----	-----
Work Problems	146	38.8	-----	-----	-----	-----
COMMUNICATION OF INTENT						
Behavioral Health Provider	-----	-----	4	6.78	1	2.17
Chain of Command/Supervisor	5	1.3	1	1.69	2	4.35
Chaplain	-----	-----	0	0.00	1	2.17
Family Member	71	18.9	-----	-----	-----	-----
Friend/Coworker	53	14.1	3	5.08	5	10.87
Helping Services	13	3.5	-----	-----	-----	-----
Made Multiple Communications	-----	-----	1	1.69	3	6.52
Other or Unidentified	-----	-----	6	10.17	4	8.70
Spouse	-----	-----	8	13.56	7	15.22
Stated Intent	195	44.1	-----	-----	-----	-----
Unknown/None	210	55.9	36	61.02	30	65.22

Variable[1]	1999-2009 SESS (*N* = 376)		2010 DoDSER (*N* = 59)		2011 DoDSER (*N* = 46)	
	Count	%	Count	%	Count	%
EVENT SETTING						
Automobile (away from residence)	-----	-----	4	6.78	1	2.17
Dorm	31	8.2	-----	-----	-----	-----
Inpatient Medical Facility	-----	-----	0	0.00	0	0.00
Other	-----	-----	5	8.47	6	13.04
Public (common)	31	8.2	-----	-----	-----	-----
Public (isolated)	46	12.2	-----	-----	-----	-----
Residence (own) or Barracks	216	57.4	40	67.80	33	71.74
Residence of Friend or Family	-----	-----	7	11.86	1	2.17
Work – Job Site	14	3.7	3	5.08	5	10.87
RESIDES WITH						
Alone	165	43.9	24	40.68	22	47.83
Child	-----	-----	16	27.12	12	26.09
Friend	30	8.0	-----	-----	-----	-----
Partner/Child	96	25.5	-----	-----	-----	-----
Partner/No Child	53	14.1	-----	-----	-----	-----
Spouse	-----	-----	24	40.68	19	41.30
METHOD						
Asphyxiation	92	24.5	-----	-----	-----	-----
Carbon Monoxide	16	4.3	-----	-----	-----	-----
Crashing Motor Vehicle	-----	-----	0	0.00	0	0.00
Cutting – Piercing	5	1.3	-----	-----	-----	-----
Drugs	-----	-----	2	3.39	0	0.00
Firearm	197	52.4	34	57.63	33	71.74
Gas (vehicle exhaust)	-----	-----	1	1.69	1	2.17
Gas (utility or other)	-----	-----	0	0.00	0	0.00
Hanging	-----	-----	20	33.90	9	19.57
Jumping from High Place	-----	-----	0	0.00	1	2.17
Other	7	1.9	0	0.00	2	4.35
Poison – Overdose	19	5.1	-----	-----	-----	-----
Sharp or Blunt Object	-----	-----	0	0.00	0	0.00
Don't Know	-----	-----	2	3.39	0	0.00

Note. SESS information provided based on tables constructed for Capt Jeffery Martin's dissertation completed at Uniformed Services University. DoDSER 2010 and 2011 information is provided from published reports by T2.

[1] Only available data is provided for the SESS column displayed on this page. Approximately 10% of data was missing for location (event setting), 8.5% for resides with, and 11% for primary method of suicide.

USAF Suicides: Brief Summary of DoDSER[1] (2011)

Risk Indicator	Findings
Access to Lethal Means	60.87% of suicide decedents had firearms in the immediate environment
Axis II Traits or Diagnosis	2.17% of suicide decedents had been diagnosed with a personality disorder.
Communication of Intent	65.22% of suicide decedents did not communicate their intention; 28.26% communicated their intent to one person, with the most frequent type of communication as verbal at 19.57% and decedents most frequently communicated their intent to their spouse (15.22%).
Deployment & Combat Exposure	13.05% of suicide decedents had served in Afghanistan or Iraq, with 2.17% having a history of direct combat experience.
Depression & Other Mood Disorders	28.26% of suicide decedents had a mood disorder, with 17.39% having a history of major depression.
Healthcare Utilization	34.78% of suicide decedents had been seen in a military treatment facility within 30 days of their death, while 13.04% had been seen in an outpatient behavioral health facility within 30 days of their death.
History of Prior Self-Injury	17.39% (2011), 15.25% (2010), and 19.57% (2009) had a history of prior self-injury.
Life Events	45.65% of suicide decedents had a history of a failed intimate relationship, 21.74% had at least one legal or administrative concern, and over 10% had financial or workplace problems.
Physical Health Problems	23.91% of suicide decedents had a known history of a physical health problem and 10.87% had received physical health diagnoses within the month prior to suicide.
PTSD & Other Anxiety Disorders	10.87% (2011), 15.25% (2010), and 23.91% (2009) had been diagnosed with an anxiety disorder. PTSD diagnoses ranged from 4.35% (2011) to 3.39% (2010) to 4.35% (2009).
Substance Related Disorders	21.74% of suicide decedents used alcohol during the suicide event and 6.52% used drugs; 17.93% had received substance abuse treatment services.
Traumatic Brain Injury (TBI)	0.00% (2011) and 1.69% (2010) of suicide decedents had been diagnosed with TBI.

[1] DoDSER Annual Reports are generally posted during Fall of each year on the T2 website: http://t2health.org/programs/dodser

USA, USMC, and USN Suicides: Brief Summary of DoDSER[2] (2011)

<table>
<tr><th>Risk Indicator</th><th>Findings</th></tr>
<tr><td>Access to Lethal Means</td><td>Percentage (%) of those who had access to firearms in the immediate environment:
<table>
<tr><th></th><th>Airmen</th><th>Soldiers</th><th>Marines</th><th>Sailors</th></tr>
<tr><td>2011</td><td>60.87</td><td>45.28</td><td>45.16</td><td>56.86</td></tr>
<tr><td>2010</td><td>45.76</td><td>53.74</td><td>54.05</td><td>52.63</td></tr>
<tr><td>2009</td><td>45.65</td><td>52.29</td><td>50.00</td><td>43.48</td></tr>
</table></td></tr>
<tr><td>Axis II Traits or Diagnosis</td><td>1.89% of Soldiers, 3.23% of Marines, and 1.96% of Sailors had been diagnosed with a personality disorder.</td></tr>
<tr><td>Communication of Intent</td><td>75.47% of Soldiers, 83.67% of Marines, and 70.59% of Sailors did not communicate intent.
19.50% of Soldiers, 16.13% of Marines, and 19.61% of Sailors communicated intent to one person.</td></tr>
<tr><td>Deployment & Combat Exposure</td><td>59.06% of Soldiers, 38.16% of Marines, and 17.65% of Sailors had been deployed to Afghanistan or Iraq.
18.87%, 29.03%, and 7.84%, respectively, had a history of direct combat experience.</td></tr>
<tr><td>Depression & Other Mood Disorders</td><td>20.75% of Soldiers, 16.13% of Marines, and 17.65% of Sailors had been diagnosed with a mood disorder.
11.32%, 3.23%, and 9.80%, respectively, had been diagnosed with major depression.</td></tr>
<tr><td>Health Care Utilization</td><td>33.33% of Soldiers, 32.26% of Marines, and 25.49% of Sailors had been seen at a military MTF within 30 days of suicide; 21.38% of Soldiers, 19.35% of Marines, and 9.80% of Sailors had been seen at an outpatient behavioral health facility within 30 days of suicide.</td></tr>
<tr><td>History of Prior Self-Injury</td><td>11.95% of Soldiers, 12.90% of Marines, and 15.69% of Sailors had a history of prior self-injury.</td></tr>
<tr><td>Physical Health Problems</td><td>20.13% of Soldiers, 25.81% of Marines, and 21.57% of Sailors had a known history of a physical health problem.</td></tr>
<tr><td>Life Events</td><td>44.65% of Soldiers, 41.94% of Marines, and 56.86% of Sailors had a history of a failed intimate relationship.
32.08% of Soldiers, 61.29% of Marines, and 49.02% of Sailors had at least one legal/administrative concern.
At least 10% of Soldiers, Marines, and Sailors had at least one type of workplace issue.</td></tr>
<tr><td>PTSD & Other Anxiety Disorders</td><td>21.38% of Soldiers, 12.90% of Marines, and 13.73% of Sailors had been diagnosed with an anxiety disorder, and 9.43%, 3.23%, and 0.00%, respectively, had been diagnosed with PTSD.</td></tr>
<tr><td>Substance Related Disorders</td><td>21.38% of Soldiers, 12.90% of Marines, and 25.49% of Sailors used alcohol during the suicide event; 7.55%, 9.68%, and 13.73%, respectively, used drugs.</td></tr>
<tr><td>Traumatic Brain Injury (TBI)</td><td>4.40% of Soldiers, 3.23% of Marines, and 1.96% of Sailors had been diagnosed with traumatic brain injury.</td></tr>
</table>

[2] DoDSER Annual Reports are generally posted during Fall of each year on the T2 website: http://t2health.org/programs/dodser

APPENDIX J: Resource Guide

The resources mentioned below have been selected to help you with the delivery of services and dissemination of information to Airmen, military families, command, and/or your professional colleagues working with suicidal individuals. While all entries and associated web addresses have been verified as of the date of preparation (December 2013) of the revised version of the Air Force's Guide for Suicide Risk, please note that some of the information listed below may not remain accurate in the days to come. Therefore, you are encouraged to check the accuracy of the information, presented below, at the time of dissemination to others.

Furthermore, please note that entries within each section are alphabetized for easy reference. As much as possible, information provided for each entry is based on what is directly publicized by the specific source to ensure that accurate details are provided instead of our interpretation of what the service provides. The Resource Guide is organized into the following sections:

National, Civilian, Military, and Veteran Suicide Prevention Lifeline 24/7

Free, confidential, and always available. Community crisis centers answer Lifeline calls.
http://www.suicidepreventionlifeline.org/
Wallet Card:
http://www.suicidepreventionlifeline.org/App_Files/Media/PDF/NSPL_WalletCard.pdf

24-hour, toll-free suicide prevention service
1-800-273-TALK (8255)

For Hearing & Speech Impaired with TTY Equipment:
1-800-799-4TTY (4889)

For overseas or international:
Dial 118 from any U. S. Air Force or U. S. Army installation in Europe
Dial 00800-1273-TALK (8255) for a commercial toll-free line in Belgium, Germany, Italy, the Netherlands, and the United Kingdom

Service members in crisis should seek help immediately by contacting the Military Crisis Line. Dial 800-273-8255 (press 1 for military) for 24/7 crisis support. The crisis line, found at militarycrisisline.net, also provides a chat and text service.

Veterans Crisis Line and Vets4Warriors
The Veterans Crisis Line connects Veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline, online chat, or text. http://www.veteranscrisisline.net/
The Vets 4 Warriors is a service available for Veterans and their families in a crisis.
http://www.vets4warriors.com/

24-hour, toll-free suicide prevention service for Veterans
1-800-273-TALK (8255) Press 1

24/7 Military Resources

DoD/VA Suicide Outreach: DCoE Outreach Center (with Link to Chat)
Provides psychological health information and connects service members/families with resources.
1-866-966-1020
http://www.suicideoutreach.org/dcoe_outreach

Military One Source
Free service provided by the DoD to service members and their families to help with a broad range of concerns including money management, spouse employment and education, parenting and child care, relocation, deployment, reunion, and the particular concerns of families with special-needs members. They can also include more complex issues like relationships, stress, and grief. Services are available 24 hours a day — by telephone and online.
(Available 24/7) 1-800-342-9647
http://www.militaryonesource.com/skins/MOS/home.aspx

Air Force Suicide Prevention Resources

Air Force Drug and Alcohol Abuse Program (ADAPT)
https://kx2.afms.mil/kj/kx7/ADAPTDemandReduction/Pages/Home.aspx

Airman and Family Readiness Center
http://www.afpc.af.mil/lifeandcareer/index.asp

Military Installations
DoD source for installation and state resources available to active duty, guard and reserve service and family members.
http://apps.militaryonesource.mil/MOS/f?p=MI:ENTRY:0

Official Site of the U.S. Air Force – Suicide Prevention
This site includes links, news stories, and more related to suicide.
http://www.afms.af.mil/suicideprevention/index.asp

Sexual Assault Prevention and Response
The Sexual Assault Prevention and Response Program reinforces the Air Force's commitment to eliminate incidents of sexual assault through awareness and prevention training, education, victim advocacy, response, reporting and accountability. The Air Force promotes sensitive care and confidential reporting for victims of sexual assault and accountability for those who commit these crimes.
http://www.afpc.af.mil/library/sapr/index.asp

U.S. Air Force Suicide Prevention Program (AFSPP)
This site is designed to provide information and tools to members of the Air Force community (Suicide Prevention Program Managers, commanders, gatekeepers, IDS members, etc.) in their efforts to help reduce Air Force suicides.
https://kx2.afms.mil/kj/kx2/AFSuicidePrevention

Support Groups

American Association of Suicidology (AAS) - Directory of Support Groups
AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.
http://www.suicidology.org/suicide-support-group-directory (Specific link to support groups)

American Foundation for Suicide Prevention (AFSP) - Directory of Support Groups
Not-for-profit organization exclusively dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide.
http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=FEE33687-BD31-F739-D66C210657168295

Heartbeat: Grief Support Following Suicide
Peer support offering empathy, encouragement and direction following the suicide of a loved one.
http://heartbeatsurvivorsaftersuicide.org/index.shtml

Suicide Prevention Resource Center (SPRC)
Document listing links to support groups and other online resources.
http://www.sprc.org/sites/sprc.org/files/library/survresources.pdf

Survivors of Suicide Loss, Inc.
Survivors of Suicide Loss - San Diego County is part of an international network that has been established to foster new support groups and to provide information about grief-related services and referrals in North America.
http://www.soslsd.org/

Family Resources

Compassionate Friends
Provides highly personal comfort, hope, and support to every family experiencing the death of a son or a daughter, a brother or a sister, or a grandchild, and helps others better assist the grieving family.
http://www.compassionatefriends.org/home.aspx

The Dougy Center for Grieving Children & Families
Provides support in a safe place where children, teens, young adults, and their families grieving a death can share their experiences. Provides support and training locally, nationally, and internationally to individuals and organizations seeking to assist children in grief.
http://www.dougy.org

National Alliance on Mental Illness (NAMI)
NAMI, is dedicated to building better lives for the millions of Americans affected by mental illness. Advocates for access to services, treatment, supports and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need.
http://www.nami.org/

Parents of Suicide
A mailing list provides that provides a supportive environment for parents whose children have died of suicide. It is intended to provide a place where parents can discuss the lives and deaths of their children with other parents whose children have died by suicide.
http://www.parentsofsuicide.com/parents.html

SiblingSurvivors.com
Share stories of surviving sibling suicide and continue supporting the need for open dialog and community amongst those affected by the loss of a sibling.
http://www.siblingsurvivors.com

Suicide: Finding Hope
http://www.suicidefindinghope.com/home

Tragedy Assistance Program for Survivors (TAPS)
TAPS provides immediate and long-term emotional help, hope, and healing to all who are grieving the death of a loved one in military service to America. TAPS meets its mission by providing peer-based emotional support, grief and trauma resources, casework assistance, and connections to community-based care.
http://www.taps.org/

United States Marine Corps
Postvention: Includes military specific survivor resources and tips for comporting a suicide survivor.
https://www.manpower.usmc.mil/portal/page/portal/M_RA_HOME/MF

Publications and Fact Sheets on Mental Health and/or Suicide Prevention

After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances
Suicide Prevention Resource Center (SPRC), 2004
A guide to help community and faith leaders who plan memorial observances and provide support for individuals after the loss of a loved one to suicide.
http://www.sprc.org/library/aftersuicide.pdf

At-a-Glance: Safe Reporting on Suicide
Suicide Prevention Resource Center (SPRC), 2005
A two page summary of the *Reporting on Suicide: Recommendations for the Media*, a 2001 publication by the Centers for Disease Control and Prevention, National Institute of Mental Health, and other organizations.
http://www.sprc.org/library/at_a_glance.pdf

Bibliography of Suicide Bereavement Books
American Association of Suicidology (AAS), 2003
AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.
http://www.suicidology.org/web/guest/books-surviving

"Helping Survivors of Suicide: What Can You Do?"
American Association of Suicidology (AAS)
A document that provides guidance on how a friend can help someone cope with the loss of a loved one to suicide.
http://www.suicidology.org/c/document_library/get_file?folderId=229&name=DLFE-77.pdf

SOS - Handbook for Survivors of Suicide
American Association of Suicidology (AAS), 2004
A pocket-sized, quick-reference booklet to help suicide survivors cope with their grief.
http://www.suicidology.org/c/document_library/get_file?folderId=229&name=DLFE-73.pdf

Suicide Prevention Resource Center
The SPRC Online Library is a searchable collection of resource materials on suicide and suicide prevention. In addition to SPRC products, the library contains selected materials developed by other organizations and professionals.
http://library.sprc.org

Suicide Warning Signs
American Psychological Association, Monitor on Psychology
November 2001, Vol 32, No. 10
http://www.apa.org/topics/suicide/signs.aspx

Suicide Survivors: Those left behind
University of Wisconsin- Eau Claire Counseling Services, Date unknown
http://www.uwec.edu/Counsel/pubs/selfhelp/suicidesurvivors.htm

Surviving a Suicide Loss: A Financial Guide
American Foundation for Suicide Prevention (AFSP) & National Endowment for Financial Education (NEFE), 2004
Website to help survivors with one of the most practical matters that survivors face – personal finances.
http://www.afsp.org/financialguide/

Survivor (SPRC Customized Information Series)
Suicide Prevention Resource Center (SPRC), 2005
http://www.sprc.org/basics/about-surviving-suicide-loss

Suicide Prevention Programs

Army G-1: Army Suicide Prevention Program
Improve readiness through the development and enhancement of the Army Suicide Prevention Program policies designed to minimize suicide behavior; thereby preserving mission effectiveness through individual readiness for Soldiers, their Families, and Department of the Army civilians.
http://www.armyg1.army.mil/hr/suicide/default.asp

Lifeline Gallery: Stories of Hope and Recovery
Provides a safe space for survivors of suicide, suicide attempt survivors, those who struggled with suicidal thoughts, and those in the suicide prevention field to share their stories of hope and recovery.
http://lifeline-gallery.org/

LivingWorks
A private, for-profit, corporation, employing all of the financial discipline, innovation and determination of any private sector business to achieve our mission. A one-on-one relationship between a person at risk and a competent helper represents a unique opportunity of effecting a lifesaving or life-altering change. Train community helpers of all kinds to work in this intervention context.
http://www.livingworks.net/

Substance Abuse and Mental Health Services Administration
Provide individuals, families, professionals, and organizations with information and resources to seek help, provide assistance, and/or implement suicide prevention programs in their communities.
http://www.samhsa.gov

The Surgeon General's Call to Action to Prevent Suicide
A Call to Action is a science-based document to stimulate action nationwide to solve a major public health problem.
http://www.surgeongeneral.gov/library/calls/index.html

U.S. Army Public Health Command (USAPHC)
Promote health and prevent disease, injury, and disability of Soldiers and military retirees, their Families, and Department of the Army civilian employees; and assure effective execution of full spectrum veterinary service for Army and Department of Defense Veterinary missions.
http://phc.amedd.army.mil/topics/healthyliving/bh/Pages/SuicidePreventionEducation.aspx

U.S. Department of Veterans Affairs
The Mental Health Services mission is to maintain and improve the health and well-being of Veterans through excellence in health care, social services, education, and research.
http://www.mentalhealth.va.gov/MENTALHEALTH/suicide_prevention/index.asp

U.S. Marine Corps Suicide Awareness and Prevention
The Suicide Prevention Program builds resiliency and promotes early help-seeking behavior in Marines. Our mission is to further effective suicide prevention through collaborative activities and information sharing in order to save lives.
https://www.manpower.usmc.mil/portal/page/portal/M_RA_HOME/MF/G_Behavioral%20Health/B_Suicide%20Prevention

U.S. Navy and Marine Corps Public Health Center - Suicide Prevention
Navy and Marine Corps Public Health Center (NMCPHC) is the Navy and Marine Corps center for public health services. We provide leadership and expertise to ensure mission readiness through disease prevention and health promotion in support of the National Military Strategy.
http://www-nehc.med.navy.mil/Healthy_Living/Psychological_Health/Suicide_Prevention/

You Matter
You Matter was created to let people know that suicide is preventable. Provides resources and support.
http://www.youmatter.suicidepreventionlifeline.org/

National Organizations Providing Suicide Prevention Information

American Association of Suicidology (AAS)
AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.
http://www.suicidology.org/home

American Association of Suicidology (AAS) Clinician Survivor Task Force
Under the auspices of the American Association of Suicidology, the task force will provide consultation, support and education to psychotherapists and other mental health professionals to assist them in understanding and responding to their personal/professional loss resulting from the suicide death of a patient/client.
http://mypage.iu.edu/~jmcintos/therapists_mainpg.htm

American Foundation for Suicide Prevention (AFSP)
Not-for-profit organization exclusively dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide.
http://www.afsp.org/

American Psychiatric Association
The American Psychiatric Association is the world's largest psychiatric organization. It is a medical specialty society representing more than 33,000 psychiatric physicians from the United States and around the world. Its member physicians work together to ensure humane care and effective treatment for all persons with mental disorders, including intellectual developmental disorders and substance use disorders.
http://www.psychiatry.org/suicide

American Psychological Association
The American Psychological Association is the largest scientific and professional organization representing psychology in the United States. APA is the world's largest association of psychologists, with more than 137,000 researchers, educators, clinicians, consultants and students as its members.
www.apa.org/topics/suicide/index.aspx

Friends For Survival, Inc.
A national non-profit organization that provides a variety of peer support services to comfort those in grief, encourage healing and growth, foster the development of skills to cope with a loss and educate the entire community regarding the impact of suicide. All staff and volunteers have been directly impacted by a suicide death.
http://www.friendsforsurvival.org

Lifekeeper
AFSP Memory Quilts are collaborative tributes created by survivors of suicide loss that are publically displayed at local and national events in order to put a human face on the tragedy of suicide.
http://www.afsp.org/index.cfm?page_id=05AFD181-E9E7-9FD9-5A7CBD93B339A9E1

Link Counseling Center's National Resource Center
The Link's NRC is a leading resource in the country for suicide prevention and aftercare. It is dedicated to reaching out to those whose lives have been impacted by suicide and connecting them to available resources. Families who have experienced a loss through suicide receive unparalleled support while they grieve.
http://www.thelink.org/national_resource_center.htm

Make the Connection
A public awareness campaign by the U.S. Department of Veteran Affairs (VA) that provides personal testimonials and resources to help Veterans discover ways to improve their lives.
http://maketheconnection.net/conditions/suicide#

Mental Health America
Dedicated to promoting mental health, preventing mental and substance use conditions and achieving victory over mental illnesses and additions through advocacy, education, research and service.
http://www.nmha.org/go/suicide

National Institute of Mental Health (NIMH)
The mission of NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure.
http://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml

SAVE: Suicide Awareness Voices of Education
Their mission is to prevent suicide through public awareness and education, reduce stigma and serve as a resource to those touched by suicide.
http://www.save.org

Advocacy

Channeling Grief into Policy Change: Survivor Advocacy for Injury Prevention
The Trauma Foundation, Date unknown
Discusses how survivors can become advocates in injury prevention. Provides examples as well as how to tips.
http://www.sprc.org/library_resources/items/channeling-grief-policy-change-survivor-advocacy-injury-prevention

Guide to engaging the media in suicide prevention
This 44-page guide teaches you how to serve as an effective media spokesperson and how to generate media coverage to create awareness of suicide prevention. The publication describes how to use television, radio, and print media and provides examples of press releases, media advisories, pitch letters, op-eds and more. It also gives tips for identifying appropriate media outlets, creating up-to-date media lists, and tracking your results.
http://www.sprc.org/library_resources/items/guide-engaging-media-suicide-prevention

Suicide Prevention Action Network (SPAN) USA, Inc.
This program is dedicated to preventing suicide through public education and awareness, community engagement, and federal, state, and local grassroots advocacy.
http://www.spanusa.org/

APPENDIX K: Prevention of Professional Burnout

Recommendations for Self-Care and Prevention of Burnout

> *"If you own a car, you have it inspected each year and you check the oil regularly. Burnout-syndrome patients [providers] never bring their 'cars' in for inspection. They drive thousands of miles at full speed and then are shocked when the motor suddenly fails. They have been neglecting routine maintenance."*
>
> *Juergen Staedt, Psychiatrist (Kraft, 2006, p. 32)*

Unique Stressors Faced by Military Mental Health Personnel

Military mental health personnel, compared with their civilian counterparts, face a number of unique occupational stressors, especially when managing suicidal patients. First, there is the responsibility of meeting the needs of the patient but also the duty to take care of the military community and serve the organization as well as the mission. Second, stressors such as multiple transitions and deployment take a toll on providers and may expose providers to direct traumatic experiences and/or vicarious traumatization. Third, when it comes to the effective care of suicidal service members and beneficiaries, accountability for the safety of the patient, timely documentation, and associated administrative tasks rests with the provider who must establish a strong working relationship with the patient, the collaborating medical personnel, and the command representative(s). Finally, working with suicidal patients is one of the most challenging and, at times, anxiety-provoking tasks for any mental health professional. For all these reasons, self-care is key to ensuring that providers are adequately prepared to deliver timely and effective services to highly vulnerable suicidal patients.

Linnerooth, Mrdjenovich, and Moore (2011) proposed that protecting the psychological health of the provider is in the best interest of preserving the military's limited mental health care resources. More specifically, they describe the unique challenges faced by military providers: (1) stress of deployment on personal life; (2) adapting clinical practice to the needs of the military (e.g., moving from pediatric practice to a brigade combat team); (3) adjusting to the culture of deployed environments (e.g., appearance, language, resources available); (4) having orders contravened by higher ranking officers (lack of control); (5) pressure to stray from ethical standards of practice (e.g., breaking confidentiality); (6) dealing with the death of a service member/patient; (7) pressure to over- or under-diagnose; and (8) the dilemma of simultaneously serving military readiness and patients with chronic conditions (e.g., Axis II). Moreover, for civilian providers working in a military setting, the challenges may include a lack of familiarity with military culture and being perceived as an outsider by patients as well as military colleagues.

Professional Burnout

Professional burnout is an occupational hazard for mental health personnel, and the interpersonal, clinical, and organizational demands of treating suicidal individuals can add significantly to feelings of fatigue and burnout. The term *burnout syndrome* was coined by American psychoanalyst, Herbert J. Freudenberger (1974). He observed that his job, previously seen as rewarding, had come to result in his fatigue and frustration. In addition, he observed that many of his colleagues had turned into depressive cynics over time. Consequently, these

doctors treated their patients indifferently, coldly and dismissively. Christina Maslach's extensive body of research (Maslach, Leiter, & Jackson, 2012) indicates that professional burnout is a psychological syndrome in response to chronic interpersonal stressors on the job. The three key dimensions of burnout are

1. Overwhelming exhaustion
2. Feelings of cynicism
3. Detachment from the job and a sense of ineffectiveness

Professional burnout results when there is a mismatch between the person and six domains of his or her job environment (Maslach, Schaufeli, & Leiter, 2001). The greater the gap, or mismatch, between the person and the job, the greater the likelihood of burnout. The six domains include: workload, control, reward, community, fairness, and values.

According to one study, psychologists' higher emotional exhaustion is related to dealing with more negative client behaviors, less control over work activities, more clinical hours, and more time spent on administrative tasks (Rupert & Morgan, 2005). Specific to military mental health care providers, a cross-sectional study (Ballenger-Browning, Schmitz, Rothacker, Hammer, Webb-Murphy, & Johnson, 2011) found that burnout levels among military providers were comparable to levels of civilian providers and that predictors of higher levels of burnout included working with more Axis II patients, having larger caseloads, being female, and being a psychiatrist. Predictors of lower levels of burnout included having more confidants at work, having a greater percentage of TBI patients, having more clinical experience, and being a psychologist.

Skovholt and Trotter-Mathison (2011) also cite factors that contribute to burnout by depleting the professional self, including the following:

1. Self-perceived unsuccessfulness as a clinician
2. Poor professional boundaries resulting in poor self-care
3. Low peer support
4. Low supervisor support
5. High level of conflict in the organization
6. Excessive seriousness
7. No long-term professional goals
8. Intolerance of ambiguous professional loss or clinical failure
9. Neglecting healthy closure when separating from colleagues

In addition to the job-related stressors noted above, there is an increased personal toll specific to working with suicidal patients. A review of the literature on stress and burnout among psychiatrists (Fothergill, Edwards, & Burnard, 2004) found that one personal stressor contributing significantly to burnout is patient suicide. A recent narrative (Carr, 2011) on the effects of an OIF soldier's suicide on the soldier's unit and caregivers revealed both acute and longer term effects on mental health providers as well as unit members and command. The increasing number of suicide-related behaviors among service members exposes military providers to greater stress and thus a higher risk for burnout (Waits & Wise, 2011).

Consequences of Professional Burnout

There are serious organizational and individual consequences of professional burnout. The organizational consequences cited by Kumar, Hatcher, & Huggard (2005) include poorer

patient care and increased patient dissatisfaction, lower productivity, absenteeism, job dissatisfaction, and decreased retention of skilled staff, which would have substantial negative impact on a military treatment facility's ability to provide adequate care to service members and their families. Individual consequences of burnout include increased anxiety, anger, sleep and eating disturbances, physical problems (e.g., hypertension, weakened immune system, back aches, digestive disorders), depression, hopelessness, negative self-worth, substance use, marital and family dysfunction, as well as in rare cases, suicide-related ideation and behaviors (Barnett, Gareis, & Brennan, 1999; Cicala, 2003; Gastfriend, 2005; Goebert et al., 2009; Kumar et al., 2005).

Warning Signs of Burnout

Many of the consequences listed above also serve as warning signs of professional burnout and compassion fatigue. You are encouraged to note these warning signs and take action to prevent their exacerbation. Mathieu (2012) provides the following listing of warning signs associated with compassion fatigue:

- ☐ Exaggerated sense of responsibility
- ☐ Avoidance of clients
- ☐ Impaired decision making
- ☐ Forgetfulness
- ☐ Silencing patients (knowingly and unknowingly)
- ☐ Emotional exhaustion
- ☐ Decreased capacity for empathy and increased cynicism
- ☐ Resentment of patients and colleagues
- ☐ Dreading certain patients
- ☐ Diminished enjoyment of clinical work
- ☐ Disrupted worldview
- ☐ Difficulty keeping personal and professional life separate

Recommendations for Prevention of Professional Burnout

Managing the many stressors that contribute to professional burnout can be difficult in military mental health facilities. Mental health personnel may have little or no control over their work environment or caseload. There are, however, a number of strategies for managing stressors and preventing burnout. An important first step is a thorough self-assessment to help you understand your unique perceived stressors and what realistic steps you can take to manage them. Often provider self-care is low priority, yet poor self-care can result in poor patient care. Skovholt and Trotter-Mathison (2011) recommend the following steps for nurturing both your professional and personal selves.

1. Change work tasks (e.g., provide more supervision, provide less direct service)
2. Learn new treatment techniques or change treatment modality
3. Set clear and firm boundaries
4. Minimize ambiguous professional loss through proper termination

Additionally, a number of practicable steps may be taken to promote self-care[1]:

1. *Conduct an honest appraisal of your personal values and choices.* This activity will help focus you on what is personally and professionally most important to you.
2. *Budget your physical resources.* Exercise regularly, eat a balanced diet, and get adequate sleep.
3. *Seek social support.* Form strong ties with at least a few trusted and respected colleagues, talk to friends and family about job-related stressors and offer guidance for how they could best help, and start a peer consultation group.
4. *Engage in pleasurable activities and cultivate one or more hobbies.* Make time for these activities in your schedule, spend time at play with family and friends, and socialize with colleagues.
5. *Learn and practice relaxation and stress management techniques* such as mindfulness which reduces stress, negative affect, anxiety (Shapiro, Brown, & Biegel, 2007), yoga, and/or progressive muscle relaxation.
6. *Seek psychological, spiritual, and/or psychiatric assistance as needed.* Allow time for self-reflection, consult a trusted colleague, seek spiritual guidance (if applicable), and consider counseling and/or psychiatric medications for short-term or long-term benefits.
7. *Learn from others' hardiness.* Seek a professional mentor – for instance, if you have not yet been deployed, ask at least one or two colleagues who have been deployed to provide some guidance to you about what to expect and how to best prepare for this new role.
8. *Set clear boundaries with patients, command, and also your colleagues.* Be honest with yourself about workload and limits, practice saying no, make compromises, and report harassment as well as other activities that create a hostile work environment.
9. *Remind yourself that self-care equals patient care.* You will be best equipped to provide effective treatment, advocacy, and decision-making guidance to your suicidal patients if you take good care of yourself

Finally, mental health facilities can also adopt policies and practices that promote provider well-being. Clinic-wide strategies recommended by Mathieu (2012) include engaging in frequent and regular consultation, making self-care a team/clinic priority by building cohesion among providers (e.g., by going out to lunch or for walks together, providing guided relaxation CDs for provider use during lunch hours), and promoting a low-impact debriefing approach by asking providers to resist oversharing (e.g., giving gruesome details or emotionally intense reports on a patient) during consultation.

[1] The recommendations provided are based on lectures on professional burnout provided by Dr. Holloway at USUHS to medical and graduate students as well as mental health staff.

Continuing Education and Recommended Readings

Continuing Education Resources

The Aeschi Working Group – Aeschi West
http://www.aeschiconference.unibe.ch/future_events.htm

American Association of Suicidology (AAS)
- Main Site - http://www.suicidology.org/web/guest/home
- Training and Accredidation - http://www.suicidology.org/training-accreditation
- Annual Conferences - http://www.suicidology.org/education-and-training/annual-conference

American Foundation for Suicide Prevention (AFSP)
http://www.afsp.org/

American Psychological Association (APA)
- Main Site - http://www.apa.org/
- Suicide section - http://www.apa.org/topics/suicide/index.aspx

Association for Behavioral and Cognitive Therapies (ABCT)
http://www.abct.org/Home/

Beck Institute – CBT for Military Populations
http://www.beckinstitute.org/cbt-for-military-populations/

Center for Deployment Psychology (CDP)
http://deploymentpsych.org/

Centers for Disease Control and Prevention (CDC) – Principles of Prevention (POP)
http://www.cdc.gov/violenceprevention/POP.html

Defense Centers of Excellence – DcoE Monthly Webinars
- Main Site - http://www.dcoe.health.mil/Training/Monthly_Webinars.aspx
- DoD/VA Suicide Prevention Conference - http://www.dcoe.health.mil/Training/Conferences/Past_Conferences/2012_Suicide_Prevention_Conference.aspx

National Center for Veteran Studies
http://www.veterans.utah.edu/

Suicide Prevention Resource Center - SPRC Training Institute
http://www.sprc.org/training-institute

Recommended Readings

Beck, J. S. (2011). *Cognitive therapy: Basics and beyond* (2nd ed.). New York, NY: Guilford.

Berman, A. L., & Pompili, M. (2011). *Medical conditions associated with suicide risk.* Washington, DC: American Association of Suicidology.

Ellis, T. E., & Newman, C. F. (1996). *Choosing to live: How to defeat suicide through cognitive therapy*. Oakland, CA: New Harbinger Publications, Inc.

Jobes, D. A. (2006). *Managing suicidal risk: A collaborative approach*. New York, NY: Guilford.

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Kennedy, C. H., & Zillmer, E. A. (2012). *Military psychology: Clinical and operational applications (2nd ed.)*. New York, NY: Guilford.

Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder*. New York, NY: Guilford.

Michel, K., & Jobes, D. A. (2011). *Building a therapeutic alliance with the suicidal patient*. Washington, DC: American Psychological Association.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change (3rd edition)*. New York, NY: Guilford.

Pompili, M., & Tatarelli, R. (2011). *Evidence-based practice in suicidology: A source book*. Cambridge, MA: Hogrefe Publishing.

Ramchand, R., Acosta, J., Burns, R. M., Jaycox, L. H., & Pernin, C. G. (2011). *The War Within: Preventing suicide in the U.S. military.* Santa Monica, CA: RAND Corporation. http://www.rand.org/pubs/monographs/MG953

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APPENDIX L: VA/DoD Clinical Practice Guidelines (2013) Recommendations

Below are the recommendations extracted from each section of the *VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide*.

Module A: Assessment and Determination of the Risk for Suicide

A. Person Suspected to Have Suicidal Thoughts (Ideation), a Recent Previous Suicide Attempt, or Self-directed Violence Episodes

1. Any patient with the following conditions should be assessed and managed using this guideline:
    a. Person is identified as possibly having risk for suicide during evaluation and management of mental disorders (Depression, bipolar, schizophrenia, PTSD), or medical condition (TBI, pain, sleep disturbance) known to be associated with increased risk for suicide
    b. Person reports suicidal thoughts on deployment-related assessments (e.g., PDHA/PDHRA), or on annual screening tools, or other evaluation such as mental health intake
    c. Person scores very high on depression screening tool and is identified as having concerns of suicide
    d. Person reports suicidal thoughts on depression screening tool
    e. Woman reports suicidal thoughts on depression screening tool during pregnancy or postpartum visits
    f. Person is seeking help (self-referral) and reporting suicidal thoughts
    g. Service member referred to health care provider by command, clergy, or family/unit members who have expressed concerns about the person's behavior
    h. Person for whom the provider has concerns about suicide- based on the provider's clinical judgment
    i. Person with history of suicide attempt or recent history of self directed violence

B. Assess Risk for Suicide

1. A suicide risk assessment should first evaluate the three domains: suicidal thoughts, intent, and behavior including warning signs that may increase the patient's acuity. (See Annotation C)
2. The suicide risk assessment should then include consideration of risk and protective factors that may increase or decrease the patient's risk of suicide. (See Annotation D)
3. Observation and existence of warning signs and the evaluation of suicidal thoughts, intent, behaviors, and other risk and protective factors should be used to inform any decision about referral to a higher level of care. (See Annotation E)
4. Mental state and suicidal ideation can fluctuate considerably over time. Any person at risk for suicide should be re-assessed regularly, particularly if their circumstances have changed.
5. The clinician should observe the patient's behavior during the clinical interview. Disconnectedness or a lack of rapport may indicate increased risk for suicide.
6. The provider evaluating suicide risk should remain both empathetic and objective throughout the course of the evaluation. A direct non-judgmental approach allows the provider to gather the most reliable information in a collaborative way, and the patient to accept help.

C. Assessment of Suicidal Ideation, Intent and Behavior

C1. Suicidal Ideation/Thoughts

1. Patients should be directly asked if they have thoughts of suicide and to describe them. The evaluation of suicidal thoughts should include the following:
    a. Onset (When did it begin)
    b. Duration (Acute, Chronic, Recurrent) Intensity (Fleeting, Nagging, Intense)
    c. Frequency (Rare, Intermittent, Daily, Unabating)
    d. Active or passive nature of the ideation ('Wish I was dead' vs. 'Thinking of killing myself')
    e. Whether the individual wishes to kill themselves, or is thinking about or engaging in potentially dangerous behavior for some other reason (e.g., cutting oneself as a means of relieving emotional distress)
    f. Lethality of the plan (No plan, Overdose, Hanging, Firearm)
    g. Triggering events or stressors (Relationship, Illness, Loss)
    h. What intensifies the thoughts
    i. What distract the thoughts
    j. Association with states of intoxication (Are episodes of ideation present or exacerbated only when individual is intoxicated? This does not make them less serious; however may provide a specific target for treatment)
    k. Understanding regarding the consequences of future potential actions

C2. Suicidal Intent

1. Patients should be asked the degree to which they wish to die, mean to kill him/herself, and understand the probable consequences of his/her actions or potential actions
2. The evaluation of intent to die should be characterized by:
    a. Strength of the desire to die
    b. Strength of determination to act
    c. Strength of impulse to act or ability to resist the impulse to act
3. The evaluation of suicidal intent should be based on indication that the individual:
    a. Wishes to die
    b. Means to kill him/herself
    c. Understands the probable consequences of the actions or potential actions
    d. These factors may be highlighted by querying regarding how much the individual has thought about a lethal plan, has the ability to engage that plan, and is likely to carry out the plan

C3. Preparatory Behavior

1. Clinicians should evaluate preparatory behaviors by inquiring about:
    a. Preparatory behavior like practicing a suicide plan. For example:
        i. Mentally walking through the attempt
        ii. Walking to the bridge
        iii. Handling the weapon
        iv. Researching for methods on the internet
    b. Thoughts about where they would do it and the likelihood of being found or interrupted?
    c. Action to seek access to lethal means or explored the lethality of means. For example: (See Annotation D5)
        i. Acquiring a firearm or ammunition
        ii. Hoarding medication

iii. Purchasing a rope, blade, etc.
iv. Researching ways to kill oneself on the internet

d. Action taken or other steps in preparing to end one's life:
i. Writing a will, suicide note
ii. Giving away possessing
iii. Reviewing life insurance policy

2. Obtain collateral information from sources such as family members, medical records, and therapists.

C4. Previous Suicide Attempt

1. The assessment of risk for suicide should include information from the patient and collateral sources about previous suicide attempt and circumstances surrounding the event (i.e., triggering events, method used, consequences of behavior, role of substances of abuse) to determine the lethality of any previous attempt:
    a. Inquire if the attempt was interrupted by self or other, and other evidence of effort to isolate or prevent discovery
    b. Inquire about other previous and possible multiple attempts
    c. For patients who have evidence of previous interrupted (by self or other) attempts, obtain additional details to determine factors that enabled the patient to resist the impulse to act (if self-interrupted) and prevent future attempts.

C5. Warning Signs – Indications for Urgent/Immediate Action

1. Assess for other warning signs that may indicate likelihood of suicidal behaviors occurring in the near future, and require immediate attention:
    a. Substance abuse – increasing or excessive substance use (alcohol, drugs, smoking)
    b. Hopelessness – expresses feeling that nothing can be done to improve the situation
    c. Purposelessness – express no sense of purpose, no reason for living, decreased self-esteem
    d. Anger – rage, seeking revenge
    e. Recklessness –engaging impulsively in risky behavior
    f. Feeling Trapped – expressing feelings of being trapped with no way out
    g. Social Withdrawal – withdrawing from family, friends, society
    h. Anxiety – agitation, irritability, angry outbursts, feeling like wants to "jump out of my skin"
    i. Mood changes – dramatic changes in mood, lack of interest in usual activities/friends
    j. Sleep Disturbances – insomnia, unable to sleep or sleeping all the time
    k. Guilt or Shame – Expressing overwhelming self-blame or remorse

D. Assessment of Factors that Contribute to the Risk for Suicide

1. Providers should obtain information about risk factors during a baseline evaluation – recognizing that risk factors have limited utility in predicting future behavior.
2. Providers should draw on available information including prior history available in the patient's record, inquiry and observation of the patient, family or military unit members and other sources where available.
3. Assessment tools may be used to evaluate risk factors, in addition to the clinical interview, although there is insufficient evidence to recommend one tool over another.

4. The baseline assessment should include information about risk factors sufficient to inform further assessment if conditions change such as firearm in the home, social isolation, history of depression, etc.
5. Risk factors should be considered to denote higher risk individuals (e.g., those with a history of depression) and higher risk periods (e.g., recent interpersonal difficulties).
6. Risk factors should be solicited and considered in the formulation of a patient's care.
7. Reassessment of risk should occur when there is a change in the patient's condition (e.g., relapse of alcoholism) or psychosocial situation (e.g., break-up of intimate relationship) to suggest increased risk. Providers should update information about risk factors when there are changes in the individual's symptoms or circumstances to suggest increased risk.
8. Patients ages 18 to 25 who are prescribed an antidepressant are at increased risk for suicidal ideation and warrant increase in the frequency of monitoring of these patients for such behavior
9. For Military Service person in transition the provider should:
    1. Inquire about changes in the patient's life and be aware of other indicators of change (retirement physical, overseas duty screening, etc.).
    2. Be willing to discuss and consider methods to strengthen social support during the transition time if there are other risk factors present

D1. Risk Factors / Precipitants

No recommendations

D2. Impulsivity

1. The assessment of risk for suicide should include evaluation of impulsivity by determining whether the patient is feeling out of control, engaging impulsively in risky behavior
2. Assess if impulsive recklessness and risk-taking characterize the pattern of behavior and life style of the individual and therefore may limit the ability to control his/her behavior.

D3. Protective Factors

1. Assessment should include evaluation of protective factors, patient's reason to for living, or other factors that mitigate the risk for suicide.

D4. Substance Abuse and Disorder

1. All patients at acute risk for suicide who are under the influence (intoxicated by drugs or alcohol) should be evaluated in an urgent care setting and be kept under observation until they are sober.
    a. Patients who are under the influence should be reassessed for risk for suicide when the patient is no longer acutely intoxicated, demonstrating signs or symptoms of intoxication, or acute withdrawal
    b. Obtaining additional information from family members, treatment providers, medical records, etc., can be invaluable in making the determination between intentional and unintentional overdose in equivocal cases.
    c. Intoxicated or psychotic patients who are unknown to the clinician and who are suspected to be in at acute risk for suicide should be transported securely to the nearest crisis center or emergency department for evaluation and management. These patients can be dangerous and impulsive; assistance in transfer from law enforcement may be considered.

2. Intoxication with drugs or alcohol impairs judgment and increases the risk of suicide attempt. Use of drugs or alcohol should routinely be assessed with all persons at any risk for suicide.
3. Assess the presence of psychiatric and behavioral comorbidities (e.g., mood, anxiety disorder, aggression) in patients with substance use disorder at risk for suicide.
4. Recognize that assessment of social risk factors such as disruptions in relationships and legal and financial difficulties are important in individuals with substance use disorders.

D5. Assess Access to Lethal Means

1. Assessment of presence and access to lethal means should include:
    a. Fire Arms: Always inquire about access to fire arms and ammunition (including privately-owned firearm) and how they are stored
    b. Medications: Perform medication reconciliation for all patients. For any current and/or proposed medications consider the risk/benefit of any medications which could be used as a lethal agent to facilitate suicide. Consider prescribing limited supplies for those at elevated risk for suicide, or with histories of overdose or the availability of a caregiver to oversee the administration of the medications.
    c. Household poisons: Assess availability of chemical poisons, especially agricultural and household chemicals. Many of these are highly toxic.

E. Determine the Level of Risk (Severity of Suicidality)

1. Patients at HIGH ACUTE RISK should be immediately referred for a specialty evaluation with particular concern for insuring the patient's safety and consideration for hospitalization.
2. Patients at INTERMEDIATE ACUTE RISK should be evaluated by Behavioral Health specialty.
3. Patients at LOW ACUTE RISK should be considered for consultation with or referral to a Behavioral Health Practitioner.
4. Patients at NO elevated ACUTE RISK should be followed in routine care with treatment of their underlying condition, and evaluated periodically for ideation or suicidal thoughts.
5. Patient for whom the risk remains UNDETERMINED (no collaboration of the patient or provider concerns about the patients despite denial of risk) should be evaluated by a by Behavioral Health Practitioner.

E1: Suicide Risk Assessment Instruments

1. Formulation of the level of suicide risk should be based on a comprehensive clinical evaluation that is aimed to assess suicidal thoughts, intent and behavior and information about risk and protective factors for estimating the level of risk.
2. Behavioral Health provider use of a standardized assessment framework may serve to inform a comprehensive clinical evaluation. The framework should:
    a. Estimate the level of risk
    b. Support clinical decision-making
    c. Determine the level of intervention and indication for referral
    d. Allow monitoring of risk level over time
    e. Serve as the foundation for clinical documentation
    f. Facilitate 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 assessment should

reflect the understanding [recognizing] that an absolute risk for suicide cannot be predicted with certainty.

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

E2. Detection, Recognition and Referral (in Primary Care)

1. Whether they have mental disorder or not, patients identified as having suicidal ideation (e.g., through routine screening for major depression or other health conditions) should receive a complete suicide risk assessment as defined in this guideline (See Annotation B).
2. When evidence of a mood, anxiety, or substance use disorder is present, patients should be asked about suicidal thoughts and behavior directly.
3. If suicidal ideation is present, the initial suicide risk assessment should be performed (See Annotation B).
4. Referral to specialty behavioral health care should be based on the level of risk and the available resources:
    a. Patients at HIGH ACUTE RISK should remain under constant observation and monitoring before arranging for immediate transfer for psychiatric evaluation or hospitalization
    b. Patients at INTERMEDIATE ACUTE RISK should be referred to, and managed by Behavioral Health Specialty Provider.
    c. Patients at LOW ACUTE RISK should be considered for consultation with a Behavioral Health Practitioner.
    d. When risk is UNDETERMINED (due to difficulty in determining the level of risk, or provider concerns about the patient despite denial of ideation or intent) the patient should be immediately

Guidance for the Assessment of Suicide Risk in Emergency Department / Urgent care Settings:

1. Providers should choose the setting for the initial evaluation to ensure the safety of the patient and the clinical staff so that potentially life-threatening conditions can be managed effectively. And make the appropriate steps to:
    a. Secure all belongings to prevent access to lethal means and elopement from the Emergency Department.
    b. Monitor the patient in a visible area, away from exits, with limited access to equipment that may be used to harm self or others.
    c. Conduct a focused medical assessment to identify and manage any life-threatening conditions such as overdose, and assess medical stability.
        I. Vital Signs, Physical Exam, Neurologic Exam, Mental Status Exam
        II. ECG, Toxicology Screen, BAL, and other tests as indicated.
        III. Treat life-threatening conditions.
    d. Request Behavioral Health Consultation to conduct a thorough suicide risk assessment and recommend a treatment plan.

E3. Comprehensive Assessment for Risk for Suicide by Behavioral Health Provider

1. Gather collateral history from family/unit members, the medical record, escorts, unit commanders (or their representatives), referring physicians, EMS, and police as appropriate.

2. Approach the patient with a non-judgmental, collaborative attitude with the aim of fully understanding the patient's suicidality.
3. Secure all belongings to prevent access to lethal means and elopement from the clinic.
4. Choose the setting for the initial evaluation to ensure the safety of the patient and the clinical staff so that potentially life-threatening conditions can be managed effectively. If the patient is intoxicated, re-evaluate when intoxication has resolved.
5. Conduct a mental status examination and a comprehensive assessment of mental health history that includes:
    a. Past and present suicidal thoughts, intent, and behaviors, impulsivity, hopelessness and the patient view of the future
    b. Alcohol use assessed per standardized tools (Audit-C), and other substance abuse history, since impaired judgment may increase the severity of the suicidality and risk for suicide act
    c. Psychiatric illness, comorbid diagnoses, and history of treatment interventions.
    d. Elicit family history of suicidal behavior.
6. Assess for access and past use of lethal means (firearms, drugs, toxic agents).
7. Assess social history of support system, living situation and potential stressful life events.
8. Consider suicidal thinking, intent, behavior, risk factors and protective factors to stratify the risk.
9. Consider the use of a standardized suicide risk assessment framework to inform the evaluation for estimating the risk for suicide.
10. Determine appropriate setting for further evaluation and management based on level of risk, legal guidance, and local policy.
11. Document in detail the data supporting the assigned level of risk, the level of care required, and treatment plans to reduce suicide risk.

Module B: Initial Management of Patient at Risk for Suicide

F. Determine the Appropriate Care Setting

F1: Matching Care level to Level of Risk

1. Consider hospitalization for patients at high acute risk for suicide who need crisis intervention, intensive structure and supervision to ensure safety, management of complex diagnoses, and delivery of intensive therapeutic procedures.
2. The inpatient psychiatric hospital setting is particularly suitable for the treatment of acute risk for suicide rather than chronic risk.
3. An 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.

F2. Criteria for Transition to Less Restrictive Settings

1. 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).

F3. Hospitalization

1. Any patient with suicidal intent or behavior who cannot be maintained in a less restrictive environment requires hospitalization in order to provide an optimal controlled environment to maintain the patient's safety and initiate treatment.
2. A complete biopsychosocial assessment should be performed upon hospitalization to determine all direct and indirect contributing factors to suicidal thoughts and behaviors. Patient and family education should be provided on techniques to manage these factors.

F4. Partial Hospitalization, Intensive Outpatient Program (IOPs)

1. There is insufficient evidence to recommend that partial hospitalization is preferable to other treatment settings for reducing the risk of suicide.

F5. Discharge Planning

1. A collaborative discharge plan should be developed to allow a suicidal patient to be discharged from inpatient psychiatric care or the Emergency Department in order to mitigate the increased risk of suicide post discharge.
2. Patients who are discharged from acute care (hospitalization, Emergency Department) remain at high risk for suicide and should be followed up within seven days of discharge.
3. Discharge planning should include the following:
    a. Re-assessment of the Suicide Risk
    b. Education to patient and support system about the risks of suicide in the post-discharge timeframe
    c. Providing suicide prevention information (such as a crisis hotline) to the patient and family/unit members.
    d. Post-discharge treatment plans for psychiatric conditions and for suicide-specific therapies
    e. Safety plan with validation of available support systems
    f. Coordination of the transition to appropriate of care setting with warm hand-offs
    g. Identifying the responsible provider during the transition
    h. Monitoring of adherence to the discharge plan for 12 weeks

G. Securing Patient's Safety

G1. Education for Patient and Family

1. The patient should be educated about conditions that are associated with their suicidal crisis, factors that increase and decrease their risk of suicide, and the risks and benefits associated with treatment options included in the treatment plan to target suicidality and associated conditions.

2. Patient and family should receive information about the resources available through the Veterans or Military Crisis Line (including phone, chat and text services).
3. The patient and family education should be done with empathy, and appropriate respect for autonomy and patient privacy. Family/unit members should be engaged with the patient consent. This education should aim to instill hope of recovery and reduce stigma and shame.
4. Strongly recommend advising all patients at intermediate to high acute risk for suicide against the use of alcohol and non-prescribed medications, and educate on the potential for drug-drug and drug-alcohol interactions that can impair decision-making and increase the risk of impulsive suicide attempts.
5. Patient and family education should be provided with the following characteristics:
    a. Tailored to the needs (e.g. language and educational level) and situational factors of the identified family or supports and patient
    b. Ensure specific focus on self-directed violence or suicide behaviors
    c. Allow plenty of time to answer patient and family member questions and establish a collaborative relationship
6. At a minimum, patient and family education should include:
    a. The nature of self-directed violence or suicide behaviors, the episodic recurrent nature of suicide risk and the applicable biological, cognitive, emotional, or psychosocial risk factors
    b. The impact of any existing psychiatric diagnoses or high risk situational stresses
    c. Risk factors associated with suicide
    d. Warning signs, reviewing any particular warning signs the patient may have demonstrated prior to any attempts or reported ideation
    e. The protective role of positive family relationships and the potential harmful impact of negative family interaction on risk mitigation
    f. The importance of assisting the patient with his/ her safety plan and means restriction, removing potentially lethal means of self-harm (e.g. firearms, medications, knives, or razor blades) from the person and their home environment, particularly if the person has mentioned specific means.
    g. Methods for contacting the patient's provider and other medical or community support resources (e.g. hotlines) should the family member become concerned
    h. The importance of encouraging the patient to comply with a collaboratively established treatment plan and follow-up care.

G2. Limiting Access to Lethal Means (Firearms, Drugs, Toxic Agents, Other)

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 (military or privately owned): For patients at highest risk, exercise extreme diligence to ensure firearms are made inaccessible to the patient. For all patients at intermediate to high acute 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 high acute 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.

c. Household Poisons: Educate how to secure chemical poisons, especially agricultural and household chemicals, to prevent accidental or intentional ingestions. Many of these chemicals are highly toxic.

G3. Safety Plan for Patient at Risk of Suicide

1. Safety planning that is developed collaboratively with the patient should be part of discharge planning for all patients who were evaluated with high acute risk for suicide before being released to a lower level of care.
2. For patients at intermediate acute risk for suicide, the safety planning process can be abbreviated to recognizing signs of elevating safety concerns and listing of practical steps for individual coping, safety precautions and support-seeking.
3. For patient at low risk, provider should discuss signs that the patient can use to recognize escalating stress or risk, provide key phone numbers and resources for help, and educate about lethal means restriction. A handout can be used to reinforce the discussion.
4. A Safety plan should be:
    a. Collaborative between the provider team and the patient
    b. Proactive–by explicitly anticipating a future suicidal crisis
    c. Individually tailored
    d. Oriented towards a no-harm decision
    e. Based on existing social support
5. The Safety plan should include the following elements, as appropriate:
    a. Early identification of warning signs or stressors
    b. Enhancing coping strategies (e.g., to distract and support)
    c. Utilizing social support contacts (discuss with whom to share the plan)
    d. Contact information about access to professional help
    e. Minimizing access to lethal means (as, weapons and ammunition or large quantities of medication)
6. The development of the safety plan with the person, family/unit members, should anticipate and discuss contingencies to address possible obstructions to plan implementation and where to keep the plan.
7. The safety plan should be reviewed and updated by the health care team working with the patient as needed and shared with family/unit members and other related if the patient consents.
8. Safety plans should be updated to remain relevant during changes in clinical state and transitions of care.
9. Providers should document the safety plan within the medical record or reasons for not completing such a plan (i.e. “Patient admitted. Inpatient provider to complete safety plan at time of discharge.”)

G4. No-Suicide Contracts

1. Recommend against the use of no-suicide contracts as intervention to prevent future suicide in patients at high acute risk for suicide.
2. Patient management should include a comprehensive evaluation of current risk factors and warning signs for suicide, a personalized safety plan that best anticipates triggers for future suicidal thoughts and collaboratively develops coping strategies that make sense for the individual patient.

G5. Addressing Needs (Engaging Family, Community; Spiritual and Socioeconomic Resources)

1. Providers should consider psychosocial interventions to address unique family, social, cultural, spiritual and socioeconomic needs of the individual identified by the treatment team and patient.
2. Providers should refer the patient to available psychosocial resources to address the identified individual patient needs.
3. Provider should maintain awareness of available coping skills programs and use clinical judgment in determining if a particular patient will benefit from referral or inclusion in such a program. These modalities may not be appropriate for some Service members.
4. Underlying psychosocial factors impacting the provision of care may include:
    a. Unemployment
    b. Homelessness or housing instability
    c. Financial difficulties
    d. Legal issues
    e. Lack of social support (i.e. self-induced or circumstantial)
    f. Substance abuse
    g. Inability to coordinate comprehensive care
    h. Spiritual issues

G6. Additional Steps for Management of Military Service Members (SMs)

1. Providers must take reasonable steps to limit the disclosure of Protected Health Information (PHI) to the minimum necessary to accomplish the intended purpose.
2. Providers should involve command in the treatment plan of Service member at high acute risk for suicide to assist in the recovery and the reintegration of the patient to the unit. For SM at other risk levels, provider should evaluate the risk and benefit of involving command and follow service Department policies, procedures, and local regulations.
3. When performing a medical profile, the provider should discuss with command the medical recommendation and the impact on the SM's limitations to duty and fitness for continued service.
4. Provider should discuss with Service members the benefit of having command involved in their plan and assure them their rights to Protected Health Information with some exceptions regarding to the risk for suicide.
5. As required by pertinent military regulations, communicate to the Service member's chain of command regarding suicidal ideation along with any recommended restrictions to duty, health and welfare inspection, security clearance, deployment, and firearms access. Consider redeployment to home station any Service member deployed to a hazardous or isolated area.
6. Service members at high acute risk for suicide who meet criteria for hospitalization and require continuous (24-hours) direct supervision should be hospitalized in almost all instances. If not, the rationale should specifically state why this was not the preferred action with appropriate documentation.
7. During operational deployment conditions or other extreme situations during which hospitalization or evacuation is not possible, 'Unit watch' may be considered as appropriate in lieu of a high level care setting (hospitalization) and service Department policies, procedures, and local regulations should be followed.
8. Because of the high risk of suicide during the period of transition providers should pay particular attention to ensure follow-up, referral, and continuity of care during the transition of Service members at risk for suicide to a new duty station, after separation from unit, or separation from military service.

Module C: Treatment of the Patient at Risk for Suicide

H. Determine Treatment Plan

1. Patients should receive optimal evidence-based treatment for any mental health and medical conditions that may be related to the risk of suicide. Patients diagnosed with a mental health and/or medical condition should receive evidence-based treatments for their underlying condition following Evidence-based Clinical Practice Guidelines:
    a. Substance Use Disorders
    b. Major Depressive Disorder
    c. Psychosis (Schizophrenia)
    d. Bipolar Disorder
    e. Post-traumatic Stress Disorder
    f. Traumatic Brain Injury
    g. Chronic Pain
    h. Medically Unexplained Symptoms
2. Care for the relevant condition-focused treatments may need to be modified to address the risk of suicide. For example, limiting the quantities of medications dispensed at any one time, enhancing social support, hospitalization and protection from harm, increasing the frequency of follow-up, increasing efforts to monitor and promote treatment adherence.
3. Treatment interventions that have been shown to be effective in reducing the risk for repeated self-directed violence or preventing suicide in patients with specific conditions need to be considered or optimized in those with these conditions who are at risk for suicide (e.g., lithium for patients with bipolar disorder, suicide-focused psychotherapy).
4. Family/unit members should be involved in the treatment plan when the patient consents. For Active Duty Service members the command should always be involved in the treatment plan of a high-risk suicidal patient.

I. Psychotherapy

No recommendations

J. Suicide-Focused Psychotherapy Addressing the Suicide Risk

1. Suicide-focused psychotherapies that have been shown to be effective in reducing risk for repeated self-directed violence should be included in the treatment plan of patients at high risk for suicide, if the risk for suicide is not adequately addressed by psychotherapy specific to the underlying condition. Psychotherapy may include:
    a. Cognitive therapy (CT) for suicide prevention for non-psychotic patients who have survived a recent suicide attempt [B] and others at high risk. [I]
    b. Problem-solving therapy (PST) that directly addresses the risk for suicide related behaviors for non-psychotic patients with more than one previous suicide attempt [B], and for other patients at high risk. [C]

J1. Cognitive Therapy (CT) for Suicidal Patients Treating the Risk for Suicide

No recommendations

J2. Problem Solving Therapies (PST) Treating the Risk for Suicide

No recommendations

K. Psychotherapy for Co-occurring Mental Disorders Associated with Suicide Risk

1. There is inconsistent evidence regarding the efficacy of psychotherapy in reducing the risk for repetition of self-directed violence in patients with co-occurring disorders. Specific psychotherapies may be considered in the following contexts:

K1. Risk for Suicide in Borderline Personality Disorder

i. Dialectical Behavioral Therapy (DBT) for patients with Borderline Personality Disorder (BPD) or other personality disorders characterized by emotional dysregulation and a history of suicide attempts and/or self-harm. [I]

ii. Specific psychotherapies based on cognitive or behavioral approaches or skills training (i.e., CBT for Borderline Personality Disorder, MACT, Acceptance Based Emotion Regulation Group Intervention) for patients with BPD who are at high risk for suicide. [I]

iii. Specific psychodynamic psychotherapies (i.e., MBT, brief psychodynamic interpersonal therapy) for patients with BPD who are a high risk for suicide. [I]

K2: Borderline Personality Disorder

K3: Risk for Suicide in Schizophrenia

i. There is insufficient evidence to recommend for or against use of CBT to reduce the risk of suicide behavior in patients with schizophrenia [I]

K4. Treatment of High Risk for Suicide and Comorbid Substance Use Disorder (SUD)

ii. Ongoing management of suicidal patients with SUD should include treatment by a licensed mental health practitioner.

iii. In addition to suicidality-focused interventions, treatment should be provided for an underlying SUD condition (e.g., addiction). Ensure that management of suicide risk is coordinated or integrated with treatment for substance use disorder and comorbid conditions

iv. Intervention strategies in patients in whom suicide risk is associated with using substances should emphasize safety, relapse prevention, and addressing the substance use.

v. In the effort to limit access to lethal means, pay special attention in this population to restriction of lethal means as firearms, and prescribed medication (dosage and quantities).

L. Pharmacotherapy to Reduce Risk of Suicide

1. This Guideline recommends against the use of drug treatment as a specific intervention for prevention of self-directed violence in patients with no diagnosis of a mental disorder
2. When a person expresses thoughts of self-harm or has demonstrated self-harm behavior, the patient's medication regimen [prescription drugs, over-the-counter medications, and supplements (e.g., herbal remedies)] should be reviewed for medications associated with suicidal thoughts or behavior. The continuation of such medications should be carefully evaluated and documented. (See Appendix B-3 Table: Drugs Associated with Suicidality)

M. Pharmacological Treatment to Reduce Risk for Suicide in Patients with Mental Disorders

1. Pharmacological intervention may be markedly helpful in managing underlying mental disorders and the danger of repeated or more dangerous self-directed violence.
2. All medications (prescription drugs, over-the-counter medications, and supplements [e.g., herbal remedies]) used by patients at risk for suicide should be reviewed to assure effective and safe treatment without adverse drug interactions.
3. When prescribing drugs to people who self-harm, consider the toxicity of prescribed drugs in overdose and limit the quantity dispensed or available, and/or identify another person to be responsible for securing access to medications. The need for follow-up and monitoring for adverse events should also be considered.

M1. Use of Antidepressants to Prevent Suicide in a Patient with a Mood Disorder

1. Antidepressants may provide benefit to address suicidal behavior in patients with mood disorders. Treatment for the underlying cause should be optimized according to evidence-based guidelines for the respective disorder.
2. Young adults (18-24) started on an antidepressant for treatment of depression or another psychiatric disorder should be monitored and observed closely for emergence or worsening of suicidal thoughts or behaviors during the initiation phase of treatment. [B]
3. Patients of all age groups who are managed with antidepressants should be monitored for emergence or worsening of suicidal thoughts or behaviors after any change in dosage.
4. When prescribing antidepressants for patients at risk for suicide, to pay attention to the risk of overdose and limit the amount of medication dispensed and refilled.

M2. Use of Antipsychotics to Prevent Suicide in a Patient with a Non-Psychotic Disorder

1. There is no evidence that antipsychotics provide additional benefit in reducing the risk of suicidal thinking or behavior in patients with co-occurring psychiatric disorders. Treatment for the psychiatric disorder should be optimized according to evidence-based guidelines for the respective disorder.
2. Patients who are treated with antipsychotics should be monitored for changes in behavior and emergence of suicidal thoughts during the initiation phase of treatment or after any change in dosage.
3. When prescribing antipsychotics in patients at risk for suicide pay attention to the risk of overdose and limit the amount of medication dispensed and refilled.

M3. Use of Lithium for Reducing Suicide in Patients with Unipolar Depressive Disorder

1. Lithium augmentation should be considered for patients diagnosed with unipolar depressive disorder who have had a partial response to an antidepressant and for those with recurrent episodes who are at high risk for suicidal behavior, provided they do not have a contraindication to lithium use and the potential benefits outweigh the risks. [C]
2. Lithium should be avoided or used in caution in patients with impaired renal function, those taking concurrent medications that increase or decrease lithium concentrations or those with other risk factors for lithium toxicity.
3. When prescribing lithium to patients at risk for suicide, it is important to pay attention to the risk of overdose by limiting the amount of lithium dispensed and the form in which it is provided.

M4. Use of Lithium for Reducing Suicide in Patients with Bipolar Disorder

1. Lithium should be considered for patients diagnosed with bipolar disorder who do not have contraindications to lithium as it has been shown to reduce the increased risk of suicide associated with this illness. [B]

2. Lithium should be avoided or used in caution in patients with impaired renal functions, taking concurrent medications that increase or decrease lithium concentrations or other risk factors for lithium toxicity.
3. When prescribing lithium to patients at risk for suicide, it is important to pay attention to the risk of overdose by limiting the amount of lithium dispensed, and to the form in which it is provided.

M5. Use of Clozapine in the Treatment of a Patient with Schizophrenia Risk for Suicide

1. Clozapine should be considered for patients diagnosed with schizophrenia at high risk for suicide, who do not have contraindications to clozapine, and will be compliant with all required monitoring. [C]

M6. Use Antiepileptic Drugs (AEDs) and the Risk of Suicide

1. Patients started or who are managed with antiepileptics should be monitored for changes in behavior and the emergence of suicidal thoughts.
2. There is no evidence that AEDs are effective in reducing the risk of suicide in patients with a mental disorder

M7. Use of Anti-anxiety Agents in Suicidal Patients

1. Use caution when prescribing benzodiazepines to patients at risk for suicide. It is important to pay attention to the risk of disinhibition from the medication, and respiratory depression (particularly when combined with other depressants) by limiting the amount of benzodiazepines dispensed. Avoid benzodiazepines with a short half-life and the long-term use of any benzodiazepine to minimize the risk of addiction and depressogenic effects.

M8. Use of Methadone and Naloxone to Reduce Death from Opioid Overdose

1. Methadone substitution therapy should be considered in opiate dependent patients to reduce the risk of death by overdose. (See VA/DoD Guideline for Management of SUD)
2. Providers should consider dispensing intranasal naloxone for patients with history of opioid overdose and those who are at high risk. When dispensed, patient and family or other caregiver should be educated on the use of the intranasal naloxone to treat the overdose while waiting for the emergency team to arrive.

N. Electroconvulsive Therapy (ECT) in the Prevention of Suicide

1. ECT is recommended as a treatment option for severe episodes of major depression that are accompanied by suicidal thoughts or behaviors indicating imminent risk for suicide, considering patient preferences.
2. Under certain clinical circumstances and, considering patient preference, ECT may also be considered to treat suicidal patients with schizophrenia, schizoaffective disorder, or mixed or manic episodes of bipolar disorder.
3. The decision of whether to initiate ECT treatment should follow evidence-based recommendation for the specific disorder, and be based on documented assessment of the risks and potential benefits to the individual, including: the risks associated with the anesthetic; current co-morbidities; anticipated adverse events; and the risks of not having treatment.
4. Since there is no evidence of a long-term reduction of suicide risk with ECT, continuation or maintenance treatment with pharmacotherapy or with ECT is recommended after an acute ECT course.
5. ECT should be performed by experts in centers that are properly equipped and experienced in the treatment.
6. In general, the following conditions increase the indications to use ECT:
    a. A history of prior good response to ECT

b. Need for rapid, definitive treatment response
c. Risks of other treatments outweigh the risks of ECT
d. History of poor response to medication treatment
e. Intolerable side effects to medication treatments
f. Patient preference.

7. The risk-versus-benefits ratio must be considered in patients with relative contraindications such as [B]:
    a. Space occupying lesions
    b. Elevated intracranial pressure
    c. Cardiovascular problems to include recent myocardial infarction, severe cardiac ischemic disease, or profound hypertensive illness.
    d. Degenerative skeletal disease
    e. Monamine Oxidase Inhibitors should be discontinued two weeks prior to ECT to prevent possible hypertensive crisis
    f. Lithium: patients may develop neurotoxic syndrome with confusion, disorientation, and unresponsiveness
    g. Retinal detachment
    h. Pheochromocytoma
    i. High Anesthesia Risk: American Society of Anesthesiologists level 4 or 5.

Module D: Follow-up and Monitoring of Patient at Risk for Suicide

O. Follow-Up and Monitoring of Patients

1. Establish timely and ongoing follow-up care for those who attempt suicide and others at high acute risk in the immediate period after discharge from acute care settings and identify the responsible provider during this period.
2. Patient should be re-evaluated following an inpatient or Emergency Department discharge, as soon as possible, but not later than 7 days.
3. High acute risk patient should be actively managed to assure adherence and coordinated care.
4. Patients at high acute risk should be followed closely (e.g., weekly for the first month) after they are identified or after inpatient or ED discharge.
5. Consider contacting the patient before initial follow-up appointment to monitor transition to the outpatient care plan and to reinforce adherence to the discharge plan.
6. The frequency of outpatient follow-up should be determined on a case-by-case basis. It should be greatest after attempts and related behaviors, after change in treatment, or after transitions to a less restrictive setting of care. Once the patient stabilizes and is engaged in care the frequency of follow-up can be decreased based on:
    a. The current level of risk
    b. The requirement of the treatment modality
    c. The patient's preference

Duration of Care Focused on Suicide Prevention

7. Patients who survived a suicide attempt or identified as high acute risk for suicide should be monitored for at least **one year**. Patients identified as intermediate acute risk for suicide (who have never engaged in suicidal behaviors) should be followed for at least **six months** after suicidal ideation has resolved. Patients who have been identified as low acute risk may be followed by their primary care provider and periodically re-assessed for suicide risk.

P. Reassessment and Monitoring

1. Follow-up appointments should include:
    a. Reassessment of: interim events, changes in suicide risk; symptoms of mental disorder; and medical conditions
    b. Provision of specific treatment targeting suicidality
    c. Continuation of treatment of co-occurring underlying conditions
    d. Monitoring the symptoms of co-occurring conditions
    e. Assessment of adherence and adverse effects
    f. Modification of treatment, as indicated
    g. Support, reinforcement, and update of the safety plan
    h. Addressing patient/family concerns
    i. Determination of the frequency of future follow-up

Q. Adherence to Treatment and Follow-up care Strategies

1. A follow-up care plan should be developed with input from the patient and, where appropriate, available support system (e.g., family, unit, friends), to address the treatment of conditions that may have contributed to the risk of suicide.
2. Follow-up care should be coordinated by an interdisciplinary team and communicated with the patient through a single identified point of contact.
3. Barriers to adherence to the care plan after discharge may be addressed by follow-up programs that include the use of:
    a. Telecommunications (phone, web based, v-tel) [I]
    b. Mailing multiple “caring letters” [I]
    c. Community workers reaching out to those at high acute risk
    d. Methods to enhance and facilitate access to care ("Green cards") [I]
    e. Home visits to support engagement [I]
    f. A facility-based registry of all high acute risk patients [I]

Patient Who Refuse Care

4. Patients who continue to be at risk for suicide and do not arrive to their follow-up appointment require a reassessment of risk, since not showing may demonstrate a risk behavior. The assessment should include: locating the patient and establishing contact, reassessment of level of risk, reinforcement of the safety plan, and directing the patient to the appropriate level of care.
5. If patient contact cannot be established, available data should be used to reassess the level of risk and corresponding effort should be made to locate the patient though direct contacts (e.g., next of kin), other points of available contacts (friends, peers, command), or, in cases of high acute risk, local emergency response (mobile crisis team, law enforcement).
6. Consider the use of caring letters for suicide attempters who refuse treatment. [I]
7. Home visit may be considered to support re-engagement of patients at high acute risk who discontinue outpatient care. [C]

R. Continuity of Care

R1: Coordination and Collaboration of Care

1. When patients are identified in primary care with intermediate or high acute risk for suicide they should be evaluated by behavioral health providers. Warm handoffs are helpful in ensuring that patients receive the evaluations they require without interruption.
2. All providers involved in the patient’s care must actively attempt to connect with others in the suicidal patients’ chain of healthcare (e.g., primary care) and with the

patient's consent, helping services network (e.g., chaplains) to ensure timely communication, coordination of care, and aftercare.

3. As patients are recovering from crisis and reduce their risk for suicide they may also be transitioning to less restrictive care settings, as to routine care by primary clinicians. It is the responsibility of the healthcare team to update the patient's written Safety Plan over time.

R2. Documentation of Clinical Care

1. Adequate clinical documentation of the care provided to suicidal patients is required for optimizing continuity of care. Providers must consider ethical, clinical, and legal issues when documenting their assessment, management and treatment of suicidal patients.

S. Monitoring after Recovery

1. Patients with a history of suicide attempt or behavior should continue to be evaluated for risk of relapse on a regular base

Acronyms

Acronym	Definition
AA	Alcoholics Anonymous
AAS	American Association of Suicidology
ABC	A=Activating Event; B=Beliefs; C=Consequences
ABCT	Association for Behavioral and Cognitive Therapies
ACSS	Acquired Capability for Suicide Scale
ADAPT	Alcohol and Drug Abuse Prevention and Treatment
AF	Air Force
AFGMSB	Air Force Guide for Managing Suicidal Behavior (2002)
AFIA	Air Force Inspection Agency
AFMOA	Air Force Medical Operations Agency
AFMS	Air Force Medical Service
AFSP	American Foundation for Suicide Prevention
AHLTA	Armed Forces Health Longitudinal Technology Application
APA	American Psychological Association
Army STARRS	Army Study to Assess Risk and Resilience in Service Members
ASPD	Antisocial personality disorder
BDI-II	Beck Depression Inventory II
BHC	Behavior Health Consultants
BHOP	Behavior Health Optimization Program
BHS	Beck Hopelessness Scale
BPD	Borderline Personality Disorder
CAMS	Collaborative Assessment and Management of Suicidality
CBT	Cognitive Behavioral Therapy
C-CASA	Classification Algorithm of Suicide Assessment
CDC	Center for Disease Control and Prevention
CDP	Center for Deployment Psychology
CLP	Caring Letters Project
C-SSRS	Columbia Suicide Severity Rating Scale
CT	Cognitive Therapy
DADT	Don't Ask, Don't Tell
DBT	Dialectical Behavior Therapy
DCoE	Defense Centers of Excellence
DLC	Duty Limiting Conditions
DoD	Department of Defense
DoDSERs	Department of Defense Suicide Event Reports
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders
DZ	Dizygotic Twins
E-CAU	Enhanced Care as Usual
ECT	Electroconvulsive therapy
ED	Emergency Department
FAP	Family Advocacy Programs
FDA	Food and Drug Administration
HIL	High Interest Log
HPA	Hypothalamic-Pituitary-Adrenal Axis
HSIs	Health Service Inspectors
IPT	Interpersonal Therapy

Acronyms

Acronym	Definition
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LGB	Lesbian, Gay, Bisexual
LPSP	Limited Privilege Suicide Prevention Program
LSSC	Life Skills Support Center
MH	Mental Health
MHC	Mental Health Clinics
MHP	Mental Health Provider
MI	Motivational Interviewing
MI-SI	Motivational Interviewing for Suicide Ideation
MINI	MINI International Neuropsychiatric Interview
MIRECC	Mental Illness Research Education and Clinical Center
MITI	Motivational Interviewing Treatment Integrity
MOUs	Memoranda of Understanding
MTF	Military Treatment Facility
MZ	Monozygotic Twins
OEF	Operation Enduring Freedom
OIs	Operating Instructions
OIF	Operation Iraqi Freedom
OQ-45	Outcome Questionnaire-45
OSHA	Occupational Safety and Health Administration
PACT	Post Admission Cognitive Therapy
PCM	Primary Care Manager
PCS	Permanent Change of Station
PE	Prolonged Exposure Therapy
PHQ-9	Patient Health Questionnaire-9
POP	Principles of Prevention
PTSD	Post-Traumatic Stress Disorder
RCT	Randomized Controlled Trial
RPT	Relapse Prevention Task
SAFEVET	Safety Planning Intervention for Veterans
SBQ-R	Suicidal Behavior Questionnaire Revised
SDVCS	Self-Directed Violence Classification System
SPI	Safety Planning Intervention
SPRC	Suicide Prevention Resource Center
SOAP	Subjective Objecting Assessment and Plan
SSF	Suicide Status Form
SSI	Scale for Suicide Ideation
SSRIs	Selective Serotonin Reuptake Inhibitors
TAU	Treatment as Usual
TBI	Traumatic Brain Injury
TDY	Temporary Duty Yonder
TSR	Traumatic Stress Response
USAF	United States Air Force
USUHS	Uniformed Services University of the Health Sciences
VA	Veteran Affairs
VISN	Veterans Integrated Service Network

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