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

June 27, 2014

DEPARTMENT OF THE AIR FORCE
AIR FORCE MEDICAL OPERATIONS AGENCY
SAN ANTONIO TEXAS

MEMORANDUM FOR ALMAJCOM/SG
ALMTF/CC

FROM: AFMOA/CC
2261 Hughes Ave, Suite 153
JBSA Lackland, TX 78236

SUBJECT: Air Force Guide for Suicide Risk Assessment, Management, and Treatment

The AFMS is committed to health and well-being of our population and to providing the best possible care anywhere. The Air Force Guide for Suicide Risk Assessment, Management, and Treatment addresses the strategic goals of Readiness, Better Care, and Better Health.

Since 1996, suicide prevention has been formally recognized as an organizational priority within the United States Air Force community. Suicidal behaviors impact the lives and well-being of the individual, family, and friends; they can also be detrimental to the ability of Air Force units to effectively accomplish their missions. Mental health staff members at our military installations are at the front lines assisting unit commanders and First Sergeants in the care of distressed personnel. I understand the immense challenges our teams face when suicidal thoughts and behaviors are part of the clinical presentation. Therefore, I believe that it is crucial that Air Force mental health staff members have access to the (1) most updated suicide prevention research, (2) evidence-based assessment, management, and treatment approaches, as well as (3) current resources for managing suicidal patients.

I am pleased to present you with the Air Force Guide for Suicide Risk Assessment, Management, and Treatment to help you with this responsibility to provide high quality care to individuals at risk for suicide. All MTFs are required to disseminate this guide and assure familiarity of its contents, and adapt local Operating Instructions as appropriate. The requirements in this guide are to be used by mental health providers, nurses, and technicians. The Guide will be posted on the Kx Mental Health site: https://kx2.afms.mil/kj/kx8/MentalHealth and will be updated as needed.

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PREFACE

The *Air Force Guide for Suicide Risk Assessment, Management, and Treatment* (hereafter referred to as the "AF Guide for Suicide Risk") was developed in an effort to help you as an Air Force mental health staff member navigate one of the most complex aspects of clinical practice. The AF Guide for Suicide Risk is intended for adult patient populations. In each clinical encounter, you potentially face the most critical series of consequences associated with the care you deliver and document for a suicidal patient. The quality and integrity of your work have the potential to save the precious life of a service member and/or a member of his or her family. Furthermore, your professional service has significant implications for suicide prevention efforts within the Air Force. Mental health personnel vary in the level of formal training in assessing and managing suicide risk and may feel insufficiently prepared to handle circumstances involving suicidal patients. The AF Guide for Suicide Risk pulls together state-of-the-art knowledge and best practices for the clinical management of suicide-related ideation and behaviors to make your job easier and more effective – and your impact on a suicidal patient's life and the Air Force community as a whole more positive.

This document is a clinical guide that offers valuable information and resources selected with the intent to help you provide quality care to suicidal patients. However, the ultimate responsibility for patient care decisions rests with you, the individual provider. Clinical performance is evaluated in post-suicide investigations and litigation proceedings in terms of the "standard of care." The standard of care is the accepted or correct actions of a provider, taken in order to arrive at a diagnosis or to implement treatment for a given disease, disorder, or patient problem, adjusted for the patient's presentation and other conditioning factors. The standard of care is what is generally accepted in the healthcare discipline or specialty involved as reasonable, prudent and appropriate and is determined by peer review. This document does not (and, by definition, cannot) define the standard of care and should not be used as a static or definitive "statement" of the standard of care in risk management activities, or legal investigations and proceedings. While mental health personnel are not expected to follow every clinical strategy in every case as outlined in the AF Guide for Suicide Risk, they are required to follow the Air Force's guidelines outlined on pages 4-8. Thorough documentation of reasons why any particular action was and was not taken in any specific case is critical for prospective reviewers to understand the clinician's decision-making process at the time. Clinic leaders may incorporate relevant information from this document into local clinic operating instructions (OIs).

The AF Guide for Suicide Risk is structured into five sections: (1) Suicide Risk Assessment and Management; (2) High Interest Log and Communication with Command; (3) Nomenclature, Documentation, and Common Errors; (4) Evidence-Based Interventions for Suicide Prevention; and (5) Special Considerations. Additionally, a set of appendices provide supplemental information.

Your work and dedication to suicide prevention is appreciated by the entire Air Force community. We hope that a careful review of the AF Guide for Suicide Risk will provide you with a foundation of knowledge that you can continue to build upon in the years to come. Please note that all mental health personnel are required to use the most current DoD and Air Force policies to provide optimal care for their patients.

ACKNOWLEDGEMENTS

Finally, the individuals listed below have kindly served as members of the Air Force Guide for Suicide Risk Working Group. Their collaboration, volunteered time, and diligence in reviewing the revised guide have resulted in an enhanced product that is hoped to deliver effective guidance to the Air Force mental health community and the patients they serve.

> <u>Listed in alphabetical order</u>: Lt Col John Bowers; Maj Donald Christman; Ms. Pamela Collins; Capt Andrew Hodge; Lt Col Kevin McCal; Lt Col Patrick Pohle; Capt Rabecca Stahl; Lt Col Joseph Villacis; and Lt Col Dawn Kessler Walker

Additional USAF reviewers who provided valuable input but did not serve as members of the Working Group consisted of the following:

> <u>Listed in alphabetical order</u>: Lt Col Lisa Bader; Col John Forbes; Col David Hammiel; Col Michael Kindt; Col Leslie Knight; Col Linda Lawrence; Maj Michael McCarthy; Col Susan Moran; Col Tracy Neal-Walden, Col Mark Oordt; Col Christopher Robinson; Col Jay Stone; SMSgt Michael Toreno; Lt Col Robert Vanecek

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INTRODUCTION

Suicide remains a major public health problem within the United States Air Force (USAF). From 1990-1994, rates of USAF suicides increased from 10.0 to 16.4 per 100,000, accounting for 23% of all deaths among active duty (CDC, 1999). In response to this observed rise in suicides, a population based program aimed at preventing and reducing stigma was implemented within the USAF community; a 33% relative risk reduction was found in those exposed to the program (Knox et al., 2003). Over the past decade, there have been several spikes in USAF suicide rates, with the latest observed in 2010 (15.5 per 100,000) (DoDSER, 2010). Despite this, the average suicide rate for the USAF (10.7 per 100,000) has remained the lowest among all service components from 2001-2009 and has been substantially lower than demographically adjusted civilian rates (19.2 per 100,000) for the same time period (CDC, 2012), however, it is still a concern.

Managing suicidal behaviors often results in stress and anxiety among mental health personnel (Pope & Tabachnick, 1993). Although, statistically, suicide remains a rare event, many mental health professionals are expected to experience a patient suicide sometime during their career. In fact, one in two psychiatrists and one in five psychologists will lose at least one patient to suicide (Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988; Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988). While inpatient psychiatric care may become a necessity at times of imminent risk, there is increasing evidence that outpatient management of service members with suicide-related ideation and/or behaviors can be appropriate, safe and often preferable to inpatient care (Rudd, Joiner, Jobes, & King, 1999). Adequate training and clear guidance on evidence-based suicide risk assessment and management, as well as targeted inpatient and outpatient care is expected to equip Air Force mental health personnel with the knowledge and skills required to provide solid care to distressed patients.

The USAF has tracked suicides of Airmen since the 1980s. In 1996, following an observed increase in suicide rates in the mid-1990s, the USAF established an integrated product team in order to address the public health problem of suicide and subsequently put in place the Air Force Suicide Prevention Program (DoD Task Force Report on the Prevention of Suicide by Members of the Armed Forces, 2010). Almost 6 years later, as part of the USAF's 2002 initiative to reduce suicide, the *Air Force Guide for Managing Suicidal Behavior* (AFGMSB) was established for use in outpatient behavioral healthcare settings (Oordt et al., 2005).

The four primary objectives for the AFGMSB, as described by Oordt et al. (2005) were: (1) to develop and disseminate a high quality guide; (2) to increase clinician confidence in working with suicidal behavior; (3) to encourage care consistent with empirical findings; and (4) to have clinics establish procedures consistent with recommendations within the guide. Development of the guide relied on a review of empirical research, existing professional guidelines, suicide risk assessment tools, organizational standards, lessons learned from past suicides, and feedback from potential users. Since its inception, the USAF has used this guide to train its behavioral healthcare personnel (Oordt et al., 2009).

In an evaluation study of the training, Oordt and colleagues (2009) reported that the guide and its 18 recommendations were used as the outline for training on suicide risk assessment and management. Trainees were given the guide and it was used in conjunction with didactic and interactive components. Training was divided into three sections: (1) assessment of suicide

risk; (2) management of suicidal behavior; and (3) military specific applications and other issues. Via a pre-, post-, and six-month evaluation, Oordt and colleagues found significant increases in the number of trainees who reported greater levels of confidence in suicide assessment, in managing suicidal patients, in changing practices for suicide management, and changing clinic policy. The evaluation study cited here highlighted the value of creating guidelines for the assessment and treatment of suicidal individuals within the USAF community.

When managing suicide-related ideation and behaviors, Air Force mental health providers are first responsible for conducting a timely and competent assessment of risk. They support unit leadership in managing personnel who are recognized to be at increased risk for suicide, and they provide consultation on issues that may impact the organization and its mission. Second, mental health professionals are responsible for facilitating and/or providing appropriate evidence-based care. Historically, mental health professionals have received variable levels of formal training on the first task (Bongar & Harmatz, 1989, 1991; Ellis & Dickey, 1998) and little to no guidance on the second. Most learning related to suicide management has occurred "on the job."

The AFGMSB has served as the basis of training for Air Force mental health personnel and allowed for a standardized evidence-based set of practices. However, over the past decade (since the 2002 dissemination of the original AFGMSB), the research in the field of suicidology, organizational knowledge about best practices in suicide prevention, as well as DoD's policies, programs, and resources have continued to evolve. The revised 2013 version of the AFGMSB, titled "Air Force Guide for Suicide Risk Assessment, Management, and Treatment," is a result of collaboration among the Laboratory for the Treatment of Suicide-Related Ideation and Behavior at Uniformed Services University of the Health Sciences, the Air Force Medical Operations Agency, and the Air Force Suicide Prevention Program which is managed through the Air Force Medical Support Agency. In addition, feedback from civilian and military subject matter experts and a number of Air Force mental health providers has very much shaped the updated version.

The purpose of the revision has been twofold: (1) to update the existing AFGMSB based on a decade's worth of scientific suicidology literature, organizational knowledge about best practices in suicide prevention, as well as DoD's policies, programs, and resources; and (2) to provide a guide for the cognitive behavioral treatment of suicidal patients which was not included in the original 2002 version. The updated guide is expected to make a significant contribution to the training of Air Force mental health personnel and the quality of care provided to suicidal patients as well as to consultation practices and support to units and leaders. To reiterate, this Guide does not create a new standard of care; such standards already exist. The goal of this Guide is to assist all Air Force mental health personnel in meeting or exceeding these existing standards.

The 2013 Air Force Guide for Suicide Risk applies to the Outpatient Specialty Mental Healthcare Settings including Mental Health Clinics (MHC) and Alcohol and Drug Abuse Prevention and Treatment (ADAPT). Mental health related services that have a unique mission, such as the Behavioral Analysis Service at Air Force Basic Military Training, Behavior Health Optimization (BHOP) and Family Advocacy Programs (FAP), may find that some sections do not apply. For instance, specific guidelines about the types of suicide screening and risk assessment instruments to be used at every Air Force mental health clinic and ADAPT setting are provided in this Guide but are not mandated for use in other programs such as BHOP and FAP, but should be considered as appropriate.

Similar to the work conducted on the original AFGMSB, the following sources have been consulted to prepare the *Air Force Guide for Suicide Risk Assessment, Management, and Treatment (2013)*:

- ☑ Empirical literature from well-designed studies
- ☑ Professional guidelines and codes of ethics
- ☑ Suicide risk assessment tools and manuals
- ☑ DoD/VA suicide nomenclature guidelines
- ☑ Representative sample of Air Force mental health personnel
- ☑ Civilian and military subject matter experts
- ☑ Recognized organizational standards from Air Force Instructions and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- ☑ New DoD instructions related to mental health care delivery
- ☑ Lessons learned from Air Force suicides and civilian malpractice litigation
- ☑ Postvention literature and views shared by military suicide survivors
- ☑ DoD 2010 Task Force Report on the Prevention of Suicide by Members of the Armed Forces
- ☑ DoD Suicide Event Reports (DoDSERs)
- ☑ Best Practices Registry for Suicide Prevention
- ☑ VA/DoD Clinical Practice Guideline for Assessment and Management of Patients At Risk For Suicide (2013)

In summary, the updated 2013 Air Force Guide for Suicide Risk is expected to equip you with the knowledge, assessment and intervention tools, as well as the professional guidance needed to optimize the quality of care you provide to each suicidal patient, his or her dependents, as well as to military units and leadership. A new section on self-care and professional burnout has also been included to ensure that you continue to consult with peers and maintain your psychological health as you provide services to patients.

AIR FORCE GUIDELINES FOR SUICIDE RISK ASSESSMENT, MANAGEMENT, AND TREATMENT

An executive summary of the critical suicide risk assessment, management, and treatment guidelines is provided below. These clinical practice guidelines are required for implementation at all Air Force Mental Health Clinics (MHC) and Alcohol and Drug Abuse Prevention and Treatment (ADAPT) programs. Air Force mental health personnel must complete a thorough review of the guide and over time, establish a working knowledge of its various sections. The guidelines summarized here serve as a Quick Reference and may be used as a checklist to ensure that you have completed all that is required of you to best take care of a suicidal patient. Please note that the documentation templates and checklists, as presented in Appendix E (i.e., intake and follow-up visit notes, High Interest Log/Hospitalization Checklist, High Interest Treatment Team Meeting, and Multidisciplinary Clinical Case Conference) are required to be completed. AFMOA regularly updates these templates and checklists – the most current versions can be found at: https://kx2.afms.mil/kj/kx8/MentalHealth/Pages/home.aspx

Suicide Risk Screening – Initial and Follow-Up Mental Health and/or ADAPT Visits

☐ Administer the Patient Health Questionnaire-9 (PHQ-9) as a screening tool at **every mental health visit**. Check the total PHQ-9 score and responses to each item before your face-to-face contact with the patient. The usage of PHQ-9 at every visit is required.
  ☐ If the patient receives a score of 1 (several days), 2 (more than half the days), or 3 (nearly every day) on the PHQ item #9 (*Thoughts that you would be better off dead, or of hurting yourself in some way*), conduct a comprehensive suicide risk assessment. As clinically indicated, ensure that your comprehensive suicide risk assessment is based on a solid clinical interview, the Suicide Status Form (SSF-II-R or SSF-III), and collateral information. Other empirically supported suicide risk instruments may be selected and utilized in addition to the required instruments noted here. Following a positive screen on the PHQ item #9, and/or collateral information indicating suicide risk, the usage of SSF-II-R or SSF-III is required. If you determine that the use of the SSF-II-R or SSF-III is not clinically indicated during this patient encounter, then document the rationale for why this action was not taken.
  ☐ Directly ask about past and/or current suicidal ideation and behaviors during (1) each intake, (2) in cases where the patient is on the High Interest Log, and/or (3) as clinically indicated. This must happen regardless of the score the patient receives on the PHQ item #9. If the patient reports any information that in your clinical judgment is indicative of suicide risk, conduct a comprehensive suicide risk assessment based on a solid clinical interview, complete the SSF-II-R or SSF-III, and collect collateral information as clinically indicated. Other empirically supported suicide risk instruments may be selected and utilized in addition to the required instruments noted here. If the provider determines the use of the SSF-II-R or SSF-III is not clinically indicated for this patient encounter, then the provider will make sure to document the rationale for why this action was not taken. If the patient denies suicide risk on the PHQ-9, verbally during intake appointments, and there is no collateral information indicating suicide risk, then there is no requirement to document the rationale for using the SSF-II-R or SSF-III.

☐ For intake evaluations, collect information on the following 5 suicide risk assessment domains: (1) suicide-related ideation and/or suicide-related behaviors AND intent/plan; (2) warning signs; (3) risk factors; (4) protective factors; and (5) other clinically relevant information. Update this information for Follow-Up visits as appropriate.

Suicide Risk Assessment

☐ Administer the Suicide Status Form (SSF-II-R or SSF-III) as a suicide risk assessment tool anytime you become aware of the presence of suicide risk. As clinically indicated, ensure that your comprehensive suicide risk assessment is based on a solid clinical interview, the Suicide Status Form (SSF-II-R or SSF-III), and collateral information. Other empirically supported suicide risk instruments may be selected and utilized in addition to the required instruments noted here. Once this form has been administered to a patient, the Suicide Tracking Form (STF) located in Appendix B can be used for subsequent encounters. The use of the STF is appropriate until its use is determined to no longer be clinically indicated and the rationale for discontinuing its use is documented.

☐ The Suicide Status Form provides the following risk levels: (1) No Significant Risk, (2) Mild, (3) Moderate, (4) Severe, or (5) Extreme. However, you are expected to use the Air Force risk levels, as presented in this Guide, for all of your documentation: (1) Not Currently at Clinically Significant Suicide Risk, (2) Currently at Clinically Significant Suicide Risk, But Not Imminent, or (3) Currently at Clinically Significant Suicide Risk, Imminent.

Determination of Suicide Risk

☐ Make an informed decision about suicide risk based on available data from all sources, your clinical judgment, and consultation with colleagues as needed. Remember that you are making a risk determination at the time of the evaluation. Risk may change as soon as the patient leaves your office.

☐ Be clear about your specific rationale for classifying risk into one of the three following levels. Document the degree of risk at each encounter. Provide supporting data or clinical information for your rationale.
   (1) Not Currently at Clinically Significant Suicide Risk
   (2) Currently at Clinically Significant Suicide Risk, But Not Imminent
   (3) Currently at Clinically Significant Suicide Risk, Imminent

Communication with Command

☐ Review and understand DoD Instruction 6490.08 and AFI 44-172.

☐ Document communication with command and discuss with suicidal service member, if clinically appropriate.

☐ In terms of Duty Limiting Conditions (which can include restrictions for military occupation, mobility, and/or fitness), follow AFI 10-203 and document all profiles within the clinical note.

Documentation for Suicide Risk Screening and Assessment

- ☐ Ensure that the screening and assessment information are entered accurately and match the date of the current appointment and do not contain artifacts from previous appointments.
- ☐ Pay close attention to language used to describe suicide-related information.
- ☐ At a minimum, include the following in your documentation:
    - ☐ Your Clinical Observations & Relevant Mental Status Information
    - ☐ Methods of Suicide Risk Assessment
    - ☐ Brief Evaluation Summary
        - ☐ Warning Signs; Risk Indicators and Protective Factors
        - ☐ Access to Lethal Means
        - ☐ Collateral Sources Used & Relevant Information Obtained
        - ☐ Suicide Risk Category & Specific Data to Support Risk Determination
        - ☐ Rationale for Actions Taken and Not Taken
    - ☐ Provision of Military Crisis Line 1-800-273-TALK (8255)
    - ☐ Implementation of Crisis Response Plan (If Applicable)

Clinic Support and Peer Consultation

- ☐ Use a "High Interest Log" IAW AFI 44-172 as a clinical tracking procedure for patients who are identified at risk for suicide AND share this information among relevant specialty mental health clinics and primary care managers.
- ☐ Consult local professional peers (e.g., other providers within your flight) regularly regarding clinical work with suicidal patients and document the consultation. External consultations with your MAJCOM Behavioral Health Consultant can be utilized, if needed.
- ☐ Set up a peer consultation group and/or seek supervision as needed to promote self-care and to reduce professional burnout.

High Interest Log (HIL)

- ☐ Review AFI 44-172.
- ☐ Use HIL checklist and associated forms, as presented in the Appendices. (*Note.* All checklists and forms may change due to DoD and Air Force policy)
- ☐ A treatment team meeting must be conducted with the patient and the patient's Commander and/or First Sergeant.

Management of Patients Classified as "Currently at Clinically Significant Suicide Risk, Imminent"

- ☐ Listen. Show empathy.
- ☐ Do not immediately suggest psychiatric hospitalization before completing a full assessment.
- ☐ Gather and consider all factors to support psychiatric hospitalization *before* presenting rationale to patient.
- ☐ Explain your rationale to the patient for hospitalization.
- ☐ Initiate local admission process, whether to emergency department or directly to inpatient unit or other higher level of care.
- ☐ Educate the patient about what to expect as a result of the referral (e.g., potential work impact [DLC-AF 469, deployment or work restrictions], psychiatric hospitalization experience) and contact command.

- ☐ Make plans for transfer to higher level of care. Be prepared to provide documentation of your assessment and the need to hospitalize to the treating facility.
- ☐ Do not leave patient alone until transfer has occurred.
- ☐ Remove and/or restrict access to lethal means (if applicable and feasible).
- ☐ Follow-up with ED physician AND document results of ED psychiatric evaluation (if admitted to ED with psychiatric evaluation) or follow up with attending physician from the inpatient unit when applicable.
- ☐ Communicate with chain of command.
- ☐ Place patient's name on the Mental Health Clinic's High Interest Log.

Coordination with Inpatient Care

- ☐ Before a patient's discharge from psychiatric hospitalization, obtain updates on the status of the patient, weekly at a minimum (or at least one contact for hospitalizations less than 1 week), and more frequently, as appropriate.
- ☐ Work with the inpatient team to have the service member discharged to his/her command AND try and prevent weekend or end of the day discharges.
- ☐ In collaboration with the inpatient treatment team, coordinate a process for transition to outpatient care.
- ☐ Your follow-up appointment with the patient should be on the same day of discharge from an inpatient/partial psychiatric hospitalization but must be no later than the next duty day after noted discharge. In the rare occasion that this cannot happen, document the reason(s).
- ☐ For instances where the patient is discharged on the weekend, the on-call mental health provider will consult with the Commander or First Sergeant to create a plan f patient safety.
- ☐ Obtain a copy of the discharge summary and review it for continuity of care purposes.
- ☐ Re-evaluate patient's clinical needs in order to resume or initiate outpatient mental health care. Update the patient's profile appropriately IAW AFI 10-203 FI 10-203. Consider documenting any treatment needs and duty restrictions in written form for the patient.

Delivery of Evidence-Based Inpatient Care

- ☐ Pay attention to all "outpatient" care suggestions listed on page 8.
- ☐ Educate the patient about self-care and the importance of connecting with aftercare following discharge from hospital.

Links with the Community

- ☐ Establish a written plan for after-hours evaluations. Ensure that other relevant agencies and individuals (e.g., Security Forces, First Sergeants) are aware of the plan.
- ☐ As a mental health staff member, you are a primary resource within the base community. Make sure to serve as a consultant to unit leadership regarding the management of at-risk personnel.
- ☐ Consult with community support resources (e.g., chaplains) as needed to enhance care for suicidal patients.

Ensuring Continuity of Care

- ☐ Ensure clinical coverage when the primary mental health provider is unavailable.
- ☐ Establish a procedure for ensuring continuity of care during provider and patient transitions.

Delivery of Evidence-Based Outpatient Care

- Emphasize a collaborative approach to understanding the reasons for living and dying.
- Continually monitor mood, agitation, hopelessness, and overall suicide risk.
- Consult with primary care physician and/or other medical personnel.
- Actively engage in safeguarding the environment and limiting access to lethal means. Initiate command involvement and provide consultation, as needed, on removal and return of lethal means.
- Target suicide-related ideation and/or behaviors *directly* in your treatment plan AND document progress or lack of progress (specify reasons).
- Consider the following in your conceptualization and treatment plan:
    - Hopelessness (Reasons for Dying > Reasons for Living)
    - Perceived Burdensomeness
    - Affect and Emotion Regulation Skills
    - Perceived or Actual Lack of Social Support OR Inadequate Utilization of Existing Social Support Network (e.g., Thwarted Belongingness)
    - Coping Strategies, Self-Efficacy, Problem-Solving Skills
    - Motivation and Readiness for Change
- Discuss possible obstacles associated with treatment compliance.
- Understand culture- and military-specific factors to maximize treatment engagement.
- Use evidence-based treatment strategies and clinical practice guidelines to provide care for the suicidal patient. Review the following as you plan for treatment:
    - Agree upon a plan to manage suicidal crises, collaboratively prepare a written crisis response plan, and assess the likelihood that the patient will comply with the plan. Consider reasons for living and reasons for dying. Implement strategies to build hope and reasons for living. Provide a copy of the plan to the patient. Encourage the patient to share a copy of the crisis response plan with a trusted work colleague, significant other, and/or family member.
    - Ask the patient to give a detailed account of his or her suicide "story." This discussion will give you an opportunity to build and/or strengthen rapport. In addition, information obtained will help you complete a case conceptualization and target the suicide mode (e.g., precipitants, maintaining factors, and patterns associated with suicide related ideation and/or behaviors.).
    - Promote linkage and compliance with other medical and/or psychiatric care.
    - Use strategies to build hope for the future.
    - Teach and practice skills (e.g., problem solving, emotion regulation).
    - Address impulsivity.
    - Focus on relapse prevention.
    - Offer additional sessions and resources as needed.

Addressing Treatment Non-Compliance

- Reach out to the patient and consider involving family members, friends, their PCM, and/or command when appropriate to maximize treatment engagement. In cases of non-compliant active duty HIL patients, you must involve command.
- Problem-solve obstacles, address issues related to stigma, and perceived barriers to care.
- Ensure AHLTA documentation for missed sessions, dropping out of treatment prematurely, medication non-compliance, and/or other instances indicative of poor treatment engagement.

SECTION 1

SUICIDE RISK ASSESSMENT AND MANAGEMENT

A comprehensive suicide risk assessment is one of the best strategies for managing risk and preventing suicide among those who seek mental health services and should be based on a solid understanding of all elements contributing to a patient's suicide ideation and/or behavior. This section provides:

- ☑ An overview of suicide risk assessment strategies, including guidance on when to assess for suicide, specific recommendations for what to assess, and methods for gathering information
- ☑ A listing of psychometrically validated suicide risk screening and assessment tools
- ☑ Levels of suicide risk
- ☑ Two procedural checklists on determining suicide risk level and how to best intervene

1.1 Suicide Risk Assessment

A suicide risk assessment is one of the best strategies for preventing suicide among those who seek mental health services. First, a suicide risk assessment, when done correctly, can generate useful information for assessing the imminence of suicide risk. Second, a suicide risk assessment allows for the monitoring of risk at the time of the evaluation and over time. Third, the information gained through a suicide risk assessment serves as the foundation for subsequent suicide risk management and treatment. Finally, a suicide risk assessment can serve the function of deescalating risk simply by having the patient feel more socially connected, understood, and hopeful about treatment options. This section provides a brief overview of suicide risk assessment strategies.

A suicide risk screening is an integral part of a suicide risk assessment and must be completed at every mental health contact.[2] In fact, Air Force mental health clinics and ADAPT programs will screen for suicide risk by administering the Patient Health Questionnaire-9 (PHQ-9) as a screening tool at every visit. Total PHQ-9 scores and responses to each item must be checked before each face-to-face encounter with the patient. If the patient receives a score of 0 (not at all) on the PHQ item #9, the provider will directly ask about past and/or current suicide ideation and behaviors during the face-to-face meeting with the patient. If the patient reports any information that in the clinical judgment of the provider is indicative of suicide risk, use of the SSF-II-R or SSF-III is required. If use of the SSF-II-R or SSF-III is not clinically indicated, then the provider will document the rationale for why this action was not taken. Reminder: Please use the AF Risk Levels and not the ones listed on the SSF-II-R, SSF III, or STF.

If the patient receives a score of 1 (several days), 2 (more than half the days), or 3 (nearly every day) on the PHQ item #9 (*Thoughts that you would be better off dead, or of hurting yourself in some way*), the provider must conduct a suicide risk assessment to include a solid clinical interview, the Suicide Status Form (SSF-II-R or SSF-III), and collateral information if appropriate. In cases where a suicide risk assessment was completed in a previous session, the provider completes a suicide risk re-assessment as clinically indicated (i.e., interview to understand the current clinical presentation, use of the appropriate the Suicide Status Form [SSF-II-R or SSF-III/Suicide Tracking Form (STF)], and collateral information as needed). If use of the SSF-II-R or SSF-III is not clinically indicated, then the provider will document the rationale for why this action was not taken. Use of the SSF-II–R, SSF III and STF is not required when the patient does not screen positive for or is otherwise absent of suicide risk. Other empirically supported suicide risk instruments may be selected and utilized in addition to the required instruments noted here.

For patients with a history of suicide ideation and/or behaviors, a suicide risk assessment (in addition to a suicide risk screening) and/or re-assessment is recommended, as clinically indicated. For example, if a patient has a history of suicide ideation, but does not screen

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[2] Expert suicidologists recommend that questions about suicide be asked at every clinical encounter similar to the way patients have their temperature and blood pressure measured at every medical visit. To date, there are no research studies that examine the relationship between suicide screening at every session and favorable treatment outcomes for all types of patients. However, given expert opinion, suicide risk must be routinely assessed for all patients, particularly those with histories of suicide-related ideation and/or behaviors at every session.

positive on a PHQ-9, it is up to the provider's clinical judgment to determine if a suicide risk assessment or re-assessment with the use of the SSF-II-R, SSF-III, or STF is needed. Additional circumstances that may warrant a suicide risk assessment include the following: (1) observations by command, military peers, and/or significant others that indicate some level of suicide risk (e.g., agitation and lack of sleep); (2) any suicide ideation, intent, and/or planning via oral and/or written communication (e.g., mention of the wish to die to one's wife); (3) observed warning signs of suicide (e.g., giving away all belongings); (4) worsening mental status (e.g., active psychosis); (5) onset of acute stressor (e.g., legal charges); and/or (6) recurrence of an event that has previously precipitated a suicide-related incident (e.g., anniversary of the end of a significant relationship). Other situations may also necessitate a suicide risk assessment. Staff members are encouraged to use clinical judgment and consult with colleagues when making decisions about suicide risk assessment.

What to Assess: Five Recommended Domains

A comprehensive suicide risk assessment should be based on a solid understanding of all elements contributing to a patient's suicide ideation and/or behavior. Mental health personnel must not rely on a single indicator to determine a patient's risk for suicide. Ideally, three sources of information can be used for the suicide risk assessment determination: (1) clinical interview with the patient where he or she is asked direct questions about past and current suicide thoughts, intent, and plan as well as risk and protective factors; (2) psychometrically sound psychological measures (e.g., self-report and/or clinician administered) given to the patient to directly assess for suicide risk[3]; and (3) collateral data from military unit, peers, medical records, and/or family environment if available and the proper releases (if needed) are obtained. For the purposes of this Guide, content to be gathered during suicide risk assessment is divided into the five domains shown in Table 1.1.

Table 1.1 Suicide Risk Assessment Domains

Domain	Suicide Risk Assessment Focus	Refer to Pages
1	Suicide-Related Ideation and/or Behaviors AND Intent/Plan	11-12
2	Warning Signs	12-13
3	Risk Factors	13-14
4	Protective Factors	14
5	Other Clinically Relevant Information	14

Domain I. Suicide-Related Ideation and/or Behaviors AND Intent/Plan

Every initial clinical meeting must include a preliminary screen for suicidality. Providers use the screening self-report instrument, the Patient Health Questionnaire-9 (PHQ-9). Other instruments such as the Outcome Questionnaire (OQ-45) or the Suicidal Behavior Questionnaire-Revised (SBQ-R) may also be used in addition to the required instruments noted here. See Appendix A and C for a brief guide to these instruments. The Suicide Status Form (SSF-II-R or SSF-III, see Appendix B), as a targeted suicide risk assessment instrument, must also be used after any clinical determination of suicide risk. The Suicide Tracking Form (STF) may be used to track and document for follow-up appointments after suicide risk has been

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[3] Note that the administration of PHQ-9 at all mental health and ADAPT visits is required. The usage of SSF-II-R or SSF-III after any clinical determination of suicide risk is required.

identified and assessed. A clinical interview, consultation with current and/or previous providers, as well as a check for collateral information (if attainable) can additionally provide a strong foundation for a well-conducted suicide risk assessment. Additional tools such as the Columbia-Suicide Severity Rating Scale, Screen Version with Triage Points (C-SSRS, Screen; see Appendix C) would be helpful to consider. Regardless of the method of assessment used[4], the following information must be collected:

- ☐ Suicide-related ideation and/or thoughts about death and dying, both in session and during the period since last appointment (or past 2 weeks, if first session).
  Frequency, duration, intensity, cognitions, associated images, active versus passive
- ☐ Suicide intent
  Extent of wish to die, likelihood of acting on suicidal urges, reasons for dying, timeframe
- ☐ Suicide plan
  When, where, how, availability and lethality of means, motivation, planning, rehearsal
- ☐ Suicide-related behaviors
  Specifics of behavior, e.g., "How many pills did you take?" or "Did you load the gun?"
- ☐ History of suicide-related ideation and/or behaviors
  Recency, frequency, and intensity

Mental health personnel are encouraged to differentiate between passive ideation and active desire or intent to die. Do not assume that a patient's statements about passive suicidal thoughts indicate low levels of risk requiring no further probing. Follow up by inquiring about intent, planning, and related behavior(s).

Domain II. Warning Signs

In 2005, an American Association of Suicidology (AAS) working group (Rudd et al., 2006) identified by consensus a set of suicide *warning signs* to differentiate them from *risk factors*. Specifically, they defined warning signs as proximal, related to functioning, and associated with near-term (minutes to hours to days) risk rather than acute (days to weeks) or longer term (years) risk (Rudd, 2008). The working group stated that recognizing warning signs is essential to determining risk. **"Warning signs help to answer the critical question: what is my patient doing (observable signs) or saying (expressed symptoms) that elevates his or her risk to die by suicide in the next few minutes, hours, or days?"** (Rudd, 2008, p. 88) Risk factors, by contrast, are more distal to suicide ideation and behavior. Although they do provide valuable clinical information, risk factors alone do not provide enough information for a thorough risk assessment. The AAS working group presented the warning signs in a hierarchical fashion, with signs of overt risk at the top of the hierarchy. Mental health personnel can assess for the following high-level warning signs of imminent risk through screening measures, clinical interviews, or collateral information and must address them immediately upon identifying them by asking specific questions and making plans to secure the patient's safety:

Higher-Level Warning Signs
- ☐ Threats of harming or killing self
- ☐ Seeking means, such as access to weapons or pills
- ☐ Talking or writing about death, dying, or suicide
- ☐ Giving away personal belongings[5]

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[4] Reminder: Do not rely on a single method.

[5] Not mentioned in the Rudd et al., 2006 or Rudd, 2008 papers as higher level warning sign – however, the AF Guide writing group inserted this warning sign to emphasize its importance.

Other behaviors were identified by the working group (Rudd et al., 2006) as less severe warning signs, but which nevertheless indicate elevated risk that must be clinically addressed. Mental health personnel are encouraged to factor these signs into the determination of the patient's risk level. You can assess for the following lower-level warning signs of imminent risk through screening measures, clinical interviews, or collateral information and must immediately address them when identified by asking specific questions and making plans to secure the patient's safety:

Lower-Level Warning Signs

"An overlap may exist between many identified risk factors and warning signs for suicide. All warning signs for suicide identified to date have been identified previously as risk factors." (Rudd, 2008)

- ☐ Hopelessness
- ☐ Rage, anger, seeking revenge
- ☐ Acting Reckless or engaging in risky activities[6]
- ☐ Feeling trapped
- ☐ Increased alcohol or drug use
- ☐ Withdrawing from friends, family, society
- ☐ Anxiety, agitation, insomnia, hypersomnia
- ☐ Dramatic changes in mood
- ☐ No perceived reason for living or sense of purpose

Suicide warning signs wallet cards are available at no cost from the Substance Abuse Mental Health Services Administration http://store.samhsa.gov/product/Suicide-Prevention-Learn-the-Warning-Signs/SVP13-0126

Domain III. Risk Factors

Understanding empirically derived suicide risk and protective factors is crucial for the assessment and identification of risk level as well as subsequent clinical care of suicidal patients. In the past decade, there has been substantial research on risk indicators for suicide-related ideation and behaviors among military personnel and veterans. Please note that a comprehensive review of suicide risk and protective factors is beyond the scope of this Guide; however, as a resource we have provided a brief summary of research results on these risk factors in Appendix H.

In addition to recognizing warning signs of imminent self-harm presented above, knowing the unique risk profile of your patient is essential to assessing his or her risk for suicide. You can gather information about risk factors through screening instruments, a clinical interview, assessment instruments, or collateral sources. As you conduct your risk assessment, consider the following:

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[6] Criminal behavior has been noted by a number of Air Force Guide for Suicide Risk Working Group members as an important warning sign.

- *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; Posttraumatic Stress Disorder (PTSD) or other anxiety disorders; sleep disorder(s); substance-related disorder(s); family history of suicide and/or psychiatric illness; psychotic disorder(s).
- *Psychological Characteristics:* Hopelessness; thwarted belongingness; perceived burdensomeness; acquired capability for suicide; impulsivity, problem-solving deficits, shame, guilt.
- *Psychosocial Stressors:* Intimate relationship problems; legal or financial problems; work-related problems; lack of social support.
- *Physical Injury or Illness:* Traumatic brain injury; other physical injury; chronic pain; other medical problems.
- *Other Risk Factors:* Access to lethal means; exposure to traumatic events; history of physical, emotional, and/or sexual abuse; mental health stigma and perceived barriers to care; sexual orientation, local cluster of suicides with possible contagion.

Domain IV. Protective Factors

Comparatively little research has been conducted on factors that protect individuals against suicide-related thoughts and behaviors and even less on protective factors among military personnel. Nevertheless, protective factors are important and must be taken into consideration when determining a patient's risk for suicide and your strategies for managing and treating suicidality. You can gather information about protective factors through screening instruments, a clinical interview, assessment instruments, or collateral sources. For a brief summary of research results on protective factors, please see Appendix H. As you conduct your risk assessment, consider the following:

- *Psychiatric History and Status:* Compliance with psychiatric medication; engagement in evidence-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 relationship with partner; children; social support and community involvement (e.g., friendships, strong family connections, military unit support, positive leadership, institutional support).
- *Physical Injury or Illness:* Medical compliance; access to care; support for help seeking.
- *Other Protective Factors:* Restricted access to lethal means; religion/spirituality, crisis response or other related training.

Domain V. Other Clinically Relevant Information

In addition to what has been mentioned within each of the four domains listed above, the following patient information is also important for a comprehensive suicide risk assessment:

- Current mental status (especially evidence of a thought disorder)
- Psychiatric and medical treatment history
- Current and past medications (for treatment compliance and evidence of stockpiling)
- Individual strengths and vulnerabilities
- Overall clinical impression of the patient's risk for suicide

Methods for Gathering Information

Methods for gathering information varies with the individual patient and the care setting. Do not rely on a single source of information to determine a patient's risk for suicide. Gathering information from two or more sources may provide a thorough understanding of patient's issues and level of risk. Methods for gathering information covered below include (1) preliminary screening, (2) initial clinical interview, (3) collateral information, (4) empirically supported risk assessment instruments, (5) peer consultation, and (6) brief ongoing suicide risk assessment.

Preliminary Screening

Suicide screening can be accomplished for all patients with a single instrument, Patient Health Questionnaire (PHQ-9), followed by further evaluation for those who screen positive. Clinics can utilize all levels of staff (providers, nurses, technicians) to accomplish preliminary screening. Of course, other suicide risk screening tools may be used as well within AF mental health clinics and ADAPT – however, the usage of PHQ-9 is required. Risk assessment falls within the scope of practice of privileged mental health care providers. Thus, any patient who screens positive on the PHQ-9 must be referred to a mental health provider for a full risk assessment.

Initial Clinical Interview

A clinical interview must always be part of any suicide risk assessment strategy. Although using multiple sources is the best approach, it is possible to gather all essential information for a suicide risk assessment in a clinical interview if it is the only feasible source. Even if you plan to use empirically supported assessment instruments, follow up with open-ended questions about the patient's current circumstances and/or crisis. This facilitates development of a positive alliance and you begin to form a conceptualization of the patient and determine which areas may need additional assessment. In addition to asking about suicide ideation, intent, and behavior, it would be important to understand the immediate triggers and underlying issues that are contributing to the patient's suicidal thoughts. Beginning to build a conceptualization of the patient's suicidal thoughts and behaviors from the first session will help you determine risk level as well as suicide management and treatment strategies. By asking questions straightforwardly and working collaboratively with the patient you will both gain a better understanding of the "functional role" that suicide holds for the individual.

Rapport building is a critical initial and ongoing strategy. Service members and beneficiaries presenting for mental health care may be reluctant to report suicidality and thus underreport ideation or behavior, or they may be concerned about not being taken seriously and over-report symptoms. Patients may be more open about disclosing suicide ideation if they feel the provider is empathetic and collaborative. Developing a rapport then, is obviously an essential factor in gaining his or her trust and candor. Shea (2002) offered several assessment tips:
> ➢ Be aware of subtle hesitation or other verbal/nonverbal cues in the patient's responses.
> ➢ Inquire about any body language that signals patient anxiety or discomfort.
> ➢ Avoid body language that may indicate your discomfort in talking about suicide.
> ➢ Be aware of your emotional responses to the patient during the interview process.

During suicide risk assessment, providers may experience emotional responses such as confusion, anxiety, and anger that can detract from the process and damage rapport. It is important to identify and manage these reactions so they do not interfere with your ability to

gather information or build trust with the patient. Ellis and Newman (1996) made the following recommendations for providing a non-threatening, supportive environment:

➢ Remain calm. Be attentive. Be forthright and confident.
➢ Use a collaborative approach to understand the patient's suicidality.
➢ Do not avoid using the word *suicide.*
➢ Do not express anger, exasperation, or hostile passivity.
➢ Model hopefulness.
➢ Do not immediately suggest hospitalization.
➢ Fully explore all options for care.

Collateral Information

Mental health personnel should seek out collateral information and incorporate it into the assessment where possible and use appropriate consent forms for release of information. Communication with command for command-directed assessments or high-interest-log patients is discussed in Section 2. Even for patients who are not in either of these categories, talking with those who know the patient can provide valuable information that may not be attainable in a clinical interview. In cases of imminent risk, patient confidentiality can be broken for such contact. In cases of non-imminent risk, clinical judgment and consultation can be used to make decisions about whether or not confidentiality may be broken – in such cases, only the information needed should be shared with involved parties to facilitate the current emergent situation and to maximize patient safety. Contacting family members, unit members, patient's Commander and/or First Sergeant, or unit chaplain can provide useful information for the clinical decision making process. It is important to discuss with the patient the benefit of speaking with these individuals to provide a comprehensive evaluation and therefore the most effective treatment. Collateral information can aid in determining risk level, as well as deciding treatment options. Ask the patient about others (in his or her life) who might be able to offer more information for a comprehensive evaluation and for permission to contact them using the appropriate consent forms for release of information. Also obtain treatment history, including past mental health and medical records, when applicable, using appropriate consent forms for release of information. Some patients may choose not to provide consent to obtain collateral information from others or some circumstance may not allow for the collection of collateral information. The provider should document information on these matters, in the note.

Empirically Supported Risk Assessment Instruments

A broad range of suicide-specific assessment instruments are available to assist mental health personnel in assessing risk for suicide. The instruments presented in Tables 1.2, 1.3, and 1.4 are mentioned[7] because they meet accepted psychometric standards of quality assessment tools, are sufficiently brief for clinical use, and some have been used in Air Force clinics. These instruments can be completed before or during the initial session or for ongoing tracking or re-assessment of suicidality. At a minimum, Air Force mental health clinics and ADAPT programs

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[7] Please note that the AF Guide for Suicide Risk mandates the usage of PHQ-9 at every visit as a screening tool and the usage of SSF-II-R or SSF-III at every instance where a suicide risk assessment is necessary. Solid coverage of additional screening and risk assessment instruments are provided here so that AF mental health personnel and clinics can make informed choices about additional tools to be used in the context of suicide screening and risk assessment. Please note that copies of instruments with no copyright-related issues and/or direct permission from author(s) have been provided in the appendices. Copyrighted instruments can be obtained directly from the sources listed in Tables 1.2, 1.3, and 1.4.

are mandated to use the Suicide Status Form (SSF-II-R or SSF-III) at any time when suicide risk is clinically indicated (e.g., based on the results of the PHQ and/or through a clinical interview with the patient). Please note that virtually no data support the idea that suicide risk assessment instruments can predict suicidal acts. As with all assessment instruments, data from suicide assessment instruments must be integrated with other sources of information and must not be used alone to determine risk level and subsequent management or treatment decisions. Detailed summaries of measures are provided in Appendix C.

Peer Consultation

Mental health personnel should regularly consult with peers regarding the management of suicidal patients. Within a facility, this can be accomplished through informal discussions or formal case conference. For instance, mental health personnel may run questions not related to a particular patient by peers. However, if pertaining to a particular patient and in cases of complicated clinical matters, a more formal case discussion should be conducted. Risk management trainings often advise clinicians not to participate in "curbside consults" unless they are willing to take some time to make a reasoned recommendation, accept some risk and allow the other provider to document the contact. Another mechanism for gaining consultation with peers who manage suicidal patients is to conduct peer review of all cases on the high-interest log. Mental health personnel who do not have peers at their local facilities can maintain a network of external colleagues, either within the Air Force Medical Service or in the civilian sector, with whom they can regularly consult. Consider consulting with your MAJCOM Behavioral Health Consultant as needed. External civilian consultation should be restricted to those with a need to know, such as for supervision purposes. Both formal and informal consultations should be documented. Such documentation can be protective in the event of an adverse outcome.

Seeking timely or contemporaneous consultation is widely accepted in clinical suicidology practice for mental health personnel who work with suicidal individuals and will ultimately help to ensure appropriate medical and psychiatric decisions. It is important to note the benefits of professional consultation, especially in the assessment, management, and treatment of suicidal behaviors. First, consultation presents the opportunity to further examine the details of a given case with another colleague. Second, consultation provides reassurance to the suicidal individual, family members, and commands that the best possible care is being provided in order to prevent any potential harm. A final note is about mental health personnel who are not licensed to practice independently and who must therefore be supervised in all clinical care. When increased suicide risk is evident, supervisees have a clear responsibility to keep their supervisors informed. Supervisors have a clear responsibility to provide solid monitoring and guidance to the supervisee for the dissemination of care to suicidal patients. All supervision must always be documented for both quality assurance and legal purposes.

Brief Ongoing Suicide Risk Assessment

Once you have completed an initial comprehensive suicide risk evaluation, it is important to assess suicide risk on an ongoing basis in order to monitor changes in the patient's status. During therapy, continue to collect information about the presence and severity of suicide ideation, intent, and planning, and access to lethal means. In all instances of reported suicide ideation (regardless of severity), you must administer the Suicide Status Form (SSF-II-R or SSF-III) in order to collaboratively review the patient's suicidality and to most thoroughly monitor risk on an ongoing basis.

Table 1.2 Listing of Suicide Risk Screening Instruments

Instrument	Measures…	# of Items	Estimated Time	Scoring	Author - Publisher Information
The Behavior and Symptom Identification Scale 24 (BASIS-24)	Treatment Outcomes by Measuring Symptoms and Functional Difficulties	24	5-10 min Self-Report	Total Score + 6 Subscale Scores	For Purchase http://ebasis.org McLean Hospital 115 Mill Street, Belmont MA 02478-9106 (617) 855-2424 basisadmin@mclean.harvard.edu
Columbia-Suicide Severity Rating Scale (C-SSRS Screen)[1]	Suicide-Related Ideation and/or Behaviors	3 IF yes to ideation, 6 items	>2 Rater-Administered or Self-Report	No Scoring Required	Posner et al. (2011) No Cost http://www.cssrs.columbia.edu/index.html
Outcome Questionnaire-45 (OQ-45.2)	Symptom Distress; Social Role; Interpersonal Functioning	45	5-10 min Self-Report	Total Score + 3 Subscale Scores	Lambert et al. (2004) For Purchase OQ Measures: http://www.oqmeasures.com/
Patient Health Questionnaire (PHQ-9)[2]	Depression 1-4=Minimal 5-9=Mild 10-14=Moderate 15-19= Moderately Severe 20-27=Severe	9	<5 min Self-Report	Total Score	Spitzer et al. (1994) No Cost http://www.phqscreeners.com/
Suicidal Behavior Questionnaire-Revised (SBQ-R)	Four Different Dimensions of Suicidality	4	< 5 min Self-Report	Total Score (scoring varies per item)	Osman et al. (2001) For Purchase *Adolescent Suicide: An Integrated Approach to Assessment of Risk and Protective Factors* Northern Illinois University Press ISBN: 978-0-87580-616-7 http://www.integration.samhsa.gov/images/res/SBQ.pdf

Notes:
1. Copy provided in Appendix C – can be photocopied and used.
2. Mandated as screening tool to be used at every initial and subsequent Air Force mental health and ADAPT visits. Copy provided in Appendix A – can be photocopied and used.

Table 1.3 Listing of Suicide Risk Assessment Instruments

Instrument	Measures…	# of Items	Estimated Time	Scoring	Author - Publisher Information
Columbia-Suicide Severity Rating Scale (C-SSRS)[1] **Military Version**	Suicide-Related Ideation and/or Behaviors	Varies based on response	2-8 min, depending on density of suicide history Rater-Administered or Self-Report	No Scoring Required	Posner et al. (2011) No Cost http://www.cssrs.columbia.edu/index.html
MINI International Neuropsychiatric Interview (MINI): Suicidality Subscale Version 6.0	Suicide-Related Ideation and/or Behaviors	9	< 5 min for Suicidality Subscale Clinician-Administered	Total Score	Sheehan et al. (1998) For Purchase https://medical-outcomes.com/index/products
Scale for Suicide Ideation (SSI)	Suicide Ideation	21	5-10 min Clinician-Administered	Total Score + Suicide Intensity Rating	Beck et al. (1979) For Purchase http://pearsonassessments.com/pai/
Suicide Status Form[2] (SSF-III) **SSF-II-R**	Suicide-Related Ideation and/or Behaviors	Varies based on response	15-20 min Self-Report AND Clinician Forms	No Scoring Required	Jobes (2006) For Purchase Book, *Managing Suicidal Risk: A Collaborative Approach* Guilford Press ISBN: 978-1593853273 No Cost

Notes:
1. Copy provided in Appendix C – can be photocopied and used.
2. Mandated as suicide risk assessment tool to be used by all Mental Health Flight Elements (Mental Health, ADAPT, and FAP) at visits during which the patient, either in written and/or verbal form, reports any level of suicidal thinking. Copy of SSF-II-R is provided in Appendix B – can be photocopied and used.

Table 1.4 Listing of Suggested Other Risk Assessment Instruments

Instrument	Measures…	# of Items	Estimated Time	Scoring	Author - Publisher Information
Acquired Capability for Suicide Scale (ACSS)[1]	Acquired Capability for Lethal Self-Injury	20	5-10 min Self-Report	Total Score (Some Reversed)	Van Orden et al. (2008) No Cost http://www.psy.fsu.edu/~joinerlab/
Beck Depression Inventory (BDI-II)	Depression 0-13=Minimal 14-19=Mild 20-28=Moderate 29-63=Severe	21	< 5 min Self-Report	Total Score	Beck et al. (1996) For Purchase http://pearsonassessments.com/pai/
Beck Hopelessness Scale (BHS)	Hopelessness 0-3=Minimal 4-8=Mild 9-14=Moderate 15-20=Severe	20	< 5 min Self-Report	Total Score	Beck & Steer (1988) For Purchase http://pearsonassessments.com/pai/

Note:
1.   Copy provided in Appendix C – can be photocopied and used.

1.2 Suicide Risk Level Determination

Once you have gathered all the information needed to determine a patient's level of suicide risk at the time of evaluation, the level must be designated as one of the required Air Force risk levels appearing in Table 1.5 (see below). A procedural checklist for determining risk level appears in Section 1.3. Please note that the 2013 VA/DoD Clinical Practice Guidelines (CPG) for Assessment and Management of Patient at Risk for Suicide (pages 18-19) recommends suicide risk levels appropriate for primary care. For clarification purposes, see below for how these VA/DoD CPG risk levels correspond with the required Air Force risk levels.

Table 1.5 Suicide Risk Level at Time of Evaluation

US Air Force Risk Levels	VA/DoD CPG Risk Levels for Primary Care
Not Currently at Clinically Significant Suicide Risk	Currently Not at Elevated Acute Risk for Suicide
Currently at Clinically Significant Suicide Risk, But Not Imminent	Low Acute Risk Intermediate Acute Risk
Currently at Clinically Significant Suicide Risk, Imminent	High Acute Risk

Note. Risk level for a patient is determined based on clinical interview, collateral data, and clinical judgment *at the time of the evaluation*. Overall, you must provide clear evidence that you reasonably and thoroughly assessed suicide risk, and how this assessment informed your decisions.

1.3 Procedural Checklist A: Suicide Risk Assessment

```
┌─────────────────────────┐
│ Patient Presents for    │
│ Mental Health Visit     │
└─────────────────────────┘
           │
           ▼
    ╱─────────────╲              ┌──────────────────┐        ╭──────────────────────────────╮
   ╱ Screen for    ╲──────────▶  │ Screen Negative  │ ─────▶ │ Treat as indicated for       │
   ╲ Suicidal       ╱             └──────────────────┘        │ presenting problem and       │
    ╲ Thinking     ╱                                          │ re-assess as clinically      │
     ╲───────────╱                                            │ indicated                    │
           │                                                  ╰──────────────────────────────╯
           ▼
┌─────────────────────────┐
│ Screen Positive         │
└─────────────────────────┘
           │
           ▼
    ╱─────────────╲                        NO               ╭──────────────────────────────╮
   ╱ Is suicide     ╲────────────────────────────────────▶ │ Refer to qualified mental    │
   ╲ risk assessment ╱                                      │ health provider for suicide  │
   ╲ within your     ╱                                      │ risk assessment              │
    ╲ scope of      ╱                                       ╰──────────────────────────────╯
     ╲ practice?   ╱
      ╲─────────╱
           │
          YES
           │
           ▼
┌─────────────────────────┐
│ Conduct Comprehensive   │
│ Suicide Risk Assessment │
└─────────────────────────┘
           │
           ▼
┌─────────────────────────┐        ┌──────────────────────┐
│ Consult with other      │........│ Remember to          │
│ mental health           │        │ Document             │
│ professionals, command, │        │ Consultation Details │
│ and other sources to    │        │                      │
│ obtain collateral       │        │ (Refer to Section 4.2)│
│ information             │        └──────────────────────┘
└─────────────────────────┘
           │
           ▼
    ╱─────────────╲              ┌──────────────────┐
   ╱ Determine      ╲──────────▶ │ NOT CURRENTLY    │
   ╲ Level of Risk   ╱           │ AT CLINICALLY    │
   ╲ (Refer to       ╱           │ SIGNIFICANT      │
    ╲ Table 1.5)    ╱            │ SUICIDE RISK     │
     ╲───────────╱               │ (at the time of  │
           │                     │ evaluation)      │
           ▼                     └──────────────────┘
┌─────────────────────────┐
│ CURRENTLY AT            │
│ CLINICALLY              │
│ SIGNIFICANT             │
│ SUICIDE RISK            │
│ (at the time of         │
│ evaluation)             │
└─────────────────────────┘
           │
           ▼
    ╱─────────────╲              ┌──────────────────┐
   ╱ Is the risk    ╲──────────▶ │ YES or NO        │
   ╲ imminent?       ╱           └──────────────────┘
     ╲───────────╱
```

DOCUMENATION REMINDERS:
At a minimum, make sure to provide the following information in your clinical note:

☐ Your Clinical Observations
☐ Relevant Mental Status Information
☐ Methods of Suicide Risk Evaluation

☐ Brief Evaluation Summary
  ☐ Warning Signs
  ☐ Risk Indicators
  ☐ Protective Factors
  ☐ Access to Lethal Means
  ☐ Collateral Sources Used & Relevant Information Obtained
  ☐ Specific Assessment Data to Support Risk Determination
  ☐ Rationale for Actions Taken and Not Taken

☐ Provision of Military Crisis Line 1-800-273-TALK (8255)
☐ Implementation of Safety Plan (If Applicable)

╭──────────────────────────────╮
│ Treat as indicated for   │
│ presenting problem and   │
│ re-assess as clinically   │
│ indicated   │
╰──────────────────────────────╯

╭──────────────────────────────╮
│ **Go to Procedural Checklist B to** │
│ **Determine How to Best**   │
│ **Intervene**   │
╰──────────────────────────────╯

1.4 Procedural Checklist B: To Determine How to Intervene

```
┌─────────────────────────────┐                           ┌─────────────────────────────┐
│ Currently at clinically     │                           │ Currently at clinically     │
│ significant suicide risk,   │                           │ significant suicide risk,   │
│ but not imminent            │                           │ imminent                    │
└─────────────────────────────┘                           └─────────────────────────────┘
              │                                                          │
              ▼                                                          ▼
┌─────────────────────────────┐                           ┌─────────────────────────────┐
│ Directly address suicide    │◄──────────────────────    │ Initiate local psychiatric  │
│ risk, implementing suicide  │                           │ admission process           │
│ prevention strategies       │                           └─────────────────────────────┘
└─────────────────────────────┘                                          │
              │                                                          ▼
              ▼                                            ┌─────────────────────────────┐
┌─────────────────────────────┐                           │ If active duty, contact     │
│ Develop Safety Plan with    │                           │ command and place on        │
│ the patient; revise as      │                           │ High Interest Log           │
│ clinically indicated;       │                           └─────────────────────────────┘
│ document & provide patient  │                                          │
│ with a copy of the plan     │                                          ▼
└─────────────────────────────┘                           ┌─────────────────────────────┐
              │                                            │ Stay with patient until     │
              ▼                                            │ transfer to higher level    │
┌─────────────────────────────┐                           │ of care is complete         │
│ If active duty, you must    │                           └─────────────────────────────┘
│ contact command. Refer to   │                                          │
│ DoD Instruction 6490.08     │                                          ▼
│ for details                 │                           ┌─────────────────────────────┐
└─────────────────────────────┘                           │ Follow-up and document      │
              │                                            │ outcome of emergency        │
              ▼                                            │ psychiatric evaluation      │
┌─────────────────────────────┐                           └─────────────────────────────┘
│ Consult with a colleague    │                                          │
│ about whether or not to     │◄──────────                               ▼
│ place the patient on the    │                                      ╱Is the person╲
│ High Interest Log; document │                          NO         ╱ psychiatrically ╲
│ rationale for decision;     │◄────────────────────────◄          ◄   hospitalized?   ╲
│ inform and discuss decision │                                     ╲                  ╱
│ with patient; re-assess risk│                                      ╲                ╱
└─────────────────────────────┘                                       ╲    YES       ╱
              │                                                              │
              ▼               ┌─────────────────────┐                       ▼
┌─────────────────────────────┐ │ Remember to       │         ┌─────────────────────────────┐
│ Consult with peers          │·│ Document          │         │ Maintain contact with       │
│ regularly during treatment  │ │ Consultation      │         │ psychiatric inpatient team, │
└─────────────────────────────┘ │ Details           │         │ obtain periodic progress    │
              │               │ (Refer to Section 4.2)│       │ reports, and coordinate     │
              ▼               └─────────────────────┘         │ discharge planning          │
┌─────────────────────────────┐                               └─────────────────────────────┘
│ Modify treatment plan as    │                                             │
│ necessary                   │                                             ▼
└─────────────────────────────┘                               ┌─────────────────────────────┐
              │                                                │ Schedule a follow-up        │
              ▼                                                │ evaluation session same day │
┌─────────────────────────────┐                               │ or within 1 duty day of the │
│ Encourage and facilitate    │                               │ hospital ...                │
│ use of support resources    │                               └─────────────────────────────┘
│ (Refer to Appendix J)       │
└─────────────────────────────┘
              │
              ▼               ┌─────────────────────────┐
          ╱Has the╲           │ All patients must be    │
         ╱ patient ╲  YES     │ contacted for no-shows  │
        ◄  missed a  ╲───────►│                         │
         ╲ session? ╱         │ If active duty, you     │
          ╲        ╱          │ must engage command     │
              │ NO            │ when tracking down      │
              ▼               │ High Interest Log       │
┌─────────────────────────────┐│ patients.              │
│ Ensure continuity of care   ││                        │
│ during transitions          │└─────────────────────────┘
└─────────────────────────────┘
              │
              ▼
        ╱Is patient ╲
       ╱ still at     ╲   YES
      ◄  clinically    ╲───────────────────────►
       ╲ significant   ╱
        ╲  risk?      ╱
              │ NO
              ▼
┌─────────────────────────────┐         ┌─────────────────────────────┐
│ Re-evaluate status on       │────────►│ Continue care as indicated  │
│ High Interest Log           │         │                             │
└─────────────────────────────┘         └─────────────────────────────┘
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SECTION 2

HIGH INTEREST LOG AND

COMMUNICATION WITH COMMAND

A High Interest Log (HIL) is used at each AF clinic to track at risk patients. At a minimum, the HIL must include: (1) the name of the patient; (2) the name of the mental health provider responsible for the patient's care; (3) the name of the primary care manager; (4) the name of the command representative; (5) date entered into HIL; (6) diagnosis; (7) nature/level of risk; and (8) next follow-up appointment. Patients and Commanders or First Sergeants (in cases of military patients) must be apprised of the purpose and procedures of the HIL. Moreover, a consultative review of the case must be completed weekly in order to monitor HIL patients. In order to provide clear instructions on the High Interest Log as well as prepare mental health personnel for effective communication with command, this section provides:

☑ An overview of the High Interest Log and specific military issues for further consideration
☑ Guidance on how to best communicate with command
☑ Information on restriction of lethal means

Briefly stated, mental health providers need to ensure that their decision-making process for entering and removing a service member's name to and from the High Interest Log is systematic and well-documented. Clinical judgment based on a solid review of case information, consultation with peer(s), Primary Care Manager, and/or other providers, as well as with a command representative, and a brief summary of the changes noted in acute risk and protective indicators and justification for adding and subsequently removing someone's name from the High Interest Log are essential components of medical documentation.

2.1 High Interest Log: Decision Making, Tracking, and Consultation

In accordance with Air Force policy, facilities must maintain a High Interest Log (HIL) for tracking at risk patients. "High Interest" is meant to refer to those who are at increased risk for harm to self or others and also those whose care may require special attention but not necessarily due to dangerousness. **For the purposes of this Guide, we are focusing exclusively on suicide at-risk cases that warrant entry into the HIL.**

In many facilities, a common HIL can be used for the various specialty mental health clinics (e.g., ADAPT, FAP, Mental Health clinic). Although we recommend that there be only one common HIL, there may be cases of separate HILs. In this case, we recommend that local OIs document the process used to inform the various specialty mental health clinics when a service member is added to a HIL to ensure that coordination between the specialty clinics occurs.

Purpose for the High Interest Log (HIL)

The overall purpose of the HIL for serving the needs of suicidal service members is threefold:

1. ***To serve as a communication strategy for coordination of care*** among mental health providers, primary care managers, emergency departments, commanders, and other involved parties in order to provide the most appropriate care for the identified at-risk suicidal service member in order to keep him or her safe. For example, if an identified at-risk suicidal service member is placed on the HIL, the mental health provider will initiate contact with command and any other appropriate individual (e.g., Primary Care Manager, PCM) in order to generate a plan of action for safety.
2. To provide a mechanism for Air Force mental health clinics, treatment teams, and providers ***to closely monitor the improvement and/or exacerbation of symptoms*** for each identified service member in order to mitigate suicide risk and keep the at-risk service member safe. For example, if a service member placed on the HIL calls to cancel an appointment, he or she must talk to a provider who will subsequently assess for suicide risk before making the decision to cancel the appointment.
3. ***To ensure timely delivery of treatment*** to the identified at-risk suicidal patient such that he or she receives assessment, management, and treatment services on a high priority basis. For example, mental health providers must make room in their schedule to allow for at least weekly contact with the identified at-risk service member.

Adding a Service Member's Name to the High Interest Log

Please note the following recommendations before making a decision to add or not to add a person's name to the High Interest Log (See Tables 2.1 and 2.2):
- ☑ DO add the name of patients identified as Currently at Clinically Significant Suicide Risk, Imminent to the HIL.
- ☑ CONSIDER adding the names of patients identified as Currently at Clinically Significant Suicide Risk, But Not Imminent to the HIL based on your clinical judgment, consultation with a colleague, and with command (if applicable). You must make this decision based

on a thorough suicide risk assessment. Regardless of the decision (i.e., to add the name or to not add the name), you must document your rationale for the decision in writing.

⊠ **DO NOT** add the name of a patient identified as Not Currently at Clinically Significant Suicide Risk to the HIL unless there is another risk reason for including in the HIL.

Table 2.1 Suicide Risk Level at Time of Evaluation and High Interest Log Status

Suicide Risk Level *at Time of Evaluation*	Placement on High Interest Log *Following Evaluation*
Not Currently at Clinically Significant Suicide Risk	Not Applicable
Currently at Clinically Significant Suicide Risk, But Not Imminent	Consider Adding Name
Currently at Clinically Significant Suicide Risk, Imminent	Add Name

Table 2.2 Additional Considerations for High Interest Log

Suicide Ideation	Suicide Intent	Suicide Plan	Placement on High Interest Log
Yes	Yes	Yes	Yes
Yes	Yes	No or Unknown	Yes
Yes	No or Unknown	No or Unknown	Usually Yes Use clinical judgment, get collateral information, and make sure to consult with your team. Document your decision and rationale for the decision.
No or Unknown	Yes	Yes	Yes This is an extremely unusual circumstance because ideation will be at the very least implied. Given direct evidence of suicide intent and plan, place on the HIL.
No or Unknown	No or Unknown	Yes	Yes This is an extremely unusual circumstance because ideation will be at the very least implied. Given direct evidence of suicide plan, place on the HIL.
No or Unknown	No or Unknown	No or Unknown	No However, use clinical judgment and team consultation in cases where the person is suspected of underreporting of symptoms or in cases where other forms of risk are of concern.

Additional Considerations for Adding a Person's Name to the High Interest Log

Please note that the recommendations provided above apply to cases of suicidal concern only. Consult Air Force policy for details on other circumstances that would require entry of a service member's name into the High Interest Log and your clinic's OI. As a reminder, consider the situations listed below:

- ☑ DO add the name of a mental health flight beneficiary (ADAPT, FAP, MH) at the time of admission to a hospital for mental health or alcohol/drug reasons. Please note that there has been some confusion on this issue in the past because some clinics add the name after the patient has been discharged. HIL notifications must occur as soon as possible, within 24 hours.
- ☑ DO have a HIL treatment team meeting with the active duty patient and the patient's Commander and/or First Sergeant.
- ☑ DO add dependents or retirees to the HIL when they are hospitalized if they are a current patient in your clinic or if you plan to provide mental health services to them post discharge. Command notifications are not appropriate for dependents or retirees.
- ☑ DO meet with the SGH to determine medical disposition, if an Active Duty patient was hospitalized for a suicide attempt.
- ☒ **DO NOT** add dependents or retirees to the HIL when they are hospitalized if your clinic does not treat dependents or retirees. If the MTF is required to keep track of these hospitalizations, then the MTF case manager should be tracking their progress.

Duration of Placement & Removal of a Person's Name from the High Interest Log

The decision to remove a patient's name from the High Interest Log must be made collaboratively among the treatment team and documented as a consensus decision. In general, standard time limitations should not be the sole strategy for making decisions about removing a patient's name from the HIL. Instead, decisions must be made based on a documented reduction of suicide risk.

Patients should stay on the HIL based on the following criteria:
- ➤ Those psychiatrically hospitalized are required to remain on the HIL for *a minimum of 4 weeks* regardless of suicide risk status in accordance with Air Force policy.
- ➤ There must be a minimum of 4 consecutive weeks of risk stability before removing a person's name from the HIL.

Communication about the High Interest Log with the Patient

A patient will be educated about the following: (1) rationale for his or her placement on the High Interest Log, (2) notification of command and PCM, and (3) mental health visits and consequences of missed appointments.

Inform patients about the HIL and related procedures as part of informed consent. Maintain regular contact with these patients to assess risk (either through a clinic visit or a telephone contact), as clinically indicated. Maintain the names of these patients at the reception desk, and keep on-call mental health staff aware of those individuals. Front desk staff will not allow patients on the HIL to cancel their appointment without talking to a mental health provider. Providers must make a reasonable effort to contact patients who cancel as well as patients who "no show" for scheduled appointments. If you cannot reach HIL active duty patients following a

no-show, notify their Commander and/or First Sergeant and recommend active outreach to ensure safety. If you cannot reach HIL patients (other than active duty) following a no-show, notify the patient's family members and/or friends if you have a signed informed consent or you believe the patient is at imminent risk– check the emergency contact information provided by the patient.

When you enter patients on the HIL, clearly discuss the purpose and procedures of the log with them. Specifically, review the policies of attempting to contact them if they fail to show for a scheduled appointment and, for active duty members, contacting their Commander and/or First Sergeant if you are unable to reach them directly. Emphasize their responsibility to attempt to contact the clinic if they are unable to attend.

Additional Considerations

Since the HIL can become lengthy and many clinics have multiple people working at the front desk, we advise clinics to develop a process for easily recognizing and tracking HIL patients. We recommend a system for flagging clinic charts to remind both front-desk staff and providers of HIL status.

Air Force policy requires that appropriate on-call and emergency department (ED) personnel be notified of *high-risk* cases. To accomplish this requirement, use the "Special Flags" function in AHLTA. Only Mental Health Flight staff should be granted privileges to assign/remove the flags "BH1 - Harm to Others" and "BH2 - Harm to Self" for High Interest Log patients. A comment must be added to this flag indicating that the patient was added to the HIL, what risk concerns there are, who the primary mental health provider is, and the clinic phone number. Mental health staff must also remove this flag when the patient is removed from the HIL. Flagging of AHLTA records protects patient privacy more than distributing a list of names, since ED staff members are only notified when they have a need to know of high-interest status, i.e., when the individual presents for care.

Mental health staff will notify a patient's PCM when they determine that a patient is at increased risk for suicide (chronic or acute). HIL cases will be shared at least weekly with PCMs. Designated mental health providers will discuss HIL cases with PCMs face to face at least monthly. Clinics must develop local procedures in how they will notify other medical providers, and on-call MH providers of HIL patients.

Since there is evidence that a substantial proportion of people who die by suicide had previously visited their general medical provider within 30 to 90 days of their suicide (Andersen et al., 2000), it is generally in the patient's best interest for their PCM to be aware of elevated risk, so he or she can be more alert to the signs and symptoms of suicidality. The PCM will also be notified when the elevated risk is resolved. It is appropriate to discuss with patients, at an early stage, the need for routine communication with their PCM to ensure coordination of care. We recommend clinical staff discussions include: suicidal status, progress with the treatment plan, case management decisions, and whether high interest status is still clinically indicated.

Multidisciplinary Clinical Case Conference

Providers shall make a practice of regularly consulting with peers regarding the management of suicidal patients. Within a facility, this can be accomplished through informal case consultation or formal case conference meetings. Providers will also conduct peer reviews of all HIL

patients. Providers who do not have peers at their local facilities can maintain a network of external colleagues, either within the Air Force Medical Service or in the civilian sector, with whom they can regularly consult. Both formal and informal consultations must be documented. Such documentation can be protective in the event of an adverse outcome. Mental health professionals who are not licensed to practice at the independent level must be supervised in all clinical care. When increased suicide risk is evident, supervisees have a clear responsibility to keep their supervisors informed. All supervision must always be documented for both quality assurance and legal purposes.

Brief Note on the Limited Privilege Suicide Prevention (LPSP) and Duty Limiting Condition/Physical Profiling System

Both the Limited Privilege Suicide Prevention and Duty Limiting Condition/Physical Profiling System are covered by AFIs and can help the medical, legal, and line communities appropriately manage individuals who are at increased risk for suicide. The LPSP program provides persons who are under investigation or suspicion of a Uniformed Code of Military Justice offense with limited protection regarding information disclosed in a clinical relationship with a mental health provider. According to current AFI and mental health guidelines, the objective of the LPSP program is to identify and provide timely treatment to USAF members who may be vulnerable to suicidal behaviors while experiencing the stress associated with impending disciplinary action under the Uniform Code of Military Justice (UCMJ).[8] The intent is to encourage help seeking by reducing barriers to care. Information that is protected under this program may not be used in the existing or any future UCMJ action, or when weighing characterization of service when a member is being separated. However, it is important that both providers and patients understand the limited nature of the protection. Mental health staff engaged in LPSP programs may disclose case-file information of military members to other medical personnel for purposes of medical treatment, to a member's confinement facility commander, and to other authorized personnel with a need to know in the official performance of their duties (e.g., commanders). **Protection is afforded for care delivered only during the period in which a patient is at continuing risk of suicide, as determined by a mental health provider.** Once you determine that a patient is no longer at risk for suicide, the limited protections afforded by the LPSP program cease, although information disclosed while the patient was on the program remains protected. Mental health personnel shall be thoroughly familiar with the policies and procedures of the LPSP program, as outlined in current Air Force policies.

Another strategy applicable to active duty members is use of **the physical profiling system for recommending duty restrictions**. Clearly, actively suicidal individuals are not mentally stable and must have appropriate duty-limiting conditions documented in each clinical note. A duty-limiting condition using Air Force Form 469 is the primary means for communicating these concerns to non-medical authorities so they can be taken into account when personnel actions (e.g., deployment, permanent change of station) or duty restrictions (weapons bearing, flying, duties requiring security clearance) are being considered. With every clinical contact, providers are also responsible for considering an active duty patient's suitability for current duties and for retention in the military services. Patients with substantial current mental health problems who have a history of more than one suicide attempt (including those occurring prior to service) are considered to be at chronic risk, and it is appropriate that they be carefully considered for separation from the military in accordance with Air Force policy.

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[8] Suicide ideation is not a requirement for LPSP protection.

2.2 Communication with Command and Confidentiality

Mental health providers are a significant source of support and consultation for Air Force commanders, particularly when a service member's safety is at risk due to suicide-related ideation and/or behaviors. Although frontline supervisors play a key role in recognizing distressed service members and referring them for help, neither these leaders nor higher level commanders have the adequate background, training, time, and resources to independently manage suicidal crises. Effective and timely communication and collaboration among Air Force mental health clinics and command is an absolute necessity in suicide prevention efforts. As we all know, a suicidal service member can directly or indirectly impact the mission readiness of a unit and its morale—the death of a single member can impact the entire Air Force community. Therefore, timely and effective communication between mental health and command is essential in delivering optimal care to the suicidal service member as well as providing support and guidance for Air Force leadership. This section provides guidance regarding communication with command and confidentiality issues in working with suicidal patients. In cases where you are not certain about the best course of action, make sure to consult with professional colleagues and/or focus on team decisions within your mental health clinic.

Confidentiality and Its Limits

As an Air Force mental health provider, you must make a genuine effort to communicate with your patients the degree to which communication and collaboration with commanders may be in their best interest. Of course, it is expected that the informed consent for treatment is reviewed with the patient prior to the initial intake. Nevertheless, a service member's privacy must be protected within the limits of Air Force instructions, the law, and commanders' legitimate need to know.[9] In addition, please note that the DoDI 6490.08 (August 17, 2011, p. 6) Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members provides the following information:

> … healthcare providers shall provide the minimum amount of information to satisfy the purpose of the disclosure. In general, this shall consist of: (1) The diagnosis; a description of the treatment prescribed or planned; impact on duty or mission; recommended duty restrictions; the prognosis; any applicable duty limitations; and implications for the safety of self or others. (2) Ways the command can support or assist the Service member's treatment.

When meeting with the service member, be sure to clearly spell out the nature of your role as consultant to the commander. This would probably be a short conversation stating that there could be times where you would need to talk to the commander, give some examples, and then explain that you will give only the information needed to fulfill your consultant role and nothing extra. Providers will have this conversation first during intake or the initial appointment with the patient and then as clinically indicated.

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[9] Providers should be cautious in issues of dual relationship, as well. For instance, you may end up in a situation where you assess and/or treat a person who you work with (e.g., from other AF agencies) and due to some reason, a referral to someone else is not feasible.

Here are a few suggestions on topics to cover – please note that the more informed the service member is, the better you can approach your job, the stronger the alliance you can build, and the lower likelihood of future complications.

- ☐ *Timing of Communication.* When you plan to initiate contact with a command representative OR when did the communication first begin?
- ☐ *Point of Contact.* Provide the name(s) and position(s) of the command representative(s) you plan to have contact with.
- ☐ *Frequency of Contact.* How often do you plan to have contact? (e.g., only as needed, when directly asked for information, after every session)
- ☐ *Mode of Contact.* How will information be disseminated? (e.g., phone, email, written reports)
- ☐ *Type of Information to Be Released.* What specific type of information may be shared with the command representative(s)?
- ☐ *Advantages and Disadvantages of Disclosure.* What are the benefits and potential risks of disclosure to the service member's command? An honest and collaborative discussion on this topic can strengthen therapeutic alliance.
- ☐ *Any Concerns and/or Anxieties about Perceived Impact of Disclosure to Command.* Allow the service member an opportunity to discuss his or her concerns about disclosure of information to command. Address each concern so that the service member is well-informed about what to expect. If you are not certain about what to expect, be honest and direct as much as possible.
- ☐ *Continually Updates to Service Member about Communications with Command.* When possible, provide regular updates to the service member about your communication with command. In cases where feasible, you can ask the patient if he or she would like to be present for the conversation.

In cases where imminent risk has been determined, keep in mind that all the following recommendations above may not be feasible to follow. Do as much as you can and document appropriately the rationale for what you have done. Therefore, in these situations (e.g., when the service member is recognized as being at imminent risk for suicide), you must communicate necessary information obtained in clinical sessions, in a timely manner, to commanders or others as needed and begin to collaboratively and promptly implement procedures to ensure the safety of the suicidal service member.

When You Must Communicate With Command

Please note the section below is quoted directly from DoDI 6490.08 (August 17, 2011, pp. 5-6) in order to serve as a reminder for circumstances that warrant command notification. Air Force mental health providers are encouraged to familiarize themselves with this important DoD document:[10]

DoDI Guidance. Healthcare providers shall notify the commander concerned when a Service member meets the criteria for one of the following mental health and/or substance misuse conditions or related circumstances:

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[10] It is important to be aware of state requirements which may be relevant off base and with non-active duty patients.

(1) Harm to Self. The provider believes there is a serious risk of self-harm by the Service member either as a result of the condition itself or medical treatment of the condition.
(2) Harm to Others. The provider believes there is a serious risk of harm to others either as a result of the condition itself or medical treatment of the condition. This includes any disclosures concerning child abuse or domestic violence consistent with DoD Instruction 6400.06 (Reference (f)).
(3) Harm to Mission. The provider believes there is a serious risk of harm to a specific military operational mission. Such serious risk may include disorders that significantly impact impulsivity, insight, reliability, and judgment.
(4) Special Personnel. The Service member is in the Personnel Reliability Program as described in DoD Instruction 5210.42 (Reference (g)), or is in a position that has been preidentified by Service regulation or the command as having mission responsibilities of such potential sensitivity or urgency that normal notification standards would significantly risk mission accomplishment.
(5) Inpatient Care. The Service member is admitted or discharged from any inpatient mental health or substance abuse treatment facility as these are considered critical points in treatment and support nationally recognized patient safety standards.
(6) Acute Medical Conditions Interfering With Duty. The Service member is experiencing an acute mental health condition or is engaged in an acute medical treatment regimen that impairs the Service member's ability to perform assigned duties
(7) Substance Abuse Treatment Program. The Service member has entered into, or is being discharged from, a formal outpatient or inpatient treatment program consistent with DoD Instruction 1010.6 (Reference (h)) for the treatment of substance abuse or dependence.
(8) Command-Directed Mental Health Evaluation. The mental health services are obtained as a result of a command-directed mental health evaluation consistent with DoD Directive 6490.1 (Reference (i)).
(9) Other Special Circumstances. The notification is based on other special circumstances in which proper execution of the military mission outweighs the interests served by avoiding notification, as determined on a case-by-case basis by a health care provider (or other authorized official of the medical treatment facility involved) at the O-6 or equivalent level or above or a commanding officer at the O-6 level or above."

Other Reasons to Communicate with Command

Consider obtaining collateral information from the service member's command to help you with suicide risk assessment and subsequent management plans even if none of the specific situations listed within the DoDI 6490.08 are met. Commanders, First Sergeants, and others in the service member's unit who have personal knowledge of his or her situation can provide valuable information otherwise unavailable to the evaluating provider. This communication is an important consideration but may be more challenging to navigate given that you want to follow the guidance provided earlier (i.e., "… *provide the minimum amount of information to satisfy the purpose of the disclosure.").* In such circumstances, be mindful and use your clinical judgment to disclose as little as possible, yet try to obtain as much information as you can to inform your risk assessment. Remember that you are gathering information in this capacity and will most likely be the one asking questions. Any disclosure should be minimal and pertinent to explain why you are asking questions to obtain collateral information.

In cases where unit leadership has expressed concern about a service member's suicide risk, you are strongly encouraged to maintain ongoing contact with the leadership as well as the

service member after his or her return to duty. This contact is generally most effective when communication is two-way. Command must be kept informed of the service member's status but command is also a valuable source of information on the service member's day-to-day activities, functioning, general well-being, and progress on treatment goals. In certain cases, communication about the results of your risk evaluation is of utmost importance to command. For example, when you complete an emergency command-directed evaluation to assess suicide risk and the assessment indicates non-imminent risk for suicide, you must communicate this information to the service member's commander (both verbally and in writing). In cases when clinical care is indicated for a suicidal service member, it is appropriate to communicate general information about the treatment plan. Other examples of communication reasons with command may include the following:

- ☐ Need to generate a collaborative plan for ongoing monitoring of risk in the workplace
- ☐ Decision to share a copy of the Safety Plan in order to request assistance with the implementation of certain components (e.g., restriction of access to lethal means)
- ☐ Consultation with unit leadership about possible responses to the service member's disruptive work-related behavior(s)
- ☐ Collaboration to increase protective factors (e.g., social support) and to decrease risk factors (e.g., hopelessness) contributing to the service member's suicidality
- ☐ Routine telephone check-ups
- ☐ Missed appointments and/or treatment compliance related issues

Special Considerations for Communication with Command

Service Members placed on High Interest Log (HIL)

When considering whether to place a service member on the HIL, collateral information is an important resource that will assist in your decision-making process. Once a service member is entered on the HIL, you must inform command and conduct a HIL treatment team meeting with the patient and the patient's Commander and/or First Sergeant. If a service member is "Currently at Clinically Significant Suicide Risk, But Not Imminent", even if you do not enter the service member's name on the HIL, you must keep command informed about the level of risk. Make sure to discuss breaking confidentiality with the patient. In deciding whether or not to remove a service member's name from the HIL, collateral information from command is an essential component. When a service member's name is removed from the HIL, inform command.

Service Members with Legal Problems

According to DoDSER (2011), approximately 43% of Airmen who died by suicide and 40% of Airmen who attempted suicide in 2010 had an administrative or legal problem of some type. Thus, it is especially important to consult with commanders regarding support for these individuals. Service members under investigation can easily feel isolated from family, friends, and other support systems when they need them most, and Air Force policy has provisions for helping them find this support. Two such policies are the Limited Privilege Suicide Prevention (LPSP) Program and the 'handoff" responsibilities of investigative agencies and commanders following member interviews. It may be helpful to remind commanders of these policies.

In situations where a commander directed evaluation is requested and you perform a suicide-risk assessment for someone referred as part of an investigative interview handoff, we

recommend that you follow-up with the individual and the command regularly throughout the time he or she is under investigation. You may need to persist in persuading the member to participate in follow-up monitoring in the event that he or she does not desire mental health support. In some high-risk cases, regular or periodic treatment-team meetings that include the providers, patient, Commander, First Sergeant, and/or supervisor can be useful. The patient's PCM and SGH may be invited to attend as warranted, but their attendance is not required. These meetings should focus on supporting the patient but also serve an educational role for Commanders and PCMs about how to best care and support the patient. Some patients who are on LPSP or under investigation will be unlikely to want to participate unless there are clear guidelines and expectations set for these meetings. Alternatively, providers can contact a Commander and/or First Sergeant by phone with the patient in the provider's office. Using either of these strategies can help avoid a breakdown in communication with the Commander and/or First Sergeant, while not risking patient/therapist rapport by communicating without the patient's awareness.

Service Members Requiring Removal of Weapons and/or Restrictions of Duty

For active duty service members, it is important to notify command to recommend the individual be relieved of weapon-bearing duties, activities involving explosive ordinance, flying duties, or duties involving knives, poisons, or other potentially harmful materials, as clinically indicated. In most cases, it will be important to try to get the service members' cooperation and collaboration so as not to increase risk by acting against the patient's wishes. Commanders can also help ensure that the individual's duties remain meaningful and do not involve significant time alone during which there would be opportunity to dwell on problems and potentially attempting suicide. These same principles of ensuring safety of the duty environment also apply to incarcerated patients, and it is important to discuss safety recommendations with the leadership of correctional facilities. There must be formal documentation of these Duty Limiting Conditions IAW Air Force policy.

Service Members Resistance to Seeking Mental Health Care

If a service member does not desire treatment and involuntary hospitalization is not indicated, it is helpful to consult with all personnel involved regarding what support is acceptable to the service member and what support is needed or desired by the Commander and/or First Sergeant. There are significant benefits to simply maintaining contact with patients who refuse treatment through periodic phone calls, letters, or clinic check-in visits. This type of contact can itself reduce suicide rates (Fleischmann et al., 2008; Motto & Bostrum, 2001; Vaiva et al., 2006), but it also can lead to a relationship with some patients that, over time, may reduce resistance to treatment. You may need to remind unit leadership of the individual's right to refuse medical treatment, as well as ways in which mental health personnel can support the unit apart from clinical treatment (e.g., consultation). As the provider, you may continue to be a consultant to command even if the person refuses treatment.

2.3 Restricting Access to Lethal Means

Restricting a suicidal patient's access to lethal means is widely recognized as an essential suicide prevention strategy (Bryan, Stone, & Rudd, 2011). A strong relationship between availability of lethal means (particularly firearms) and suicide death has been shown. Brent and Bridge (2003) found higher suicide risk associated with loaded weapons in the home. Those who purchased handguns were at a higher risk for suicide up to 6 years after the purchase. Given the variable nature of suicide ideation and intent, and the role that impulsivity plays in suicide, restricting at-risk individuals' access to lethal means can reduce the incidence of death by suicide. For someone in crisis who impulsively or desperately seeks a means to die, restricting access to lethal means can allow time for the crisis to pass and the urge to suicide to decrease to a manageable level. Research on means restriction has shown that when access to firearms is limited, suicide rates decrease significantly (Loftin, McDowall, Wiersma, & Cottey, 1991). Results from research on means-restriction counseling indicate that when suicidal individuals and their caregivers receive such counseling, the likelihood of their taking steps to restrict lethal means increases significantly. In one study (McManus, Kruesl, Dontes, Defazio, Piotrowski, & Woodward, 1997), among parents who received means restriction counseling as an intervention for suicidal adolescents, 86% reported locking up or throwing away medications, compared with only 32% of parents who did not receive the training.

Recommendations

In situations where patients are at increased risk for suicide, yet hospitalization is not indicated, mental health personnel will take steps to limit accessibility to means of self-harm. A first step can be to facilitate the removal of personal firearms. Generally, this can be done by counseling the patient and his or her support system (i.e., First Sergeant, family, friends) about the danger of keeping the firearm available and recommending its removal from the patient's access. Means restriction counseling also helps to limit access to other lethal means. Bryan et al. (2011) provide a step-by-step guide to means restriction counseling, as outlined below.

Means Restriction Counseling Steps

1. Describe to the patient the rationale for means restriction with emphasis on ensuring safety and overcoming suicidality. Specifically, discuss the following points:
   - ☐ Removing means in advance of a suicidal crisis is important because emotional and problem-solving deficits are common when a person is acutely suicidal.
   - ☐ Having lethal means readily available during a suicidal crisis can be very dangerous.
   - ☐ The primary goal of treatment is to reduce mental distress; by developing a means-restriction plan that goal is achievable.
   - ☐ Restricting access to lethal means reduces the chance of a bad outcome during times of crisis.
2. Conduct means restriction counseling:
   - ☐ Review rationale and motivational strategies to enhance your patient's buy-in.
   - ☐ Collaboratively identify and agree upon specific strategies for restricting means.
   - ☐ Develop a "menu" of options for restricting access to means, which can include:
     (1) Complete removal of means through disposal; (2) Complete removal by giving means to a significant other; (3) Restrict access by locking up means.

□ For firearms, if complete removal is unacceptable or impractical:
    (1) Dismantle the firearm and give firing pin to supervisor or significant other; (2) Store firearms in tamper-proof safe - Security Forces will generally secure personal firearms in their armory; and/or (3) Remove ammunition.
□ Hiding unlocked means is not advised because they can be found.

3. Implement means restriction: Enact the agreed-upon measures from Step 2, providing the patient (and significant other) a means receipt and having the significant other complete a Crisis Support Plan or Safety Plan. In the means receipt, the clinician and the patient agree in writing to follow the means restriction plan created previously. "In the means receipt, the clinician and patient formalize the means-restriction plan by placing critical pieces of information in writing: the name of the supportive other identified for restricting or securing the means; contact information for the supportive other; the specific means to be restricted; and the agreed-to plan for restricting means. The means receipt also includes a section detailing the specific conditions under which the means are released or returned to the patient. This latter component is especially important for all concerned, as it clearly defines the criteria by which the patient is judged to be safe enough to discontinue the plan." (Bryan et al., 2011, p. 5, sample Means Receipt provided in manuscript).

Follow-up inquiry as to whether firearms were removed is clearly indicated. It is important to make sure medications are supervised, as well. After appropriate instruction by a medical provider, a family member, friend, or unit member can provide this supervision. Carefully assess for all means of self-harm that a patient has seriously contemplated. While it is impossible to limit a patient's access to all potential suicide means, it is important to take reasonable steps to ensure safety by reducing access when possible, especially with means that have most clearly been shown to increase risk, such as firearms.

For active duty suicidal patients, it is also important to notify their commander to recommend the individual be relieved from weapon-bearing duties, activities involving explosive ordinance, flying duties, or duties involving knives, poisons, or other potentially harmful materials. In most cases, it is important to collaborate with patients so as not to increase risk by acting against the patient's wishes. Commanders also can help ensure that the individual's duties do not involve significant time alone during which there would be opportunity for dwelling on problems and potentially attempting suicide. These same principles of ensuring safety of the duty environment also apply to incarcerated patients, and it is important to discuss safety recommendations with the leadership of correctional facilities.

Inquiring about Privately Owned Firearms

Since 2010 there have been changes in legislation pertaining to the military maintaining records of privately owned firearms. This has led to some uncertainty for commanders and mental health personnel alike. However, since the National Defense Authorization for Fiscal Year 2013 was signed into law, health professionals and commanding officers may "inquire if a member of the Armed Forces plans to acquire, or already possesses or owns, a privately-owned firearm, ammunition, or other weapon, if such health professional or such commanding officer has reasonable grounds to believe such member is at risk for suicide or causing harm to others." This change gives mental health personnel and commanding officers greater latitude in means restriction, which is an important tool in preventing suicides in vulnerable individuals. Overall, mental health providers should recommend that commanders directly contact the Staff Judge Advocate regarding any means restrictions including privately owned firearms.

SECTION 3
NOMENCLATURE, DOCUMENTATION, AND COMMON ERRORS

The language used to describe suicidal thinking and/or behaviors must be as precise as possible in order to enhance verbal and written communication which is at the heart of effective suicide prevention. Moreover, as every well-trained mental health provider knows, clear and timely documentation practices are an essential component of our work with suicidal patients. Errors in any field of healthcare may occur. However, with effective usage of language, standard documentation practices, and lessons learned from previous experiences, we can all aim to provide optimal care to our patients. This section provides:

- ☑ A review of the DoD/VA nomenclature on suicide
- ☑ Recommendations for how to best document the care provided to suicidal patients
- ☑ Information on common errors in suicide prevention care and lessons learned

3.1 DoD/VA Nomenclature for Suicide

Using a common language to conceptualize and refer to suicide-related ideation and behaviors is essential for assessment and management of risk, case conceptualization, treatment planning, and consultation. Yet the understanding and usage of suicide-related terminology varies widely across healthcare settings, documented psychiatric records, and types of mental health personnel.

You may be familiar with several different suicide nomenclatures, such as that created by the American Society for Suicidology and National Institute of Mental Health work group (O'Carroll, Berman, Maris, Moscicki, Tanney, & Silverman, 1996) or the FDA-commissioned Columbia Classification Algorithm of Suicide Assessment (C-CASA; Posner, Oquendo, Gould, Stanley, & Davies, 2007). Most recently, in an effort to provide consistency and clarity on suicide terminology, the Office of the Under Secretary of Defense (DoD, 2011) has mandated that all branches of the military adopt the Self-Directed Violence Classification System (SDVCS) developed by the Centers for Disease Control and Prevention (CDC) for "future data collection, reporting, and/or system-wide comparisons" between the DoD and the VA. The SDVCS system is the product of the CDC in collaboration with the Veterans Integrated Service Network (VISN) 19 Mental Illness Research Education and Clinical Center (MIRECC). Its terms and definitions for suicidal and nonsuicidal thoughts and behaviors are based on earlier nomenclatures, including those mentioned above. A system-wide adoption of the SDVCS was tested at two VA Medical Centers and included training in use of SDVCS terms and categories as well as a clinical decision-making tool. Results of the implementation study (Brenner et al., 2011) indicated that the classification system and clinical tool were acceptable and useful.

In the SDVCS, the two main types of events are thoughts and behaviors. Subtypes of thoughts are nonsuicidal self-directed violence ideation and suicidal ideation. Behavior subtypes include preparatory behaviors, nonsuicidal self-directed violence, undetermined self-directed violence, and suicidal self-directed violence. Each behavior subtype is further subdivided into terms, which are modified by intent, presence of injury, and interruption by self or other. The SDVCS and clinical tool are both included in the Appendix F. A VA web page provides resources for training on the SDVCS: http://www.mirecc.va.gov/visn19/education/nomenclature.asp

One final point regarding nomenclature: The Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5) defines malingering (V65.2) as the "intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs." Assigning this diagnostic label to a suicidal patient should be considered very cautiously as the usage of the term to describe self-directed violence is stigmatizing and counterproductive to the DoD suicide prevention mission in the absence of factual information to support such a label. The DoD Task Force on the Prevention of Suicide by Members of the Armed Forces has recommended against using the term malingering in association with self-directed violence (DoD, 2010). Mental health personnel may consider using the phrase *over-reporting of symptoms* as a less pejorative and less stigmatizing alternative for characterizing patients' suicide-related presenting symptoms.

3.2 Documentation Recommendations

Documentation pertaining to your work with a suicidal patient and consultation with the individuals involved in collaborative care is one of the most essential components of your work as an Air Force mental health provider. Staff should not fall prey to the erroneous (but common) belief that minimal documentation gives better legal protection than detailed notes. When documenting, use a thorough, methodical approach to gathering, reviewing, and recording information. Clinical records are most complete when they document not only the initial risk assessment procedures and associated data, but also all activities and decision making processes for the clinical management of the at-risk individual, such as your rationale for entry of an individual's name into the High Interest Log and subsequent removal, coordination and continuity of care plans, handling of treatment non-compliance, communication with command, and progress during treatment.

In general, intake documentation must be comprehensive, detailing at a minimum all risk and protective factors, history of suicide-related ideation and behaviors, and current levels of suicide ideation, planning, and intent. Standardized assessment instruments, such as those mentioned in Section 1.1 (pp. 10-20) and/or other psychometrically valid measures can provide a systematic means for documenting evidence for your risk screening, assessment, and subsequently planned interventions. Most importantly, a risk level determination must also be documented. Risk level (see Figure 3.1) is determined based on your clinical interview, collateral data collected, and clinical judgment *at the time of the evaluation*. Overall, you are required to provide clear evidence that you reasonably and thoroughly assessed suicide risk, and how this assessment informed your decisions.

Figure 3.1 Suicide Risk Levels at Time of Evaluation

Not Currently at Clinically Significant Suicide Risk

Currently at Clinically Significant Suicide Risk, But Not Imminent

Currently at Clinically Significant Suicide Risk, Imminent
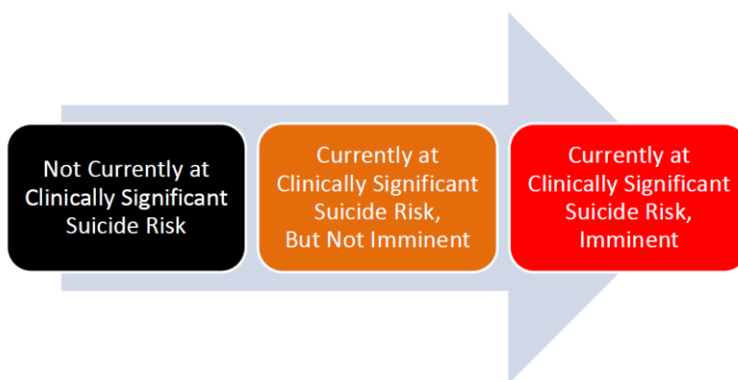
Follow-up entries can be much briefer but will note the status of elevated risk indicators (e.g., hopelessness, recent discharge from psychiatric inpatient facility) until these risks have been resolved. Please note that in certain situations, a risk indicator may chronically remain. For instance, a patient may experience chronic suicide ideation during the entire outpatient care process. In these situations, use your clinical judgment and comment on reasons why risk status remains the same or is more or less elevated. For instance, if religious beliefs serve as a protective factor for this particular patient and there is an indication by the patient that despite the chronic suicide ideation, he would not act on self-harm due to involvement with his church,

perceived social support, and beliefs in respecting one's body, make sure to document your perspective on risk based on the weighing of risk and protective factors.

Information on suicide risk assessment and interventions as well as changes in clinical status are recommended to be documented in the outpatient medical and mental health records to ensure continuity of care. The following checklists provide guidance on documenting various aspects of your interactions with a suicidal patient. Make sure to use your clinical judgment such that you document other pertinent information that may not be adequately covered below.

Documentation – Suicide Risk Assessment

- ☐ Ensure that the assessment note entered is accurate to match the date of the current appointment and does not contain artifacts from previous appointments. Be careful when using the "Copy Forward" function in AHLTA in order to not duplicate wrong or outdated information
- ☐ Pay close attention to language used to describe suicide-related information. Be knowledgeable of DoD/VA suicide nomenclature.
- ☐ Document any discrepancies between a patient's written and verbal statements, and how these were reconciled.
- ☐ At a minimum, include the following in your documentation:
    - ☐ Methods of Suicide Risk Assessment
    - ☐ Your Clinical Observations; Relevant Mental Status Information
    - ☐ Brief Evaluation Summary
        - ▪ Warning Signs; Risk Indicators; Access to Lethal Means
        - ▪ Protective Factors
        - ▪ Collateral Sources Used & Relevant Information Obtained
        - ▪ Specific Assessment Data to Support Risk Determination
        - ▪ Rationale for Actions Taken and Not Taken
    - ☐ Provision of Military Crisis Line 1-800-273-TALK (8255)
    - ☐ Implementation of Safety Plan (If Applicable)

Documentation – Treatment Non-Compliance

- ☐ For all patients, regardless of risk level at the time of evaluation, document missed sessions, dropping out of treatment prematurely, medication non-compliance, and/or other instances indicative of poor treatment engagement.
- ☐ For patients on the High Interest Log (HIL), document specific details and examples of treatment non-compliance.
    - ☐ If the patient calls to cancel, document the date and time of the call, reason for cancellation, date and time of rescheduled appointment, and any relevant clinical content and concerns. Make sure to assess for suicide risk before determining that it is acceptable to cancel/reschedule the appointment and document this.
    - ☐ If the HIL patient does not follow up as agreed, notify the unit commander and document notification date and time. It is possible that the command would need to do a welfare check to ensure that the service member is safe.
    - ☐ For patient no-shows, document date and time of missed appointment, attempts to reschedule, and date and time of rescheduled appointment.
    - ☐ Document notification of commander when HIL patient no-shows and contact cannot be made within one hour.

Documentation – Coordination of Care

- ☐ Document and share any significant changes in the risk status, treatment plan, or precautionary measures with the patient's primary care manager or designee, the on-call mental-health provider, emergency department, and command immediately, and document date and time of this communication.
- ☐ Upon a patient's psychiatric hospitalization, for a status check, the primary mental health provider must have regular contact (weekly at minimum or at least one contact for hospitalizations less than 1 week) with the treatment team at the psychiatric higher level of care facility to ensure continuity of care, and obtain treatment progress information. Document this contact. It is preferable that the status check happen twice per week, once early in the week and once right before the weekend. Weekly status updates received from the hospital must also be documented.
- ☐ Enter patients who are psychiatrically hospitalized for suicide risk or attempted suicide into the HIL for at least 4 weeks following discharge and/or longer if clinically indicated.
- ☐ Document the process for the patient's transition to outpatient care (which is likely to involve collaboration with the inpatient treatment team).
- ☐ See patient on the same day of discharge from an inpatient or partial psychiatric hospitalization but no later than the next duty day (24 hours after noted discharge). Document visit and if unable to schedule an appointment, document reason.
- ☐ Obtain a copy of the Discharge Summary and document its review for continuity of care.
- ☐ Re-evaluate a patient's clinical needs in order to resume or initiate outpatient mental health care. Update the patient's profile appropriately IAW AFI 10-203. Consider documenting any treatment needs and duty restrictions in written format for the patient.

Documentation – Targeted Intervention(s) for Suicide Prevention

- ☐ Document use of evidence-based treatment strategies specifically targeting suicide-related ideation and behaviors (e.g., cognitive behavior therapy, Safety Planning).
- ☐ Use SOAP format (see Appendix E) to document delivered care, response, and prognosis.

Documentation – Continuity of Care

- ☐ Document safety and fitness for duty assessment following discharge from higher levels of care (e.g., inpatient psychiatric care, substance abuse rehabilitation).
- ☐ Prepare a new outpatient crisis response plan based on the assessment conducted after the patient's discharge and enter the plan into the patient's record.
- ☐ Document notification of a service member's commander when the service member is released from inpatient care or partial hospitalization. This communication will be made directly to the commander (or his or her designee) to ensure clear communication at this time of heightened risk. Document transfer of care in accordance with Air Force policy.

Documentation – Consultation

- ☐ For all patients with elevated risk for suicide, consult professional peers regularly regarding clinical work and document the consultation.
- ☐ For HIL patients, document all information, discussions, and recommendations that are shared at weekly multidisciplinary clinical case conferences.

3.3 Common Errors in Suicide Prevention: Lessons Learned

The best approach to preventing unfavorable suicide-related outcomes for a service member, his or her family and unit, mental health personnel, and the Air Force community is to provide solid clinical care. Proper documentation and consultation with peers and the chain of command (when appropriate) are likely to mitigate risk. Overall, a number of additional lessons can be learned from previous suicide-related events. The following sections outline the types of suicide management actions or inactions that have led to (1) Headquarters Air Force Inspection Agency (AFIA) findings, and (2) common failure scenarios (as noted in the scientific literature, legal malpractice lawsuits, and in some situations, disciplinary actions by the military or by state licensing boards). By reviewing the information provided in this section, you can be mindful of avoiding common errors in the management of your suicidal patients.

Headquarters Air Force Inspection Agency Findings

In the 2002 edition of this Guide, the following concerns were reported based on a review by the AFIA of suicide-related findings from Health Services Inspections (HSIs) over 15 months:

1. "… some providers in Life Skills Support Centers (LSSC), Alcohol and Drug Abuse Prevention and Treatment (ADAPT) programs, and Family Advocacy Programs (FAP) were *failing to assess and/or document suicidal and homicidal risk.* This suggests that there is room for improvement related to assessing and managing suicidal risk even at the most rudimentary level."
2. "A second concern related to how adequately patients are informed about the duty to report dangerousness. Dangerousness to self or others is one of the primary precipitants for providers to reveal information obtained through a therapeutic relationship. Yet, HSI inspectors found several instances where *client information sheets did not fully inform patients* about this duty."[11]
3. "The final concern stemming from HSI inspections was *a failure to use approved abbreviations for suicidal/homicidal risk assessments.* Non-approved abbreviations can result in miscommunications among healthcare providers that can lead to inappropriate decisions and inadequate care."

A decade later, AFIA representatives reported that when AF providers employ the standards outlined in the first edition of the Guide, inspection results are favorable. In addition, incorporating content from the original AFGMSB into other AF documents such as the AFI 44-172 has led to fewer of the types of problems documented in the original Guide. The current trend in errors involves lack of documentation of contact with Commanders and First Sergeants when patients are *removed* from the High Interest Log. This can clearly have implications on how leadership is incorporated into safety planning.

Additionally, the AFIA inspectors shared the following observations in order to enhance the quality of management and care provided to suicidal service members and beneficiaries. The guide provides recommendations to address each of the AFIA findings (see below) such that all AF clinics and staff can benefit directly from these lessons.

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[11] Therefore, AF mental health staff members are encouraged to inform patients about the limits of confidentiality and the therapeutic duty to report dangerousness to self or others.

Observation 1: Use of the High Interest Log

AF providers may have difficulty deciding whether to add a service member's name to the High Interest Log and when to safely remove him or her from the log, especially when there is no clear event to delineate a start/stop, such as psychiatric hospitalization. AFIA inspectors noted that providers typically do not adequately document their decision-making rationale. Given that a 4-week timeframe is the minimum standard for maintaining a service member on the High Interest Log after medical and/or psychiatric hospitalization for a suicide-related event, the temptation may be to rely exclusively on a time-based approach for log removal decisions.

> **Recommendation 1:** Make sure that your decision-making process for entering and removing a service member's name to and from the High Interest Log is systematic and well-documented. Your clinical judgment based on a solid review of case information, consultation with peer(s), Primary Care Manager, and/or other providers, as well as with a command representative, and a brief summary of the changes noted in acute risk and protective indicators and justification for adding and subsequently removing someone's name from the High Interest Log are essential components of medical documentation.

Observation 2: Determining Risk Level

A critical observation by the AFIA inspectors relates to risk determination and the meaning associated with different labels used to classify the risk level of a suicidal service member. This partly involves having a unified understanding of what risk level really is, which remains problematic in the field of suicidology as no consistent system of risk level classification exists. First of all, providers seem to be confused about differentiating, or at least documenting, between risk categories and risk levels proposed in the original 2002 AF guide. The clearest documentation on risk assessment outlines risk and protective factors providing a rationale for risk level. The question that remains is whether or not, noting a risk level (which may be ambiguous in terms of meaning such as *mild risk*) is helpful and meaningful in terms of clinical documentation practices for suicidal cases.

> **Recommendation 2:** Refer to Table 1.5 (p. 21) or Figure 3.1 (p. 39) which addresses much of the confusion surrounding how to best classify and document identified risk. Please note that a risk level determination will occur after a suicide risk assessment is conducted by a qualified mental health provider. The determination of suicide risk level is made based on all information available *at the time* of the suicide risk assessment. Providers are reminded that the suicide risk of any given patient may change (decrease or increase) upon departure from the mental health appointment, depending on a number of biopsychosocial factors.

> ☐ **Example 1.** A service member classified as Not Currently at Clinically Significant Suicide Risk may become suicidal 3 days following her mental health visit following the traumatic experience of a sexual assault.

> ☐ **Example 2.** A service member classified as Currently at Clinically Significant Suicide Risk, *Imminent* may move to Currently at Clinically Significant Risk, *But Not Imminent*, given the removal of lethal means, the positive effect of psychiatric medication, and delivery of social support from peers, family, and command. Therefore, assessment during each mental health visit is required to track changes in the risk levels. Providers must give justification for the decision <u>at the time</u> of the evaluation, and may include a list of risk and protective factors.

In order to determine the imminence of suicide risk, use clinical judgment, consult with peers, collect collateral information as needed, and consider all clinical and assessment data. Think about what elevates someone's risk for suicide. The inspectors have seen cases where many risk factors existed with few protective factors, but because of an absence of explicit suicide ideation, the risk level was documented as "not significant" or "not elevated." Some providers still seem to equate suicide risk, most directly, to self-reported suicide ideation. While this is understandable, there are cases where a patient is at suicide risk when he or she denies suicide ideation.

Think about the fact that your risk determination is made at the time of assessment and that it may change an hour, a week, or a month later. The inspectors have seen language such as "not elevated" to refer to the lowest level of risk without any acknowledgement that the decision was made at the time of the assessment. Risk status changes over time, so it is important to document the time-limited nature of your assessment. Language such as "at the time of this assessment" conveys that an assessment is limited to the date and time it occurred. You also can add the types of stressors that may elevate risk or complicate the assessment of risk level.

Observation 3: Interactions with Local Agencies

AF clinics vary in their level of interaction with local agencies and/or facilities. Clinics with the best practices go beyond simply having Memoranda of Understanding (MOUs). They develop a working relationship with one or more local facilities, sometimes assigning a provider as a liaison. AFIA inspectors have noted that stronger ties tend to result in better hand-offs, more immediate follow-ups, and more effective overall management of suicidal cases.

> ***Recommendation 3:*** Each AF clinic is encouraged to initiate and maintain a working relationship with local agencies and medical/psychiatric facilities. It may be helpful to have one or more members of your staff serve as liaisons such that there is clear communication and documentation of hand-offs, follow-ups, and overall management of the suicidal service member. Such a system allows for the best continuity of care, which contributes greatly to the well-being of the individual under treatment.

Common Failure Scenarios[12] for Suicide Management

The Institute of Medicine of the National Academies (Kohn et al., 1999) defines clinical error as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim." To translate this language to suicide prevention, common failure scenarios fall into one of the two broad categories:

1. Failure of a planned action to be completed as intended (e.g., during risk assessment, a mental health provider does not ask specifically about suicide ideation, intent, and planning or fails to document that such communication with the patient took place).
2. Reliance on an insufficient plan – think of a scenario where a provider may use a widely recognized *non-evidence-based* practice to manage a patient's suicidality (e.g., usage of a safety *contract* compared with a safety plan).

Two models of causation of human error have been identified by Reason (2000). The *person approach* emphasizes the errors of individuals who may forget to document appropriately, be

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[12] Term used by Bongar et al. (1992)

inattentive to important details pertaining to risk, or morally fail their patients. The *system approach* emphasizes errors associated directly with the conditions and the systems set for individual performance. For instance, an inpatient unit may not have implemented adequate physical safety measures for the suicidal patient. The Institute of Medicine report (Kohn et al., 1999) and Oyebode (2006) indicate several strategies for reducing clinical error. This Guide has paid close attention to these factors:

- ❑ Reducing the complexity of a task (e.g., providing guidance such as that outlined above in this section on how to appropriately, clearly, and simply label risk determination decisions instead of using subjective and ambiguous terms such as mild, moderate, severe to describe suicide risk)
- ❑ Optimizing information processing by the use of protocols or aids (e.g., procedural checklists provided in Sections 1.3 and 1.4)
- ❑ Automating wisely and as necessary (e.g., sample templates on documentation provided to assist clinics and staff with adaptation of standardized procedures for their specific site)
- ❑ Mitigating unwanted side-effects of change, particularly when new techniques or treatments are first introduced (e.g., Guide provides detailed instructions and resources to be used for correct implementation of new procedures)

The information shared in the civilian literature has a lot to teach us about how to best formulate and maintain a healthy and collaborative relationship with patients while mitigating risk. Oyebode (2006, p. 225) reports that a poor relationship with the provider, the impression of not being kept informed by the provider, and/or financial concerns are several of the noteworthy reasons for patients who file a malpractice claim. What this means in terms of your work with suicidal patients is that you should remain mindful of fostering a solid relationship based on respect and a genuine desire to deliver optimal care. For instance, if you decide to contact command, no matter the possible reaction of the service member, it is your duty to inform him or her of your decision and the rationale for your decision. Spend time to process the patient's reaction. This is respectful to the patient and minimizes the chances of a person feeling that he or she was not kept informed about what to expect along the way. Your practices as an AF provider are important not only in terms of the patients receiving care but also in terms of enhancing an environment within the AF community that minimizes the role of perceived stigma and barriers to care in suicide prevention.

The following is a brief review of the scientific literature (chronologically based on date of publication) that AF mental health staff should consider in order to avoid common errors in the assessment, management, and treatment of their suicidal patients.

- ❖ Five common types of suicide management errors (Krieger, 1978, pp. 649-651):
    1. Failure to use appropriate therapy when indicated
    2. Staff's attitude that the case was hopeless and would inevitably end in suicide
    3. Failure to properly assess a patient's communication
    4. An intra-staff failure to communicate clearly
    5. Returning a patient to the same social system in which the suicidal event had occurred

❖ Five recommendations for providers (Berman & Cohen-Sandler, 1983, pp. 16-17):
  1. Relative risk for suicidal behavior should be evaluated constantly and noted in all patients' charts.
  2. Precautions against self-injury should be taken for all patients identified as at risk for suicide.
  3. Observations, judgments, and orders must be adequately documented.
  4. Contemptuous attitudes toward the suicidal patient must be guarded against.
  5. Postventive treatment should follow a patient's suicide.

❖ Five legal defenses against allegations of failure to prevent suicide (Simon, 1992):
  1. Clinician acted in concordance with accepted clinical practice.
  2. The lack of knowledge of suicidality was reasonable.
  3. There was a justifiable allowance of freedom of movement given that the individual was on an open ward.
  4. Clinician's decision was reasonable regarding diagnosis and/or course of treatment.
  5. Extraordinary circumstances precluded or circumvented reasonable precautions or restraint.

❖ Twelve common failure scenarios (Bongar, Maris, Berman, & Litman, 1992, p. 463):
  1. Failure to evaluate properly the need for psychopharmacological intervention or unsuitable pharmacotherapy
  2. Failure to specify criteria for and to implement hospitalization
  3. Failure to maintain appropriate clinician-patient relationships
  4. Failures in supervision and consultation
  5. Failure to evaluate for suicide risk: At intake
  6. Failure to evaluate suicide risk: At management transitions
  7. Failure to secure records of prior treatment/inadequate history-taking
  8. Failure to conduct a mental status exam
  9. Failure to diagnose
  10. Failure to establish a formal treatment plan
  11. Failure to safeguard the outpatient environment
  12. Failure to document adequately clinical judgments, rationales, and observations

❖ We can learn important lessons from malpractice suits in civilian courts, to ensure that Air Force mental health personnel meet the standard of care. Clinicians have fared well in suicide-related malpractice claims when issues of *foreseeability, treatment planning*, and *follow-up/follow through* were adequately covered and documented. The following practices provided below are derived from malpractice suits, reported by Jobes and Berman (1993), and provided for the optimum protection of mental health staff and the government:

  1. Foreseeability
     ☑ Conduct a thorough risk assessment
     ☑ Consider using psychological tests and assessment instruments
     ☑ Make an overall clinical judgment of suicide risk
     ☑ Adequately document assessment information
     ☑ Seek and document consultation

2. Treatment Planning
   - ☑ Use overall risk to inform and shape treatment plan
   - ☑ Identify both short- and long-term treatment goals
   - ☑ Consider a full range of treatments—what will be used and why
   - ☑ Consider various safety contingencies
   - ☑ Routinely revise and update treatment plan
   - ☑ Overhaul treatment plan when necessary
   - ☑ Seek consultation
   - ☑ Adequately document treatment information

3. Follow-up and Follow-Through
   - ☑ Make sure treatments are being implemented
   - ☑ Coordinate care with others, as needed
   - ☑ Always ensure clinical coverage, when unavailable
   - ☑ Make referrals carefully and follow-up (issues of clinical abandonment)
   - ☑ Seek consultation and adequately document follow-up/follow through

Jobes and Berman (1993) also provide the following step-by-step model for assessing and revising suicide policies, procedures, and practice:

Step 1. Know the relevant laws and ethics.
Step 2. Maintain a written policy and procedure statement.
Step 3. Assure clinical competency.
Step 4. Provide adequate documentation.
Step 5. Develop relevant resources.

❖ Two important reminders (Oyebodi, 2006, p. 225):
   1. "In a case of foreseeable but unforeseen suicide it is usually alleged that the doctor failed properly to assess the patient and thus did not recognize the risk."
   2. "In the case of foreseeable but unprevented suicide the allegation is of failure properly to supervise or restrain a patient whose risk of suicide is already recognized."

Finally, suicide survivors' perceptions of the treating clinician may also provide an opportunity to generate lessons learned and minimize common suicide risk assessment, management, and treatment errors. In a study by Peterson, Luoma, and Dunne (2002), 71 suicide survivors were asked about their perceptions of the staff members who were treating their loved ones at the time of suicide death. The following mistakes, from the perspectives of the suicide survivors, were reported:

1. Medication decisions
2. Clinician did not involve the family
3. Treatment was not aggressive enough
4. Clinicians didn't take possibility of suicide seriously
5. Release from hospital and/or treatment too soon
6. Electroconvulsive Therapy decisions
7. Clinician did not consult with others
8. Loved one "fooled" the clinician
9. Clinician did not connect with the patient
10. Misdiagnosis
11. Clinician "ignored" a nurse's note

12. Clinician did not allow review of medical records
13. Clinician was overly optimistic
14. Clinician did not see loved one soon enough
15. Clinician failed to review past history

In summary, this section of the Guide has presented an overview of common errors when working with suicidal patients. AF mental health personnel deliver a valuable service to each patient, his or her family, as well as the USAF community. Our goal is to put processes in place to minimize the chance that human error can occur and harm others. To err is, of course, human. Lessons learned from the sources listed above should be reviewed carefully to minimize the likelihood of repeating similar errors in the future.

SECTION 4
EVIDENCE-BASED INTERVENTIONS FOR
SUICIDE PREVENTION

Having an understanding of the theoretical models for suicide and a working knowledge of evidence-based interventions will enhance mental health personnel's understanding of why suicide occurs and provides a framework for conceptualizing patients with suicide-related ideation and/or behaviors. This section provides:

☑ Four brief clinical practice guides covering CAMS, CBT, Safety Planning, and Motivational Interviewing to Address Suicide Ideation
☑ Information on psychiatric medications and suicide prevention

4.1 Cognitive Behavior Therapy (CBT) Guide[13] for Suicide Prevention

A limited number of studies have examined the efficacy or effectiveness of psychosocial interventions with suicidal persons. Cognitive behavioral psychotherapies and dialectical behavior therapy have shown promising results in the treatment of individuals with a recent suicide attempt (Hawton et al., 1998; Linehan et al., 2006; Rush, Beck, Kovacs, Weissenburger, & Hollon, 1982; van der Sande et al., 1997). Most recently, a 10-session outpatient cognitive therapy protocol (Brown et al., 2005) has proven efficacious in reducing suicide attempts in adult outpatients. Findings indicate that an average of 9 hours of individual outpatient cognitive therapy reduces the likelihood of repeat suicide attempts by approximately 50%. The efficacy of this promising new intervention is currently being tested in both outpatient (Rudd and colleagues) and inpatient military settings (Ghahramanlou-Holloway and colleagues).

Given the brief nature of this cognitive therapy protocol and the ongoing usage of evidence-based therapeutic practices within the Air Force, this section of the guide provides a clinician-friendly set of instructions on how to best implement targeted cognitive behavior therapy for patients with suicide-related ideation and/or behaviors. Please note that in the scientific literature, the term "Cognitive Therapy" is often used by Aaron Beck and colleagues. However, the intervention uses both cognitive and behavioral strategies and therefore, for the remainder of this section, we will use the term "cognitive behavior therapy" to refer to the efficacious suicide prevention program developed by Dr. Gregory Brown, Dr. Aaron Beck, and colleagues at the University of Pennsylvania's Center for the Prevention of Suicide.

Brief Description of Cognitive Behavior Therapy for the Prevention of Suicide

According to Beck (Beck, 1976; Beck, 1996; Beck, Rush, Shaw, & Emery, 1979; Rudd, 2004), a series of biopsychosocial vulnerabilities combined with an individual's suicide-related thoughts and behaviors contribute to the formation, maintenance, and exacerbation of a suicide-specific mode. A mode refers to the structural and operational units of personality. Each unit within the suicide mode consists of an amalgam of unified, functionally synchronous cognitive, affective, motivational, and behavioral systems. The frequency and severity of activation of the suicide-specific mode may increase over time, especially for individuals without protective factors. In particular, patients with a history of prior suicide attempts may require minimal internal and/or external triggers to re-activate their suicide-specific mode. Some individuals experience a chronic state of suicide mode activation and thus remain at elevated risk for suicide-related behaviors. Once a suicide-specific mode has been activated, suicide appears as the *only* option and may even be considered by the individual as rational (Beck, 1976, p. 123). The perception of suicide as the only option highlights the cognitive rigidity of the suicidal person 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 translate to a state of arrested flight, in which the suicidal person loses the ability to consider reasons for living, becomes hopeless, feels trapped, wants to escape, and views suicide as the only option to resolving his or her problem(s).

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[13] Dr. Marjan Holloway has served as the primary source of information on cognitive behavior therapy for the prevention of suicide as provided in this section of the guide.

Cognitive behavioral providers must take a step-wise approach to treatment by first de-activating the suicide mode, second, modifying its structure and content, and finally, constructing and practicing more adaptive structural modes. Furthermore, providers help patients challenge their distorted cognitions, such as excessive pessimism and high estimations for future negative outcomes and build hope. Patients are taught problem-solving skills and are assisted in developing healthy coping strategies and emotion regulation skills so that attempting suicide is no longer the *only* available option worth considering. Suicide modes occur independently of psychiatric diagnoses and therefore treatment is transdiagnostic and directly targets the suicide mode (Ghahramanlou-Holloway, Brown, & Beck, 2008). This does not mean that providers should not pay attention to the psychiatric diagnoses of suicidal patients. This means that treatment for suicide ideation and/or suicide attempt must directly target the suicidality instead of treating it as a symptom of a psychiatric diagnosis. Additionally, psychiatric diagnoses are conceptualized in the context of how associated symptoms contribute to the activation of the suicide mode.

General Cognitive Behavior Therapy Session Structure

Judith Beck (2011) provides a comprehensive overview of session structure in her book, titled, *Cognitive Behavior Therapy: Basics and Beyond,* briefly summarized here. Inform the patient about the session structure and provide psychoeducation about what to expect from treatment. A typical CBT session for a suicidal patient consists of the following components: mood check (including assessment of mood during the past 7 days and completion of suicide risk assessment measures such as the BDI-II and/or BHS), risk assessment (assessing suicide ideation, intent, and plan[s]), alcohol and substances check (severity, frequency, and duration of usage for each abused substance during the past week), adjunctive treatment and compliance check (type, dosage, and adherence to medications are noted, as well as the previous and next medication appointments), agenda setting, bridge from the last session, suicide protocol task (described later in this section), action plan review and new assignment, and session feedback.

Objectives of Cognitive Behavior Therapy for Prevention of Suicide

The cognitive behavior therapy protocol for the treatment of suicide aims to accomplish the following six objectives:

1. Decrease severity of depression, hopelessness, and suicide ideation.
2. Increase effective coping, emotion regulation, and problem-solving skills, especially those relating to the problems and stressful life events that preceded and triggered the most recent suicide-related ideation and/or behaviors.
3. Increase gradual establishment and adaptive use of a broad social support network.
4. Increase use of and compliance with adjunctive medical, substance abuse, psychiatric, and social interventions.
5. Educate on the interconnection between feelings, thoughts, and behaviors such that patients fully understand the cognitive conceptualization formulated to explain the suicide-related ideation and/or behaviors and how to best prevent relapse.
6. Prepare patients, family members, and/or friends for the implementation of emergency safety plan procedures in cases where suicidal urges may recur.

Step-by-Step Guide for Outpatient Cognitive Behavior Therapy for Suicide Prevention

For detailed guidance on how to best implement the CBT protocol for the treatment of patients with suicide-related ideation and/or behaviors, please refer to the following sources: Berk, Henriques, Warman, & Brown, 2004; Brown, Henriques, Ratto, & Beck, 2002; Ghahramanlou, Brown, & Beck, 2008; and Wenzel, Brown, & Beck, 2009. In addition, training on this model can be obtained generally through the annual meetings of the Association for Cognitive and Behavioral Therapies (ABCT), the DoD/VA Suicide Prevention Conference, and/or the American Association of Suicidology. The script for a training workshop on CBT for suicide prevention which was presented at the 2012 DoD/VA Suicide Prevention Conference is provided on the Defense Centers of Excellence website at the following link, (http://dcoe.health.mil/Training/Conferences/Past_Conferences/2012_Suicide_Prevention_Conference/Video_Footage.aspx). A brief summary of the intervention steps are provided here to assist you in the delivery of this efficacious intervention.

Cognitive behavior therapy for the prevention of suicide consists of one 60- to 90-minute psychoeducation session and approximately ten 45- to 50-minute weekly psychotherapy sessions. During the psychoeducation session, inform patients about the time limited nature of this type of treatment and its direct focus on reduction of suicide risk. Provide information on the general CBT session structure and emphasize the importance of completing work outside of the session (i.e., homework). Provide patients with (if feasible) or recommend a self-help CBT book, *Choosing to live: How to defeat suicide through cognitive therapy* (Ellis & Newman, 1996). Discuss perceived obstacles to treatment and problem-solve these with the patient. Initiate treatment after informed consent has been obtained and limits of confidentiality have been discussed. Remember that this intervention is flexible and should not be followed strictly in its sequence of presentation at the expense of therapeutic rapport and clinical judgment. The primary objective is to collaboratively develop an *individualized* cognitive conceptualization of the patient for the purposes of treatment planning. An active and directive role for the provider is encouraged. In cases of severe suicide ideation, you may need to be more directive and you can adjust the level of your active coaching as you move forward in the process of treatment.

Therapy is offered in three stages:

1. Early Phase of Treatment (Sessions 1–3)
   Activities: Engage the patient in treatment, plan for safety, and develop an initial cognitive conceptualization based on a review of the patient's suicide history or, if applicable, the most recent incident of suicide-related ideation and/or behavior.

2. Middle Phase of Treatment (Sessions 4–7)
   Activities: Teach various cognitive and behavioral strategies to reconstruct patient's problematic coping and problem-solving styles, address impulsivity and other types of emotion regulation deficits, rebuild hope and reasons for living, build a social support network or encourage linkage with existing social support system, and increase participation in adjunctive medical and psychiatric services.

3. Final Phase of Treatment (Sessions 8–10)
   Activities: Educate the patient about relapse prevention strategies and assess the patient's increased cognitive-behavioral skills through a relapse prevention task, update safety plan, and plan for booster sessions as needed.

Early Phase of Treatment (Sessions 1–3)

The primary objectives of this early phase are to build a strong therapeutic alliance, plan for safety, and construct a cognitive case conceptualization that best explains the activation of suicide ideation and behaviors for the patient.

Objective 1: Engage the Patient in Treatment

Develop a strong early therapeutic alliance with the patient by gaining an accurate understanding of the patient's experience and how the patient has come to see his/her life situation as utterly hopeless. Show empathy. Discuss ways in which treatment will help the patient with preventing a future suicide-related event in the future. Convey the importance of building reasons to live and visualizing a hope continuum for various life domains (e.g., relationship with children, work situation, improved mood).

Objective 2: Generate a Safety Plan

A crisis response or a safety plan should be completed in the first session. Discuss thoroughly the patient's prior experiences, specifically, maladaptive cognitions and behaviors that involve self-injury at times of crises. Collaborate with the patient to develop an individualized, hierarchically arranged, written list of coping strategies to implement in future distressing circumstances. Make sure that the safety plan, at the very least, contains contact information for the provider, the on-call provider (if available), the local 24-hour emergency department, and at least one reliable suicide hotline number as well as information on how to best limit access to lethal means. Contact information for Military Crisis Line's (1-800-273-TALK [8255] or 00800-1273-TALK [8255] in United States Air Forces in Europe [USAFE]) 24 hours a day, 7 days a week suicide crisis hotline must be provided along with name and address of the nearest Emergency Department. Remember that safety planning is a collaborative process. You must check on the patient's willingness to follow the safety plan and help problem solve perceived obstacles in implementation. The crisis response plan needs to be evaluated for its effectiveness and further expanded throughout the course of treatment as the patient learns new coping skills. Multiple copies of the plan can be generated and kept at different locations. Additional copies of the plan can be shared with a designated family member and/or friend.

Objective 3: Develop a Cognitive Case Conceptualization to Understand Suicide Mode

The cognitive case conceptualization is an individualized cognitive map of a patient's current automatic thoughts, conditional assumptions, and core beliefs activated before, during, and after suicide-related ideation and behaviors. Collect data about the patient's early childhood experiences, typical suicide activating events, associated automatic thoughts and images, emotional responses, and subsequent behavior. You can generate a cognitive case conceptualization diagram collaboratively with the patient (see Judith Beck, 2011, text for examples). Because the diagram is based on a series of hypotheses, its content should be refined periodically as needed during the course of treatment.

The most important aspect of generating this conceptualization is to provide patients an opportunity to "tell their story" about the most recent suicide-related experience (either ideation and/or behavior) and the specific events leading up to it. The patient's suicide narrative provides a wealth of information for the purposes of cognitive case conceptualization and treatment planning. Additionally, this activity provides the patient with an opportunity to disclose

the details surrounding his/her thoughts and actions on suicide, provides a supportive and nonjudgmental environment, and allows for the cathartic experience through storytelling and the narrative approach. During the process of generating a cognitive case conceptualization, you can begin to educate the patient about the interrelatedness of thoughts, feelings, and behaviors that serves as the foundation for CBT. A frequent review of the generated diagram allows the patient to see the patterns of association between specific situational problems and subsequent activation of the suicide mode. At this point, you can collaboratively develop a suicide-related problem list, prioritize the problems, and develop a plan for addressing each.

Here's an example of how you can present this activity to the patient who has recently attempted suicide.

> *Let's first focus on your suicide narrative. Please tell me about the circumstances, thoughts, feelings, and actions that resulted in your decision to attempt suicide. I am interested to hear about your reasons for wanting to die and your reactions to the hospitalization, and your reactions to having survived the attempt. Please tell me about what happened on the day of your suicide attempt as if it were a story with a beginning, a middle, and an end. Your job in today's session is to share your suicide story so that both of us can understand (as much as possible) how you reached the decision to kill yourself. My job in today's session is to best understand what happened, and hearing your description of the events will help me do that. I will remain quiet for the most part, will take notes for both of us, and will let you do most of the talking. If you move away from the story, I will help refocus you. Given our limited time together, it is my responsibility to make sure that we get you the highest dose of this treatment by keeping us focused. Talking about these events may be uncomfortable. But please keep in mind that it is important that the two of us, together, understand the thoughts, feelings, and behaviors that led up to the suicide attempt so that our work can be most effective. Do you have any questions before we start?*

Middle Phase of Treatment (Sessions 4–7)

In this phase of treatment, the information obtained from the case conceptualization is used to generate an individualized cognitive behavioral plan of intervention for the patient. The overall goal is to determine skill-based problem areas (underdeveloped or overdeveloped) that are associated with the most recent episode of suicide ideation or behavior. For example, consider the following problematic areas that are often noted in suicidal patients:

☐ Ineffective Coping Strategies, Poor Self-Efficacy, & Deficits in Problem-Solving
Example of Automatic Thought: "Nothing is going to change so I give up."

☐ Problematic Emotion Regulation (e.g., shame, guilt, anxiety, anger)
Example of Automatic Thought: "I can't stand feeling this way. I will make them pay."

☐ Hopelessness; Reasons for Dying > Reasons for Living
Example of Automatic Thought: "I have nothing to look forward to – my life has been a complete waste."

- ☐ Perceived or Actual Lack of Social Support OR Inadequate Utilization of Existing Social Support Network (e.g., thwarted belongingness; sense of burden to others)
  Example of Automatic Thought: "My family will be better off without me."

- ☐ Acquired Capability for Self-Harm and Motivation to Repeat Suicidal Behavior
  Example of Automatic Thought: "If things don't get better, I know how to end it all."

- ☐ Non-Compliance with Medical and/or Psychiatric Treatment
  Example of Automatic Thought: "Nothing is going to help. What's the point?"

Objective 1: Modify Negative Suicide-Relevant Automatic Thoughts and Core Beliefs

Once you have identified the patient's automatic thoughts, associated images, and core beliefs in relation to his or her suicide mode, you can help the patient in evaluating these cognitions and, second, in modifying them. A Dysfunctional Thought Record can be used to teach the patient about more effective responses to daily cognitive distortions. Patients can also be educated about how their core beliefs may be associated with their suicidal thinking. What is important for the patient to understand at this stage is that such beliefs are generally rooted in childhood events, not in absolute truth, and can be tested, as well as changed. Cognitive restructuring techniques such as Socratic questioning, cognitive continuum, historical tests of core beliefs, behavioral experiments, and/or restructuring early memories may be used to help the patient devise more positive, realistic, and functional core beliefs.

One sample activity that you may use to help your patient challenge suicide-activating core beliefs (e.g., "My life is worthless.") involves the construction of a hope box or a hope kit. The purpose of the hope box is to help patients directly challenge their maladaptive thoughts by being reminded of previous successes, positive experiences, and current reasons for living, especially at times of extreme distress. The process of constructing the hope box allows patients to work actively on modifying their core beliefs that they are worthless, helpless, and unlovable. It can be helpful to have the patient construct their hope box in session to ensure that everything that is put in the box is truly helpful for that particular patient. Items included in the box vary depending on each patient and may consist of pictures of loved ones, a favorite poem, a religious prayer, and/or coping cards. One of our patients, for instance, chose to include a picture of herself in her early 20s as a reminder of a very positive and fulfilling time in her life. Dr. Nigel Bush and colleagues at the National Center for Telehealth and Technology are currently developing a virtual hope box for military personnel, (http://www.dcoe.health.mil/Content/Navigation/Documents/SPC2012/2012SPC-Bush-Hope_Box.pdf).

Objective 2: Teach Problem-Solving Skills

Research indicates that suicidal patients, once faced with life challenges, may feel threatened, demonstrate low self-efficacy and have difficulty using a rational problem-solving approach that involves generating alternative solutions (Ghahramanlou-Holloway, Bhar, Brown, Olsen, & Beck, 2011). In fact, most may use an avoidant or an impulsive style of problem-solving and some may vacillate back and forth between the two ineffective styles. CBT for the prevention of suicide teaches patients to cope with adversities by learning about effective steps to adaptive problem solving. Arthur Nezu at Drexel University has several published papers and books that guide providers through how to best teach problem solving to their patients. Figure 4.1 demonstrates some of these recommended steps.

Figure 4.1. Problem Solving Steps
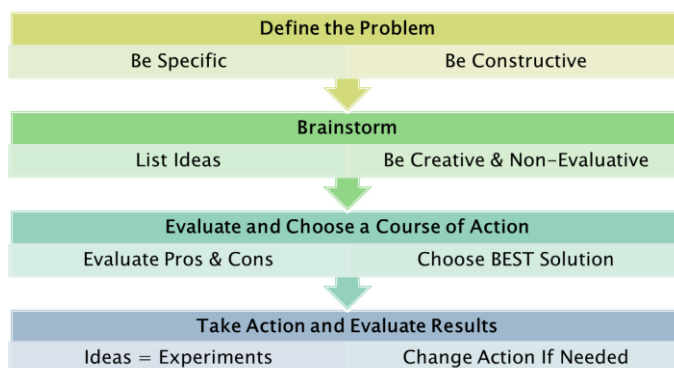
Objective 3: Develop Healthy Behavioral Coping Skills

Suicidal patients are likely to have low distress tolerance and poor affect regulation. Thus, another goal of CBT for suicide prevention is to teach patients a variety of relaxation activities such as progressive muscle relaxation and controlled breathing exercises. The National Center for Telehealth and Technology has developed a portable stress management application, Breathe2Relax (http://t2health.org/apps/breathe2relax) and this resource can be shared with patients. Patients can also learn about physical (e.g., exercise), cognitive (e.g., distraction), and sensory (e.g., music) self-soothing strategies. The development and continual practice of healthy coping strategies are important steps in teaching a patient to "procrastinate" their suicidal impulses, which generally occur in waves. Urge surfing is a technique that can be taught as well. For instance, you can construct a diagram of a patient's mood and suicidality over time that illustrates a gradual or sudden increase and subsequent decrease in an impulsive need for self-harm. The goal is to teach the patient to "ride out" suicidal urges. An important delay tactic is the removal of lethal means from the patient's environment. As therapy progresses, the patient can be prepared to implement long-term coping strategies (e.g., marital therapy to practice effective communication skills) in addition to these short-term strategies.

One activity that promotes effective problem solving is to construct coping cards, which are small, wallet-size cards generated collaboratively in session. Coping cards (refer to Appendix E for a sample) can provide the patient an easily accessible way to "jump-start" adaptive thinking during a suicidal crisis. The patient is encouraged to use the coping cards to practice adaptive thinking even when not in crisis. Three types of coping cards may be constructed.

1. Place a suicide-relevant automatic thought or core belief on one side of the card and the alternative, more adaptive response on the other.
2. Write down a list of coping strategies.
3. Write a list of instructions to motivate or "activate" the patient toward completing a specific goal.

Objective 4: Increase Social Support and Compliance with Adjunctive Services

A common observed core belief in patients with suicidal behavior is that "no one cares." In addition, keep in mind that according to Joiner's (2005) interpersonal psychological theory for suicide, perceived burdensomeness and thwarted belongingness are two important risk

indicators for suicide. For patients who already have an existing network of supportive friends, family members, or coworkers, the goal is to increase their perception of social support and to practice communication skills that make future social support likely. A patient may be encouraged, for instance, to share his safety plan with a military peer and/or a chaplain. For patients who truly lack a social support network, the goal is to establish gradually an adaptive network of accessible social support. Connecting patients to people and resources in the military community is an effective way to accomplish this task, for example, by encouraging someone does not feel connected to seek support from the local faith community. Another important therapeutic goal is to increase the patient's compliance with adjunctive medical, psychiatric, and substance abuse treatment services. Engagement in a comprehensive range of services and a team approach to treating suicidal patients will help with this goal.

One important activity may focus on collaboratively generating a comprehensive list of individuals within the patient's circle of social support. Next, the patient outlines the potential contributions each individual is capable of making to assist with minimizing risk for suicide. The patient is asked to keep track of positive interactions involve each supportive person in at least one aspect of the treatment process. The following questions are helpful for this task:

Who have you relied on in the past?
Who called or sent you a birthday card? Who has sent you a holiday card?
Who has complimented you recently?
Who is really good at listening to you?
Who are the people that you email or call the most often?
Who would be deeply saddened on learning about your death?
Who would be happy to hear from you because it has been a long time since you last spoke?
Who have you kissed, hugged, or told "I love you" within recent memory?
Who do you find the most helpful or caring within your command?

Late Phase of Treatment (Sessions 8–10)

Relapse prevention is a common CBT strategy that aims to strengthen self-management such that the likelihood of returning to a previously stopped behavior is minimized. For patients who present only with suicide ideation, relapse prevention is directed at identifying triggers for suicidal thoughts and preventing the likelihood of experiencing these thoughts in the future. For patients who present with suicide-related behaviors, relapse prevention is directed at identifying triggers for suicidal actions and preventing the likelihood of acting on suicidal urges in the future. The final phase of CBT for the prevention of suicide focuses primarily on a relapse prevention task (RPT) and guides the patient through its five stages. The brief guidance provided below will familiarize you with each of the RPT stages which may be completed in multiple sessions:

1. Describe the purpose of the RPT (i.e., to minimize the chances of recurrence of suicidal thinking and actions), address questions and concerns, and obtain permission to begin the procedure. This activity involves detailed imagery and discussion of previous suicide-related ideation and/or behaviors that some patients may avoid. Similar to how a trauma patient would be guided through a prolonged exposure activity and encouraged not to avoid the traumatic stimuli, you will inform your patient that the RPT may activate strong physiological and emotional responses. Assure the patient that this is a collaborative activity and you will be in the room to ensure comfort and safety.
2. Ask the patient to imagine the chain of events, thoughts, and feelings leading to the most recent episode of suicide ideation (select most severe) or suicide behavior (select most

severe). Guide the patient through the exercise, scene by scene, using all senses to construct a detailed sequence of events and their meaning to the patient on the day of the suicide crisis. Similar to how you would implement a prolonged exposure session, make sure to slow things down. Tell the patient you want them to construct a motion picture story to describe the chain of events that resulted in the suicide crisis – but to do so slowly, taking enough time to describe the details of each frame.

3. Ask the patient again to take you through the sequence of events leading to the most recent episode of suicide ideation or suicide behavior. However, this time, direct the patient to use the skills learned in therapy to appropriately respond cognitively, affectively, and behaviorally to move further away from the previously occurring negative outcome of suicide ideation or behavior. This is the patient's opportunity to relive the experience and apply what has been learned in therapy to control the outcome. If the patient is moving too fast or neglecting important points, you can stop and ask about alternative ways of thinking, feeling, and behaving. This stage can be until the patient is able to demonstrate solid learning of the strategies taught in treatment.

4. In this stage, (given your knowledge of the patient's psychosocial history, case conceptualization, and suicide mode triggers) create a future scenario that is likely to activate suicidal thinking and behavior. In other words, take the patient through another imagery exercise, this time, one that involves a future suicidal crisis. Question the patient about possible coping strategies, provide helpful feedback, guide the patient through each link in the chain of events, and propose additional alternative strategies if the patient is clearly neglecting important points of the intervention.

5. Debrief the patient by providing a summary of learned skills in therapy, congratulate the patient for completing this final therapeutic task, and assess overall emotional reaction to this activity. Remind the patient that mood fluctuations and future setbacks in the form of lapses are to be expected. Provide the option for requesting future booster sessions and make plans for next steps in accomplishing general therapy goals.

Treatment may be terminated when the patient is able to complete the relapse prevention task. If the patient is not ready or able to complete this exercise successfully, treatment must be extended. A checklist may be used to determine whether a patient is ready to end treatment. For instance, reduced scores on self-report measures for x number of weeks; evidence of improved problem-solving; homework compliance; engagement in adjunctive medical, psychiatric, and substance abuse treatment services; and development of a social support system are factors that may be considered in assessing the patient readiness for termination.

Inpatient Cognitive Behavior Therapy for the Prevention of Suicide

An inpatient cognitive behavioral protocol for the prevention of suicide, which is adapted from the efficacious outpatient model described above, is currently being evaluated at the Walter Reed National Naval Medical Center and Ft. Belvoir Community Hospital for military personnel and beneficiaries. The inpatient intervention is titled, Post Admission Cognitive Therapy (PACT). PACT is administered to the patient in approximately six 60-90 minute face-to-face individual sessions over the course of 3 days during his or her inpatient psychiatric hospitalization. A full description of the inpatient model is provided by Ghahramanlou-Holloway, Cox, and Greene (2012) in *Cognitive Behavioral Practice*. A case study is provided in *Clinical Case Studies* (Neely, Irwin, Carreno-Ponce, Perera, Grammer, & Ghahramanlou-Holloway, in-press).

Adherence to Cognitive Behavior Therapy

The Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980) measures a provider's competency in delivering CBT. The CTRS allows for a designation of specific provider strengths and weaknesses in a given therapy session. The *CTRS Rating Manual* provides detailed instructions. Many providers may not have sufficient time and/or resources to use a rating scale to measure their own competency and/or that of another colleague. However, at the very least, you are encouraged to review the CTRS in order to have a better awareness of how to provide competent cognitive behavioral care to your patients. Please note that the CTRS is currently being adapted for measuring therapist competency in providing CBT for suicide prevention.[14] The CTRS and Rating Manual are provided at no cost on the Beck Institute for Cognitive Behavior Therapy website, http://www.beckinstitute.org/cognitive-therapy-rating-scale/.

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[14] If interested to obtain a copy, please contact Dr. Holloway at Uniformed Services University, marjan.holloway@usuhs.edu or mholloway@usuhs.mil.

4.2 Collaborative Assessment and Management of Suicidality (CAMS) Guide[15]

The Collaborative Assessment and Management of Suicidality (CAMS) is a therapeutic framework that modifies how providers engage, assess, and treat Suicidality. CAMS can be initiated with any patient who has current suicidal thinking or behaviors. The CAMS framework emphasizes a unique collaborative assessment and treatment planning process between a suicidal patient and his or her provider. This process is fundamentally designed to enhance the therapeutic alliance and increase treatment motivation in the suicidal patient.

Unlike other suicide-relevant treatments, CAMS is not a type of psychotherapy such as CT, DBT, or IPT. Instead, CAMS is an organizational clinical framework—a therapeutic platform—for maintaining a collaborative focus on the elimination of suicide as a means of coping and getting one's needs met. CAMS does not rigidly prescribe the specific interventions a provider must use. Instead, the CAMS provider is free to use his or her own expertise and experience to select and implement evidence-based interventions. Moreover, when the provider is uncertain about a particular problem area, a CAMS consultation team can be used to obtain helpful input, resources, and/or further training. From a theoretical standpoint, CAMS is "non-denominational", meaning that providers from a range of training perspectives can use CAMS without having to learn a completely new theoretical approach.

Taken together, these considerations make CAMS adaptable and easy to use for providers who have a range of experience. While clinical flexibility is attractive to many experienced senior providers, for less experienced providers or those anxious about working with suicidal patients, CAMS provides a framework that guides the clinical assessment and treatment process.

Suicide Status Form (SSF)

Central to the CAMS approach is the use of the Suicide Status Form-II-R (SSF-II-R; see Appendix B) which is a multi-purpose clinical assessment, treatment planning, tracking, and outcome tool. Portions of the SSF tool are completed with the patient and the provider sitting side-by-side as they endeavor to systematically deconstruct the patient's suicidality through quantitative and qualitative assessments and consideration of empirically based risk factors (e.g., suicidal planning, access to means, attempt history). The provider and the patient then use the totality of this assessment information to collaboratively develop a suicide-specific/problem-focused treatment plan that is designed to stabilize the patient through a "Crisis Response Plan"[16] and the further identification and treatment of the "drivers" of suicidality—those patient-identified issues that make the patient suicidal. Please note that the term, Crisis Response Plan is one that Jobes uses in describing the safety planning that occurs in the context of CAMS. Information on the Safety Planning Intervention which is a step-by-step crisis response plan designed by Barbara Stanley and Gregory Brown is provided later in this Guide.

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[15] Dr. David Jobes has served as the primary source of information on CAMS as provided in this section of the guide.

Components of CAMS

All interventions in the CAMS clinical framework are designed to either eliminate or reduce the impact of direct (e.g., hopelessness) or indirect (e.g., work-related problems) drivers of the patient's suicidal risk (i.e., any suicide-specific contributing factor that may lead to suicidal ideation and/or behaviors). Specific strategies used in CAMS routinely include use of a Crisis Response Plan (aka Safety Plan), and other suicide-specific interventions (e.g., removing access to means, addressing suicide-promoting beliefs, cultivating reasons for living, increasing interpersonal support, and reducing barriers to treatment attendance). CAMS-informed care often leads to the engagement of related auxiliary services (e.g., substance abuse treatment, psychopharmacology, treatment of health care issues, or vocational counseling).

Session 1: The Index Use of CAMS and the SSF-II-R

1. There should be early identification of suicidal risk, ideally through a screening tool in the waiting room or early-on within a given clinical session.
2. Within a first CAMS session, the topic of suicide is raised in the first ten minutes and the SSF is introduced as a useful vehicle for understanding the patient's suicidal suffering more thoroughly.
3. The initial CAMS SSF-based assessment should be done using side-by-side seating (with the patient's permission) wherein the patient completes both quantitative and qualitative SSF-based assessment collaboratively with the provider's help.
4. There is further assessment conducted by the provider with the patient's help of various empirically-based risk factors.
5. Still seated side-by-side, the clinical dyad collaboratively work on the CAMS treatment plan, focusing on the development of a Crisis Response Plan and the identification of two suicidal "drivers" that are targeted and treated with problem-focused interventions. A primary goal in CAMS is to keep the suicidal patient out of the hospital if at all possible.
6. After completion of a satisfactory CAMS Treatment Plan, the clinician completes an additional page of SSF documentation that includes information about mental status, diagnosis, overall formulation of risk, and a case note.

CAMS Suicide Status Tracking Sessions

1. Each CAMS Suicide Status Tracking session begins with the patient rating key SSF assessment scales on the SSF Tracking Form.
2. The bulk of the tracking session is then spent on further crafting the Crisis Response Plan and treating the suicidal drivers.
3. All CAMS Suicide Status Tracking sessions end by collaboratively updating the CAMS Treatment Plan in the side-by-side seating arrangement.
4. Additional SSF documentation is completed by the provider after each tracking session.
5. SSF Tracking Forms and all CAMS-related procedures are used until criteria for clinical resolution are met or other clinical outcomes occur.

CAMS Resolution and Other Clinical Outcomes

1. When a CAMS patient on Suicide Status has three consecutive sessions where suicidal coping is essentially eliminated, a final set of SSF Outcome Forms are completed about the case disposition providing key documentation marking the end of CAMS care.

2. If another clinical outcome is realized (e.g., transfer to another provider or a unilateral termination), the CAMS Outcome Forms are similarly used to mark the end of CAMS.
3. Should a resolved CAMS patient become suicidal again, the provider and the patient initiate the index session CAMS procedures and Suicide Status care as noted above.

Adherence to CAMS

Beyond the initial engagement, adherence to CAMS requires an on-going suicide risk assessment process, the continuous crafting of the Crisis Response Plan, and use of problem-focused interventions to target and treat suicidal drivers. Adherence to CAMS care can be objectively measured by using an adherence tool called the CAMS Rating Scale (contact Dr. David Jobes at the Catholic University of America, jobes@cua.edu for permission to use the CAMS Rating Scale). Full adherence to CAMS care includes the following: (1) collaborative assessment and treatment planning, (2) the systematic deconstruction of suicidal drivers, (3) the development of suicide-specific problem-focused interventions, and (4) the collaborative development of existential purpose and meaning (i.e., a life worth living).

4.3 Safety Planning Intervention[17] (SPI) Guide

The Safety Planning Intervention (SPI; Stanley & Brown, 2008; Stanley & Brown, 2012) can be used by Air Force mental health personnel as a stand-alone intervention (e.g., in the emergency room, primary care, inpatient unit prior to discharge) or as an adjunctive intervention integrated into ongoing outpatient treatment of suicidal individuals. SPI serves as the suicidal individual's crisis response plan[18] to short circuit the suicidal crisis. Brief, easy-to-use clinical tools such as the SPI are important adjuncts in helping individuals manage suicide ideation and urges (Joiner et al., 2003; Jobes, 2006; Stanley & Brown, 2012). SPI can be distinguished from a safety contract because it provides concrete strategies for managing suicide ideation and feelings whereas safety contracts do not. The intent of SPI is to help individuals lower their imminent risk for suicide by having a pre-determined set of potential coping strategies that include distraction techniques, as well as sources of support to help manage the crisis. SPI provides a detailed, hierarchically-arranged action plan for managing suicidal thoughts and urges. The SPI consists of four evidence-based suicide risk reduction strategies within an easy-to-use written plan: (1) means restriction; (2) problem-solving and distress tolerance coping skills; (3) social support and use of emergency contacts; and (4) motivational enhancement to increase engagement in appropriate treatment.

SPI Form (Simply Stated, "Safety Plan")

A structured SPI form (see Appendix D) ensures that each important element of the plan is covered collaboratively with the suicidal patient you are working with. The form serves as written documentation for the decisions made by the provider and the patient for the purposes of most effectively handling a future suicidal crisis. A collaborative safety plan generally takes about 20 to 45 minutes to generate and once constructed can be signed by the provider and the patient. One copy of the safety plan must be kept for the patient's electronic or paper medical records. One or more copies of the safety plan (i.e., if the patient wishes to place copies in different locations – e.g., car and kitchen counter) must be provided to the patient. Additional copies can also be shared with a peer, a significant other or family member, and/or the patient's command. Providers are permitted to share copies of the safety plan with everyone involved in the patient's care in cases of imminent suicide risk. In cases of no imminent suicide threat, written authorization from the patient prior to sharing this document directly with another individual must be obtained. The written safety plan must be updated as needed.

Providers are reminded that the SPI procedure is not just filling in the blanks on a form. All aspects of the SPI, including the individual's warning signs, coping strategies, and external supports are generated together by the provider and the patient. Importantly, the patient's own words are used in the written document so that the language is familiar and readily understood during a crisis. A provider-generated list of coping strategies is unlikely to be helpful to a patient in the absence of knowing what strategies are most engaging. On the other hand, the individual is not left alone to figuring out suicide crisis triggers and coping strategies.

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[17] Dr. Barbara Stanley has served as the primary source of information on the Safety Planning Intervention as provided in this section of the guide.

[18] The safety plan delineates what steps a patient should take during an emotional crisis to replace his or her suicidal behavior with more adaptive coping skills. A crisis response plan is created for the individual, and is part of a larger safety plan which involves the individual, the mental health provider, and command.

Components of the SPI

The SPI is typically developed with a suicidal patient following a suicide risk assessment. Explain to the suicidal patient that creating and using the steps in a systematic and orderly manner will help develop a sense of control over suicidal urges and ideation. Similar to military procedural checklists, following each step ensures mission success. A crucial aspect of the SPI is recognizing the signs and responding quickly, before suicidal thoughts and impulses become overwhelming. There are six steps in the SPI:

- ☐ Step 1.   Warning signs
- ☐ Step 2.   Internal coping strategies – self distraction
- ☐ Step 3.   Distracting social situations and people
- ☐ Step 4.   People I can ask for help
- ☐ Step 5.   Professionals or agencies I can contact during a crisis
- ☐ Step 6.   Making the environment safe

Step-by-Step Guide to SPI

Begin the conversation about safety planning by requesting the cooperation of the patient in order to develop a plan to help manage his or her suicidal thoughts and urges if they should reemerge in the future. If there is an agreement, the plan is collaboratively developed in a step-by-step manner.

Step 1. Warning Signs

The first step is to identify personal warning signs for an impending suicidal crisis. Examples of warning signs include feeling irritable or hopeless, or having thoughts such as, "I am a failure and that's never going to change." Problematic behaviors often associated with suicidality are spending more and more time alone, isolating, or drinking more than usual. The suicide risk assessment should have familiarized the provider with examples of such warning signs, which can be directly shared with the patient at this time.

Step 2. Internal Coping Strategies – Self-Distraction

The second step is to identify coping strategies to manage a suicidal crisis if warning signs are present. Distraction is a key strategy. Patients can be asked to identify activities that are very engrossing where they do not notice time passing. Prioritizing internal strategies as a first-level technique is important because they enhance individuals' self-efficacy and can help to promote the idea that suicidal urges can be mastered. This, in turn, may help suicidal patients to feel less at the mercy of their suicidal thoughts. Examples of these coping strategies include going for a walk, listening to music, playing video games, exercise, meditation or prayer. Activities that serve as "strong" distractions vary from person to person and, therefore, the patient should be an active participant in identifying these activities that will work best for him or her. However, the mental health provider must make sure that the noted strategies are positive and healthy – and unlikely to lead to further deterioration. The activities should be prioritized. Once the internal coping strategies have been generated, the provider uses a collaborative, problem solving approach to ensure that obstacles to using these strategies are identified and removed.

Step 3. Distracting Social Situations and People

The third step is to generate strategies for socialization as a source of distraction from suicidal thoughts and worries in general. If the internal coping strategies are ineffective in reducing suicidal thinking, patients can utilize the following two types of socialization strategies: (1) visiting healthy social settings, and/or (2) socializing with people in their social environment. In this step, you can help patients identify settings where socializing occurs naturally (e.g., coffee shop, places of worship, Alcoholics Anonymous [AA] meetings). Having a discussion about what social settings are healthy versus problematic would be helpful. These settings depend, to a certain extent, on locale, but encourage the individual to exclude environments in which alcohol or other substances may be present. Further, help the patient identify people such as helpful and supportive friends or family members who can be readily contacted. Socializing with these friends or family members, without explicitly revealing one's suicidal state, may assist in distracting patients from their problems. Please note that this strategy is not intended as a means of seeking specific help with the suicidal crisis. The purpose of this step is to provide a source of distraction but also to help patients develop a sense of possible connection and belongingness within their social setting and network.

Step 4. People I Can Ask for Help

The fourth step is to identify individuals that the patient can contact for help in coping with the suicidal crisis. If the internal coping strategies or social contacts used for purposes of distraction (steps 2 and 3) do not alleviate the suicidal crisis, the patient may choose to inform certain individuals within his or her social network about personal experiences with suicidal thinking or urges. This step is distinguished from the previous one in that a patient will explicitly reveal to one or more individuals the suicide crisis and the immediate need for support and assistance. Given the complexity of deciding if patients should or should not disclose to others that they are thinking about suicide, you can guide the patient in formulating an optimal plan. This may include weighing the pros and cons of disclosing information about one's suicide crisis. More specifically, patients should be asked about the likelihood that they would contact the identified individuals and whether these individuals are expected to improve or exacerbate the crisis. If possible, someone close to the patient with whom the safety plan can be shared should be identified and should be named on the plan. At times, patients may be unable to identify someone because of discomfort about self-disclosure and this desire for privacy should be respected.

Step 5. Professionals or Agencies I Can Contact During a Crisis

The fifth step is to identify helping resources and/or professionals who could provide assistance during a suicide crisis. A listing of various providers and the corresponding telephone numbers and/or locations may be listed on the plan and subsequently prioritized. Patients are instructed to utilize helping resources and/or contact professionals if the strategies from previous steps are not effective. For patients actively engaged in mental health treatment, the safety plan at a minimum should include contact information for the outpatient and/or inpatient mental health provider. At this point, the provider can discuss obstacles to remaining in care and help to enhance motivation for continued treatment. Similarly, if the patient is not receiving regular care, you can use this opportunity to enhance motivation to seek treatment and problem solve with the personal obstacles to receiving care. The SPI should include, if possible, other professionals besides the primary provider, who can be contacted, especially during non-business hours. Additionally, contact information for Military Crisis Line (1-800-273-TALK

[8255] or 00800-1273-TALK [8255] in United States Air Forces in Europe [USAFE]) 24 hours a day, 7 days a week suicide crisis hotline must be provided along with name and address of the nearest Emergency Department. See Appendix J for a listing of resources.

Step 6. Making the Environment Safe

The final step is to discuss removing or limiting access to lethal means for suicide. This discussion can be very difficult particularly when the patient has ready access to firearms or other lethal means. Please note, however, that this is a very important conversation given that the risk for suicide is greater when an individual has a specific plan that involves a readily available lethal method (Joiner et al., 2003). Even if a patient has no specific plan, eliminating or limiting access to any potential lethal means in the environment is crucial. This may include safely storing and dispensing medication, implementing firearm safety procedures, or restricting access to knives or other lethal means. Depending on the lethality of the method, the manner in which the method is removed or restricted will vary. Generally, you should ask the patient which means he or she would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means. Providers, in fact, should routinely ask whether suicidal patients have access to firearms (or plans to purchase firearms) and ammunition, regardless of whether it is considered a "method of choice," and make arrangements for securing them. The civilian literature indicates that an optimal plan would be to restrict individuals' access to a highly lethal method by having it safely stored by a designated, responsible person—usually a family member or close friend, or even the police (Simon & Gutheil, 2002). In the context of military service, Air Force providers can work closely with command in order to ensure that access to lethal means is limited during high risk periods. Providers should educate command that restricting access to one lethal method does not guarantee a service member's safety because he or she may decide to use another one. The specific behaviors necessary to make the patient's environment safer should be noted on the safety plan. In addition, specific restrictions and the length of time (e.g., one week, two weeks) at which a re-evaluation is recommended can be noted.

Once all these steps have been completed, discuss with the patient where he or she will keep the written safety plan. As stated previously, multiple copies of the plan may be kept at various locations. The size or format of the safety plan can be modified such that the patient can easily store it in a wallet or an electronic device. You should also discuss whether and how the patient will share his safety plan with family and friends. Furthermore, you must assess the patient's reactions to the final safety plan and the likelihood that the plan will be used to cope with a future suicide crisis. If the patient reports that there is reluctance to use the plan, then you should help problem solve potential obstacles and difficulties in using the safety plan.

Adherence to SPI

Providers with varying backgrounds, including psychiatrists, psychologists, social workers, nurses, crisis hotline counselors and mental health technicians have been trained to administer SPI. Given the systematic step-by-step nature of SPI, mental health providers even without formal training can walk through each step with a suicidal patient. However, competency is enhanced with continued usage, peer consultation, and training. Currently, there is no disseminated measure or procedure for verifying clinical adherence to the SPI. A quick glance at the written safety plan of a patient can provide adequate documented information for evaluating whether each step was appropriately implemented.

4.4 Motivational Interviewing to Address Suicidal Ideation[19] (MI-SI) Guide

Individuals who are thinking about suicide are often ambivalent, having both reasons to die and reasons to live (Jobes & Mann, 1999), and the resolution of their ambivalence often influences their risk for suicidal behavior (Brown, Steer, Henriques, & Beck, 2005; Kovacs & Beck, 1977). Motivational Interviewing to Address Suicidal Ideation (MI-SI) was developed as a method for addressing ambivalence about living and suicide, by enhancing the motivation to live and engage in life-sustaining and enhancing activities (Britton, Williams, & Conner, 2008). The overarching goal of MI-SI is to shift motivation away from suicide and toward living and recovery by eliciting, identifying, and reinforcing reasons for living, and developing a plan that patients believe in.

Although it is possible to use MI-SI as a stand-alone treatment, it is conceptualized as a component of a comprehensive suicide prevention strategy. A brief intervention consisting of one or two sessions, MI-SI is ideal for crisis settings such as emergency departments or acute psychiatric inpatient units where longer treatments are impractical. However, it may also be beneficial to add a course of MI-SI before other suicide prevention interventions. Individuals who want to die more than they want to live may have little motivation to engage in intensive treatments that directly target suicide risk or risk factors for suicide such as depression or substance abuse. MI-SI can therefore be used to strengthen patients' motivation for more intensive treatment (Britton, Wenzel, Patrick, & Williams, 2011).

The Phases of Motivational Interviewing to Address Suicide Ideation (MI-SI)

Process and outcome research on MI suggests the use of a four-phase process that transitions through (1) engaging, (2) focusing, (3) evoking, and (4) planning. The process is conceptualized as linear in that engagement increases the likelihood of agreeing on a focus, which is required for strategic evocation, which improves planning. However, it is also recursive in that engagement is required throughout the process, and evocation may increase engagement and improve planning.

Engaging

At the start of the intervention, you can establish a collaborative relationship with patients. Objectively, this means avoiding the "righting reflex" or the need to tell patients what to do, and listening to patients so that they feel that you are working with them rather than against them.

Focusing

MI-SI requires that the provider and the patient negotiate a focus for treatment. Take a guiding approach, taking into consideration the patient's concerns, the demands of the setting, and the patient's own preferences, but working toward a focus on suicide. For example, some patients

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[19] First draft of this section has been provided by Dr. Peter Britton at the Canandaigua VA, Center of Excellence.

may be willing to address suicide, after they discuss an issue they think is more important such as the event that triggered their suicidality.

Evoking

MI-SI is based on the premise that people often convince themselves that they need to live or make changes to make life worth living. Providers listen for, ask about, and reinforce their patients' reasons for living and engaging in recovery-related behavior. Suicidal thoughts are acknowledged, respected, and integrated into the larger context including reasons for living.

Planning

When patients begin to talk about committing to change or taking steps, it may be time to introduce planning. It should follow the natural course of conversation as premature focus on planning may interfere with motivation. You help the patient develop a concrete plan that he or she is willing to engage in and think will work. Patients with self-efficacy in certain activities are more likely to engage in them.

Components of MI-SI

The MI process outcome literature suggests that MI works through two pathways (Miller & Rose, 2009), a relational process exemplified by what is called the spirit of MI, and a technical process tied to specific provider behaviors. MI-SI is proposed to work by the same processes.

The Spirit of MI-SI

The MI spirit emphasizes the importance of creating an interpersonal environment that supports individuals' inherent capacity to grow and adapt.
- ☐ *Acceptance.* Acceptance is a composite of multiple factors. It consists of a belief in the patient's *absolute worth* as an individual*, autonomy support* or the notion that patients must provide the reasons to live and the means of doing so, *accurate empathy* which requires providers to share their understanding of the patient's perspective, and *affirmation* or open acknowledgement of the patient's strengths and efforts.
- ☐ *Evocation.* MI providers believe that the critical reasons to live and elements of change are within an individual and it is the provider's job to elicit and reinforce them.
- ☐ *Collaboration.* Providers see patients as experts on their lives, and consider themselves a resource to help patients make important decisions and solve their problems.
- ☐ *Compassion.* Providers make a commitment to helping others. This commitment is to help the well-being of those in need, rather than for their own gain.

The Techniques of MI-SI

MI-SI has an explicit target of increasing patient's motivation to live and strategically uses specific techniques to accomplish this goal.
- ☐ *Open Questions.* Providers use open-ended question, or questions that don't require closed or short answers, to elicit reasons for living and engaging in activities that may make life worth living, and to evoke solutions to the patient's problem.
- ☐ *Reflections.* The most widely used technique in MI is reflective listening, which requires providers to share their understanding of what the patient is trying to communicate.

Reflections should extend beyond what the patient is saying, encouraging elaboration and increasing the depth of the conversation.

☐ *Affirmations.* Affirmations, or statements of appreciation, understanding, and support are used to establish rapport, encourage participation, reinforce reasons for living and engaging in life sustaining activity, and enhance self-efficacy that changes can be made.

☐ *Summaries.* Providers use summaries or long reflections to integrate important aspects of the patient's narrative. They serve a number of purposes including communicating that the provider has been listening, creating a coherent narrative, reinforcing the patient's reasons for living, and preparing the patient to shift focus or elaborate.

Adherence to MI-SI

Easy to describe, MI can be challenging for some providers to learn. Research suggests that a one-day workshop plus individual coaching and/or practice feedback increased proficiency compared to a one-day workshop alone (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). Additional findings indicate that there is great variability in providers' ability to learn MI. Although some may only need web-based training to achieve competency, others may require an additional workshop or supervision (Martino, 2011). Unfortunately, there is no easy way to assess adherence to MI-SI as providers tend to be poor judges of their MI skills (Miller & Mount, 2001). To determine fidelity, researchers use the Motivational Interviewing Treatment Integrity (MITI) scale to code transcripts (Moyers, Martin, Manuel, Hendrickson, & Miller, 2005). However, it is labor intensive both to learn and to administer.

4.5 Psychiatric Medications and Suicide Prevention

Although an exhaustive literature review of the possible effect(s) of psychiatric medications on suicidality (suicidal ideation, plans for suicide, suicide attempt, and death by suicide) is beyond the scope of this Guide, a few summary findings and recommendations are relevant for mental health personnel who provide services to suicidal patients:

- There is no clear evidence that antidepressants increase suicidality, and many studies indicate a protective effect. The potential for increased suicidal ideation and suicide attempts appears to be greatest in individuals 24 years of age or younger (Leon, 2007).

- There may be a small, age-independent increase in suicidality in patients taking antiepileptic drugs (FDA, 2008) although this finding has also been questioned (Leon, 2012; Gibbons, Hur, Brown, & Mann, 2009).

- The only two medications which have been definitively shown to decrease suicidality are lithium in bipolar patients and clozapine in schizophrenic patients (Baldessarini, Tondo, & Hennen, 2001; Meltzer & Okayli, 1995).

- Prescribing providers must discuss FDA-issued black box warnings during their medication informed consent process with patients. For antidepressant, antiepileptic, antipsychotic or other psychotropic medications, the discussion must include the FDA black box warning of potential for an increase in suicidality (FDA, 2012).

For a sample of suicidal risk information to be provided during informed consent discussions, see FDA guide, at
http://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM100211.pdf.

SECTION 5

SPECIAL CONSIDERATIONS

Several topics related to suicide prevention deserve a focused discussion. Air Force mental health personnel, at some point over the course of their work with suicidal patients, are likely to encounter the issues discussed here. This section provides:

☑ A review of suicide prevention challenges in deployed settings and recommendations for best managing the delivery of effective care within these stressful environments
☑ An overview of suicide prevention strategies in primary care settings
☑ Information on maximizing coordination and continuity of care
☑ Reminders about postvention which refers to the provision of crisis management and support services to those affected by suicide

5.1 Suicide Prevention in Deployed Settings[20]

The DoD Suicide Event Report (2011) indicates that 10.68% of suicides, during calendar year 2010, occurred during Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) deployments. In terms of Air Force data, in 2010, suicides most commonly occurred in the United States (88.14%; with only 1 documented suicide in Afghanistan and 0 in Iraq) and this observation was similar to 2009 (89.13%) as well as 2008 (91.43%) rates. Given the low rates of suicide in combat zones for the USAF in deployed settings, Air Force mental health personnel may be likely to provide services to members of other Services who may become suicidal. Since the rate of suicide among other Services' members who die by suicide in theater is higher than that of the Air Force, mental health personnel will need to address these issues when deployed.

Suicide risk in deployed settings is of particular concern given the availability of firearms and other potentially lethal methods for self-directed violence. Indeed, military issue firearm-related suicides, relative to other methods for suicide, occur at a significantly higher rate among service members who are deployed as compared to those who are in garrison, with over 90% of military suicides in-theater occurring by gunshot wound from military-issue firearm, as compared to 13.88% of military suicides in-garrison occurring by gunshot wound from military-issue firearm (DoD, 2011). Further, the breadth of resources and services available to deployed mental health professionals can differ substantially from those available within the garrison context. This is not to suggest that the core *principles* of effective risk management change within the deployed context, although the specific decision-making processes and strategies for managing risk might. Clinical decision making while deployed must therefore be modified to fit the unique circumstances of the combat zone in order to optimize outcomes. In light of these realities, the issue of suicide risk management in combat zones is a topic of frequent discussion and debate among DoD mental health professionals and military leadership. To date, no systematic guidelines for the management of suicide risk within deployed settings have been developed.[21] The sections below highlight some of the key issues for consideration by AF mental health personnel serving suicidal service members within deployed settings.

Access to Firearms

Availability of lethal means for suicide—notably firearms—is perhaps the single most salient factor that distinguishes deployed from garrison settings and is the factor that must be weighed most heavily by deployed personnel. Suicidal crises are inherently time-limited and suicide attempts often are impulsive reactions to short-term peaks in distress. For example, 24% of suicide attempters interviewed in an emergency department immediately after their attempt report making their final decision within the five minutes immediately preceding the act, and 70% report making the decision within the preceding hour (Simon et al., 2011). This extremely short period of deliberation has also been observed among active military personnel, who tend to report making their suicide attempts "impulsively," with no active planning or forethought

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[20] First draft of this section has been provided by Dr. Craig Bryan who previously served as a deployed AF psychologist.

[21] New US Army Research and Materiel Command funded study (Principal Investigators [listed alphabetically]: Drs. Brown, Holloway, and Stanley) aims to develop evidence-informed decision making guides for management of suicide-related events during deployment.

(Bryan & Rudd, 2012). Having ready access to lethal methods for suicide significantly increases the likelihood of an adverse outcome and almost assuredly accounts for the relatively larger proportion of suicide deaths by self-inflicted gunshot wound among deployed military personnel as compared to non-deployed personnel.

Because suicidal desire fluctuates from moment to moment, sometimes very rapidly and with considerable intensity, it cannot be predicted with any reasonable amount of reliability. Restriction of means for suicide is therefore a common clinical strategy for managing suicide risk, especially with individuals exhibiting specific planning and preparatory behaviors and a sense of courage or fearlessness about death in general and suicide in particular. Research has demonstrated that, where a particular method of suicide is common and sufficiently lethal, restriction of access to that particular method results in decreased suicide deaths (Brent & Bridge, 2003; Eddleston et al., 2006; Peterson, Peterson, O'Shanick, & Swann, 1985).

In garrison settings, taking away a service member's firearm or removing the firing pin is a reasonable and common intervention that can be accomplished fairly easily in collaboration with chain of command. However, in combat zones, restriction of access to firearms is neither practical nor realistic in a setting where everyone is required to carry a firearm. In many areas, military personnel are required to carry a firearm at all times and will even be denied access to basic facilities (e.g., dining halls) if unarmed. Removing a service member's firearm or ammunition does little to restrict his or her access to others' firearms and ammunition. Rendering a service member's firearm inoperable (e.g., by removing the firing pin) suffers from the same limitation and introduces an additional operational hazard (i.e., reducing the availability of a functional weapon in a context where it might be needed for survival). The widespread availability of firearms in combat zones, combined with their extremely high lethality profile, therefore creates a considerable challenge for effective suicide risk management. Although there is the possibility of a suicidal individual taking a weapon from someone else, service members are trained to maintain positive control over their own weapon. Therefore, removing the weapon or firing pin from the suicidal service member adds a barrier to suicide even if it does not completely mitigate the risk. Thus, mental health personnel must discuss with the commander the relative risks of harm to self through easy access and not carrying a firearm in a hostile environment and should then decide the better option.

Sleep Disturbances and Insomnia

Insomnia is a well-established suicide risk factor, with several studies suggesting it predicts suicidal ideation and suicide attempts independent of depression, hopelessness, and other common risk factors (Bernert & Joiner, 2007; Pigeon, Pinquart, & Conner, 2012; Ribeiro et al., 2012). Because of factors such as mission requirements and loud environmental noises (e.g., helicopters, trucks, generators), sleep deprivation is common in combat zones. Similarly, many contextual factors of the deployed environment can make implementing common strategies for improving sleep, such as stimulus control and sleep restriction, difficult or impractical. For instance, group living quarters can limit the effectiveness of an individual service member's modifications to his or her sleep behaviors. Similarly, a service member's bed or cot might be the only piece of furniture available to him or her. Mental health personnel therefore need to adapt commonly used strategies to minimize service members' sleep disruption and maximize restorative sleep within the limits of the deployed context. For example, providers can recommend use of sunlight to regulate circadian rhythms and scheduling naps in blocks (20- to 40-minutes, not close to usual sleep period) that minimize the likelihood of waking during deep

sleep stages, or can use cognitive strategies to heighten acceptance of erratic sleep-wake cycles and to minimize catastrophizing thoughts that can exacerbate subjective discomfort. Beyond the effects of general insomnia, nightmares and other trauma re-experiencing symptoms appear to further increase risk for suicidal ideation and behaviors (Cukrowicz, Otamendi, Pinto, Bernert, Krakow, & Joiner, 2006; Sjostrom, Hetta, & Waern, 2009). Early and effective interventions such as imagery rehearsal therapy, prolonged exposure (PE) or cognitive processing therapy (CPT) that target disturbing dreams or intrusive memories could reduce the frequency and intensity of re-experiencing symptoms that might fuel suicidality. Such interventions need not be limited to clinic-based care; they can be delivered in the back of an armored vehicle, at a helipad, or another location that resembles the source of the distress (i.e., in vivo exposure). Indeed, one benefit of early intervention in combat zones is the ready access to stimuli directly associated with combat-related traumas, which lends itself to exposure-based interventions. Deployed personnel have found that delivering these treatments daily, as opposed to the standard weekly format, yields similar positive outcomes and increases the likelihood of treatment completion. Preliminary research with active duty military personnel shows that exposure-based interventions (i.e., PE and CPT) are associated with decreased suicide ideation, in contrast to the common misconception that these treatments increase suicide risk (Clemans et al., 2012; McLean et al., 2012).

Social Support

Social support is a well-established suicide protective factor but our understanding of how and under what conditions it functions as a buffer is limited. Social support has been proposed to function in the following ways (Cohen, Mermelstein, Kamark, & Hoberman, 1985):
1. Promotes *belonging,* which entails having access to people with whom one can engage in social or recreational activities (e.g., someone to hang out with on the weekend).
2. Provides *appraisal,* which entails having access to someone with whom one can share secrets, emotional distress, or problems (e.g., someone to confide in).
3. Nurtures *self-esteem,* which entails having access to positive others with whom one can compare oneself and feel respected (e.g., someone who makes you feel important).
4. Allows for *tangible support,* which entails having access to individuals who can offer material support or aid when in need (e.g., someone who will give you a ride).

Although all these are associated with decreased risk, in deployed settings some forms of social support might be more salient than others. For instance, limited recreational or morale activities restrict opportunities for personnel to develop behavior plans focused on strengthening belonging. Similarly, tangible support, which directly buffers the effects of distress through the provision of material resources may not always be available in combat zones. Furthermore, in combat zones, a service member's primary source of social support is likely to be his or her unit, which could also be the primary source of distress. In light of these factors, personnel should focus on strengthening other forms of social support, such as identifying supportive peers or colleagues with whom the patient can discuss problems, engage in activities, or have meals.

Unit Watch

Unit watch is a strategy that is conceptually based on a combination of means restriction and social support and is similar to "line of sight" designation on an inpatient psychiatric facility. As typically implemented, unit watch entails a collaborative effort involving both the provider and

the military chain of command, in which an at-risk service member's access to potentially lethal methods for suicide (e.g., firearms, medications) is removed or restricted by the chain of command, and another unit member, usually of equal or higher rank, is assigned to constantly monitor the at-risk member. As noted above, however, firearms restriction in the deployed context can be significantly limited in its effectiveness given the ready availability of other service members' firearms, especially the firearm of the unit escort who has been charged to maintain constant watch over the at-risk service member. The intrinsic limitations to unit watch and firearms restriction in deployed settings was most tragically demonstrated in the 2009 Camp Liberty killings, when an at-risk service member forcibly obtained his escort's weapon and used it to murder five service members at a combat stress control clinic.

In combat zones, unit watch can also be impractical and resource-intensive for military leadership, as it requires the removal from duty of a second unit member (i.e., the escort). Thus, personnel may find that commanders push back on unit watch recommendations in deployed settings more often and forcefully than when in garrison because command must invest a high level of human resources, and must assume a very high level of responsibility, to effectively ensure the safety and well-being of the at-risk service member, which can detract from operational demands and mission capabilities. Diverting personnel and resources in a deployed setting for unit watch may result in retaliatory treatment of the suicidal individual. Given these limitations, unit watch will be implemented only as a last resort and only as a temporary measure until more appropriate care can be arranged.

Motivational Issues

A common concern for military leaders and mental health personnel is the issue of intentional exaggeration of risk, intentional deception, and "malingering" on behalf of service members. Without a doubt, there is some (unknown) proportion of service members who verbalize suicidal intent and/or use suicide-related behaviors as a method for escaping or avoiding unpleasant tasks or situations. For example, some service members might threaten to attempt suicide if they are not sent back home to garrison because they do not want to be deployed, do not like their supervisor or peers, or because there is some issue or problem back home that cannot be easily solved while deployed. Military leaders and mental health personnel are especially alert to these motivational issues so they are not reinforced either explicitly or inadvertently. The reasoning is often expressed in some version of the following: "If we allow one person to get away with it, then everyone will try to get away with it."

Although the extent of intentional deception and exaggeration of suicide risk among deployed personnel is not known, empirical evidence from other military sources suggests that these issues occur in less than 5-10% of military patients (Bryan, Rudd, & Wertenberger, 2012), and when "secondary gain" is present and endorsed, suicidal service members simultaneously report a desire to alleviate emotional distress associated with the situation. Thus, intentional exaggeration of suicide is not common, but when it does occur, this exaggeration often is driven by emotional distress associated with environmental demands. The challenge for the deployed provider is balancing the desire not to reinforce deception or exaggeration with the desire to maximize safety in an efficient and context-appropriate way.

If a deployed service member is suspected of exaggerating suicidal thoughts or threats to attempt suicide, mental health personnel and military leaders must nonetheless increase monitoring of the individual and enact safety precautions, because the likelihood of adverse events and behavioral problems is increased, even if they are nonsuicidal in nature (e.g., "acting

out"). This increased monitoring can be resource-intensive in a resource-limited setting. When balancing the desire to avoid reinforcement of intentional deception with the desire to prevent adverse outcomes, the provider must weigh the costs and benefits of increased resource (both human and materiel) investment. In many cases, it may be a better decision to recommend aeromedical evacuation for a service member who is verbalizing suicide risk, even if this risk is strongly suspected to be exaggerated, because it conserves resources and enhances focus of other unit members on achieving mission objectives. In these situations it is best to consult the commander to determine the appropriate disposition.

Summary

Deployed mental health personnel will use the same core principles of risk assessment and management that are used in non-deployed settings but must be careful not to dismiss or overlook contextual factors that can influence the effectiveness of these strategies. Deployed mental health personnel not only must take into account typical clinical considerations, they also must realistically appraise resource expenditure relative to limited resource availability. Because of these issues, a provider's decision-making process while deployed should differ from his or her decision-making process while in garrison, although he or she will nonetheless be assessing for the same risk and protective factors and using similar interventions across both settings. General recommendations include limiting the suicidal service member from going outside the wire on missions, limiting his or her stay on base, following up with him or her multiple times per week, limiting access to lethal means, involving command, and implementing buddy care or unit watch. Unit watch is defined as 24-hour line-of-sight observation of an individual at imminent risk of suicide and is usually implemented while waiting for the individual to be transported out of theater. By contrast, buddy care may be used when an individual is not at imminent risk and involves assigning a unit member to keep an eye on the individual. The level of vigilance varies depending of risk level and is decided by the provider in consultation with command.

Note that buddy care can be used in cases of suicide ideation with no imminent risk where the service member is in treatment with the hope of resolving the suicide ideation while restricted to base, with the firing pin removed from his or her weapon. Unit watch can be implemented in cases of imminent suicide risk, post-suicide attempt, and/or cases of homicidal intent and planning. If medical evacuation is required, a team decision-making process is very helpful. The service member to be evacuated must be closely watched until transferred to an inpatient psychiatric facility. It is extremely important, particularly in deployed settings, to work closely with command and to communicate effectively about the risk to the service member's risk as well as the unit. In some cases, it may be beneficial to work with command to have a service member sent to another base while continuing with treatment, which may allow the person to stay in theater and function effectively under close monitoring. Please note that guidance for every type of situation in a deployed setting cannot be provided here. Your duty as a mental health provider is to consider available resources, the safety of the service member and the unit, and ways to best inform and maintain effective communication with command in order to assist with the management of the suicidal service member and keep him or her safe. Similar to other types of settings, keep up with your documentation standards, engage in regular consultations as needed and when feasible, establish a good working relationship with the unit medical authority, and keep the chain of command well-informed. Don't forget about collaboration with military chaplains who can provide assistance on a variety of issues. You are providing an important service to the entire military community during the time of your deployment and your expertise will be instrumental to the welfare of others deployed with you.

5.2 Suicide Prevention for Primary Behavioral Health Care Services[22]

The Air Force's Behavioral Health Optimization Program (BHOP) has continued to expand throughout the Air Force Medical Service (AFMS) since its original pilot testing at Tinker Air Force Base, Oklahoma, during 1997-1998. As BHOP's role within the USAF's larger medical and mental health care system has grown, increased emphasis on defining practice standards has emerged. Of particular concern has been the appropriate management of suicide risk in primary care clinics. At one end of the spectrum, some argued that suicide risk assessment and management was inherently outside the scope of practice of BHOP. Consistent with this perspective, it was argued that Internal Behavioral Health Consultants (IBHCs) should not routinely screen for suicide risk, conduct comprehensive suicide risk assessments, or intervene with suicidal patients. At the other end of the spectrum, some argued that IBHCs, as credentialed mental health providers, were sufficiently trained to manage suicide risk in BHOP clinics, and should use the same standards and expectations as specialty mental health clinics.

It has been noted that behavioral health providers working in primary care settings can have a significant impact on preventing suicide (Bryan, Corso, Neal-Walden, & Rudd, 2009). Thus, a new, more balanced approach to suicide risk management in BHOP clinics should be organized around the following principles:

1. *The approach must fit within the clinical context of primary care.* To improve the management of suicide risk in primary care, any approach must fundamentally embrace the philosophy and clinical reality of primary care and must not mistakenly apply specialty mental health principles and expectations to a setting where they are inappropriate and cannot be realistically sustained, as this increases vulnerability to adverse outcomes.

2. *Clinical approaches must be consistent with the consultative model.* To remain within the scope of care of the IBHC model, any approach must preserve the consultative relationship between the Primary Care Manager (PCM) and IBHC, in that the PCM maintains primary responsibility for all aspects of the treatment plan. Approaches that move outside the consultative model by placing primary decision-making responsibility in the hands of the IBHC are inconsistent with the parameters of BHOP.

3. *Clinical approaches must be informed by science and empiricism.* To balance the competing demands for efficiency and comprehensiveness, and to provide the highest level of evidence-based medicine, any approach must be based upon the most current scientific knowledge base of suicidal behaviors and clinical practice.

4. *Clinical approaches must be competency-based.* To ensure adequate skill mastery and clinical competence, any approach must be definable and measurable, with identified skill sets (i.e., competencies) directly contributing to best practices and expectations of clinical care. Approaches must therefore be described with adequate detail for ease of implementation and measurement of skill mastery.

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[22] First draft of this section has been provided by Dr. Craig Bryan who has previously served as a deployed AF psychologist.

As a result of these ongoing conversations and emerging practice standards based upon these principles, the most recent revision of the BHOP Manual (https://kx.afms.mil/bhop) now includes much clearer guidelines for the appropriate and effective management of suicide risk in BHOP clinics. IBHCs should be familiar with this information. In general, the principles of effective suicide risk management do not differ in BHOP clinics relative to other clinical settings, but the specific methods, procedures, and strategies implemented by IBHCs are much more targeted, as will be discussed below.

Assessing Suicide Risk in BHOP

Most mental health personnel would argue that the assessment, management, and treatment of suicide risk are among their most challenging and stressful tasks, regardless of setting. However, the unique constraints of the primary care setting (e.g., brief appointments, high patient volume, comorbid medical conditions, limited follow-up schedules, and restricted management options) serve to further complicate an already complex task. Suicide risk management in BHOP clinics should therefore mirror the approach seen in general in primary care: (1) screen for the indicated condition; (2) for positive screens, conduct a more detailed evaluation; (3) arrive at a reasonable diagnosis and assessment of risk; (4) initiate interventions and management strategies; and (5) refer to specialty health care when indicated.

Routine Screening for Suicide Risk

Because suicide is such a low base-rate phenomenon, it is not possible to predict its occurrence with any reasonable level of reliability or consistency. It is therefore recommended that IBHCs routinely screen every referred patient for suicide risk during initial appointments, even among those who are being referred for a problem or condition that might not initially seem like an "indicated" condition for screening (e.g., diabetes, insomnia, tobacco cessation). Similarly, because suicide risk can fluctuate over time, sometimes very quickly, it is also recommended that IBHCs continue to screen for suicide risk during follow-up appointments, even if a patient denies suicide risk during an initial appointment. Routine screening can be accomplished via use of symptom checklists or questionnaires, or via clinician questioning although sufficient evidence has shown that patients are more likely to endorse suicidal thoughts on questionnaires, suggesting there is considerable benefit to using these methods.

Targeted Risk Assessment

For patients who screen positive for suicide risk, IBHCs will conduct a risk assessment to better determine the overall risk level, which will ultimately drive clinical interventions and management strategies. As with any other aspect of IBHC clinical work, the IBHC should approach risk assessment in a manner that provides the most useful information with the fewest variables. As applied to suicide risk, IBHCs should therefore focus on gathering information about those factors that have the strongest empirical association with suicidal behaviors. It is therefore recommended that IBHCs *sequence* their risk assessment questions in a particular order to minimize patient anxiety and obtain more accurate self-report leading to optimal clinical decision-making. The following risk factors will be prioritized by IBHCs since they have consistently shown to best predict suicidal behaviors relative to other risk factors:

1. *Past suicide attempts.* All things being equal, previous suicidal behavior is the best predictor of future risk, and therefore should be prioritized.

2. *Resolved plans and preparations.* Resolved plans and preparations include factors such as specificity of suicide plans, high intensity of suicidal thoughts, preparation for suicide (e.g., acquiring the method, counting pills, writing a suicide note), and rehearsal behaviors (e.g., "practicing" or going through the motions of an attempt).

3. *Protective factors.* Although protective factors (e.g., social support, living with others) have much less empirical support as compared to risk factors, it is nonetheless recommended that IBHCs assess for protective factors since they provide critical clues for developing risk management strategies and targeted interventions.

For more detailed guidance on assessing suicide risk in primary care settings, IBHCs need to consult the *BHOP Practice Manual*: https://kx.afms.mil/bhop.

Brief Interventions for Suicide Risk in Primary Care

Similar to the general clinical approach for other clinical presentations in BHOP, suicide risk management strategies and interventions must be based on empirically-supported mental health treatments, such as brief cognitive behavioral therapy. Although the administration of psychotherapy protocols in BHOP is outside the scope of practice, the individual interventions and procedures used in such treatments are feasible within the brief, time-limited primary care context and are consistent with the IBHC practice model. To determine whether a patient can be treated in primary care, IBHCs must consult the *BHOP Practice Guide* and consider their clinic's resources as well as mental health resources available to the patient. If it is determined the patient can be treated in the primary care setting, providers should consider a suitable, empirically supported intervention. Several interventions that are consistent with the BHOP philosophy of skills training and patient self-management include the following:

1. *Crisis response plan.* The crisis response plan (also known as a "safety plan" in the Safety Planning Intervention, see pp. 63-66) is a widely-used and simple strategy for helping to delineate what steps a patient should take during an emotional crisis so they can replace suicidal behavior with more adaptive coping skills. In general, a crisis response plan is created for the individual, and is part of a larger safety plan, which involves the individual, the mental health provider, and command.

2. *Relaxation exercises.* Relaxation is a common intervention in BHOP, and can be useful for helping suicidal patients to reduce their emotional distress.

3. *Mindfulness exercises.* Mindfulness is another common intervention in BHOP, and can help suicidal patients to manage rumination and reduce emotional distress.

4. *ABC[23] worksheets.* ABC worksheets can be used to help suicidal patients identify negative beliefs that sustain suicidal crises, and to replace them with more positive thought processes that facilitate hope.

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[23] A = Activating Event; B = Beliefs; C = Consequences

5. *Activity planning / behavioral activation.* Formulating specific plans for patients to increase meaningful or pleasurable activities (e.g., exercise, hobbies, outings with friends) can reduce emotional distress and facilitate social support.

6. *Means restriction counseling.* Developing a specific plan for suicidal patients to temporarily remove or otherwise restrict their access to potentially lethal means for suicide can reduce the likelihood of an adverse outcome during a crisis.

Given the time limits of the BHOP clinic, in most cases it is feasible for an IBHC to administer only one intervention during any given appointment. Indeed, it is much better for an IBHC to implement a single intervention very well than to implement multiple interventions with less fidelity or quality. Given the range of options for intervention, IBHCs should therefore select interventions that flow directly and naturally from the risk assessment and are best matched to the unique presentation of the suicidal patient. In all cases, the intent of the selected intervention(s) should be the immediate and aggressive reduction of suicide risk while assisting the patient in transitioning to specialty mental health care. IBHCs should always be aware of the limitations of their primary care site and bear in mind the BHOP recommendations for referring suicidal patients to mental health providers. See the BHOP practice guide for further details.

Summary

Managing suicidal patients in BHOP clinics does not entail developing new or different assessment and management strategies; rather, it requires IBHCs to adapt strategies and interventions that have been found to work in specialty mental health settings to fit within the context of primary care. A growing body of empirical evidence suggests that patients not at imminent risk for suicide (e.g., suicide ideation with low intent and an absence of a plan) can be managed in primary care using these general principles. Nonetheless, IBHCs should consider referring such patients to more intensive mental health treatment. IBHCs must consult the *BHOP Practice Guide* on when it is appropriate to refer to Mental Health clinics and what instances are appropriate to manage in Primary Care settings. As part of the larger spectrum of mental health care system, IBHCs are uniquely positioned to detect and provide early interventions for a large segment of the Air Force community, and to facilitate ongoing monitoring and care for at-risk patients over time.

5.3 Coordination and Continuity of Care

Coordination and continuity of mental health care is essential to the short- and long-term well-being and safety of suicidal individuals as well as the Air Force community. The DoD Task Force on the Prevention of Suicide by Members of the Armed Forces report (2010) provides the following recommendation:

> Implement coordination of care plans across longitudinal lines (e.g., permanent change of station, temporary change of station, deployment and redeployment transitions, temporary duty with other units, release from active duty, demobilization, confinement, hospitalization, and extended leave periods).

Lack of coordination of care has been found to be one of the root causes of suicide among OEF/OIF veterans (Mills, Huber, Watts, & Bagian, 2011). Similarly, lack of continuity of care for suicidal individuals puts them at risk for dying by suicide. A retrospective chart review (Huisman et al., 2010) of 505 suicide cases concluded that one of the lessons learned was the need for greater continuity of care. In another study (Burgess et al., 2000), a clinical audit of 629 suicides found that 23% of preventable suicides were due to poor continuity of care. To date, no studies have been conducted on continuity of care for suicidal service members or veterans. However, results from a study of female veterans with PTSD (Greenberg, Fontana, & Rosenheck, 2004) found that patients who had greater continuity of care had greater decreases in violent behavior as well as PTSD symptoms and greater increases in global functioning. Given these findings and the importance of coordination and continuity of care efforts to the broad suicide prevention endeavors within the Air Force, providers must ensure that these two aspects of care are not neglected in their work with suicidal patients.

Coordination of Care

Coordination of care refers to collaboration and communication among providers at two or more types or levels of treatment. To facilitate coordination of care for suicidal individuals, we make the following recommendations:

1. **Establish a procedure for transfer of patients between levels of care.** When deciding to change a patient's level of care, consult with the new treatment team or provider. Whether you are a primary care provider referring a patient to a mental health care specialist for a comprehensive suicide risk assessment or a mental health clinic provider deciding to hospitalize a patient due to imminent risk, collaboration and communication between treatment teams is essential. Communication between treatment facilities may be difficult to achieve, especially when the new clinic or provider is not at a military treatment facility. Clinic staff must make every effort to maintain contact with inpatient psychiatric staff when mental health beneficiaries are hospitalized. Similarly, when a patient is transferred to outpatient care after hospitalization for suicidality, collaboration between treatment teams is essential. It is particularly helpful when the outpatient provider of follow-up care participates in discharge planning. Barriers to collaboration between facilities may not be easily overcome; however, a number of strategies have been used by Air Force clinics with some success.

- ❑ A memorandum of understanding (MOU) with inter-Service and civilian facilities regarding sharing of clinical information and coordinating discharge planning can document agreement on some coordination issues in advance so that these issues do not have to be addressed anew with each new case.
- ❑ Clinics can obtain release of information consent forms from the most frequently used inpatient facilities so that signatures can be obtained *prior* to hospitalization.
- ❑ It may also be helpful to get the TRICARE office involved, since information sharing pathways are often better established through administrative/financial channels.
- ❑ Establish a point of contact at the facility who can be assigned to give feedback on all military patients. If there is chronic difficulty with obtaining status reports or being involved in discharge plans, it may help to change the point-of-contact person. Some health professionals are more comfortable sharing information with those from their own profession (e.g., psychiatrist to psychiatrist, nurse to nurse).
- ❑ Obtain a copy of the Discharge Summary and document your review for continuity of care purposes.

2. **Reassess patients following inpatient or partial hospitalization before assuming or reassuming responsibility for outpatient care.** One of the times of highest risk for suicidal behavior is following a reduction in intensity of care (e.g., transitioning from inpatient to outpatient treatment; Pirkola, Sohlman, & Wahlbeck, 2005; Troister, Links, & Cutcliffe, 2008). Clinic staff and providers must not assume that patients are suitable for outpatient care simply because an inpatient facility has discharged them. Furthermore, when hospitalization occurs in the midst of ongoing outpatient therapy, it is not appropriate to simply resume treatment after discharge at the point where it was left prior to hospitalization. A prompt reassessment of risk, status, and needs following discharge will help providers determine whether the treatment plan should be revised. If the patient is not suitable for outpatient care, attempt to re-hospitalize. If you are unsuccessful, document your attempt. It is recommended that a standardized timeframe for re-evaluation be established at the local level and documented in the clinic OI.

Continuity of Care

Continuity of care refers to follow-up steps taken by mental health providers to ensure that a suicidal patient is continuing with treatment at another facility. To facilitate continuity of care, we make the following recommendations:

1. **Use a standardized follow-up and referral procedure for all previously suicidal patients who terminate treatment prematurely.** We recommend that clinics adopt a usual and customary practice for handling patients who terminate prematurely. For example, providers shall encourage patients who notify the clinic of their intent to terminate to return to treatment, either at the clinic or through another source of care (e.g., private sector care, primary care). Document these discussions in the clinical record.

Clinics must have a policy for handling established patients who do not keep scheduled appointments or fail to schedule follow-up appointments. For example, a policy might require staff to make and document three attempts to contact the patient in order to address barriers to continuing treatment and encourage returning to care. To protect privacy, messages left on answering machines can include the rank and name of the provider (rather than "doctor"), and not refer to the name of the clinic (e.g., "This is Captain Smith from the Medical Group. Please return my call at extension 5555"). If providers cannot reach the

patient after the designated number of attempts, send a standard "no-show" letter. It is important to formally close cases when patients have dropped out of treatment.

Although these standard procedures apply to all patients, providers must take additional steps in high-risk or high-interest cases. For example, it is prudent to contact the patient's PCM and Command when high-risk patients withdraw from treatment prematurely. (*Note:* Clearly inform patients of this practice in the informed consent process). Additionally, it may be wise to use registered mail for proof of receipt when sending "no-show" letters to these patients. In accordance with Air Force policy, you must contact patients referred by other providers who fail to keep their initial appointments to reschedule as soon as possible. You must also notify the referring provider whenever a referred patient fails to keep an initial appointment.

2. **Ensure clinical coverage when the primary provider is not available.** It is also important for clinics to establish a usual and customary practice for clinical coverage after duty hours and when a patient's primary provider is on leave or TDY. Document this procedure in the clinic OI. Ensure that patients are aware of the procedures for obtaining afterhours care, and document that this has been covered with patients. We recommend a written handout outlining procedures. In accordance with Air Force policy, mental health providers must notify on-call providers and MTF ED/acute care staff when individuals are identified as being at high risk for lethal or dangerous behavior.

3. **Establish a procedure for ensuring continuity of care during provider and patient transitions.** Providers and clinics must take special care when high-interest individuals are facing transitions, such as base reassignment or separation from the military. Not only do people typically face multiple significant stressors during these times, but individuals and families are also separated from their interpersonal support systems. Actively suicidal patients should not PCS until stabilized. This emphasizes the importance of using the duty-limiting conditions profiling system to reflect the patient's psychiatric status and limitations. If a PCS is not advisable, it is necessary to discuss this recommendation with the patient's current commander. When relocation is expected to be clinically helpful in reducing suicidal risk (e.g., the current environment is a factor in suicidal risk), it is still important that providers address and plan for the stress of transition with the patient. For continuity of care, providers must arrange a hand-off with a mental health provider at the receiving facility and this must be documented.

In addition, if the patient fails to keep the scheduled appointment at the gaining base, the designated provider at the gaining base must follow up to determine the reason and to reschedule. Providers, at the losing base, are responsible for coordinating follow-up if the patient is diverted in route. Transfer mental health records to the receiving installation in accord with current Air Force policy. In cases where the patient does not desire follow-up care, providers can at least ensure he or she is informed about how to obtain mental health services. When high-risk patients are separating, providers might help them develop a plan for follow-up care in the civilian sector, facilitate implementation of the plan, and document it. En route support may be necessary, and can be delivered through periodic phone contacts with the clinic or collaboration with the patient's family (again, all of which must be documented). Be sure to document all attempted and successful contact with the gaining or losing base and the patient.

Clinics are encouraged to develop written procedures for ensuring continuity of care for patients when providers are transitioning due to PCS or deployment. This plan might involve suicidality reassessment of all the departing provider's active patients. Consider establishing a process for reviewing the departing providers' charts to ensure that patients at moderate risk or higher have a documented crisis response plan. Consider establishing processes to ensure ongoing monitoring and appropriate care through the transition period. The inTransition Program (http://www.health.mil/intransition/) can also be an invaluable resource for patients and providers, providing case management for patients who are between two mental health clinics – while simultaneously decreasing the workload for providers.

4. **Establish a written plan for after-hours evaluations. Ensure other relevant agencies and individuals (i.e., Security Forces, First Sergeants) are aware of the plan.** After-hours mental health evaluations pose a potential danger to on-call personnel that must be addressed in local policy. The Occupational Safety and Health Administration (OSHA, 2004) notes that "health care and social service workers face an increased risk of work-related assaults stemming from several factors, including…isolated work with clients during examinations or treatment (and)…solo work, often in remote locations… with no back-up or means of obtaining assistance such as communication devices or alarm systems." Given this, OSHA recommends establishing policies and practices that place "as much importance on employee safety and health as on serving the patient or client."

Also, when conducting after-hours mental health evaluations, you must do so in accordance with Air Force policy. Specifically, after-hours MH assessments will only be conducted only in an emergency department. For clinics without access to emergency department, emergency evaluations will be conducted by community medical resources. Mental health providers will not perform evaluations where medical support and security are not available, such as in the duty section, at the patient's residence, or in a closed, non-bedded facility.

In accord with DoD Directive 6490.1, *Mental Health Evaluations of Members of the Armed Forces*, the unit commander is responsible for taking precautions to ensure the safety of the service member and others, pending arrangements for and transportation to the evaluation site. Mental health personnel are not necessary for transport of at-risk individuals. It is important to consider the safety of both the patient and escorts when formulating plans, particularly whether Security Forces personnel are needed. The on-call mental health provider can advise the unit on safety precautions twenty-four hours per day seven days per week. The presence of established procedures, coordinated and communicated *in advance of a crisis,* can ensure cooperation between mental health personnel and unit leadership when managing at-risk individuals.

5.4 Postvention and Support for Military Survivors

Shneidman's (1969) assertion that every suicide affects six individuals may underestimate the impact of suicide within the military community. A suicide in a base community is a traumatic event with far-reaching implications. The unexpected death of a service member or a member of his or her family may become a source of guilt and anger for survivors in the military unit and the decedent's family. Whereas most survivors will manage to cope effectively, others may struggle with the aftermath of the suicide and subsequently experience adjustment and/or grief-related responses. In worst-case circumstances, survivors (including military personnel exposed to a peer's suicide) may experience an exacerbation of psychological symptoms leading to suicide ideation and be at elevated risk for suicide themselves.

Postvention[24] is a term, first introduced by Shneidman (1981) and defined by the American Association of Suicidology (1988) as "the provision of crisis intervention, support and assistance for those affected by a completed suicide." Of course, postvention is a form of prevention by aiming to minimize suicide risk in others who survive a suicide. Mental health providers are in a unique position of being much needed by the military community at such times. However, many providers may not have had work experience that prepares them for effective postvention practices. Therefore, providers are encouraged to work as a team and in collaboration with colleagues in the chaplaincy to address the needs of the survivors and the community following a suicide loss. The objectives are to deliver crisis services, foster group cohesion, support the healing process, disseminate helpful information about resources, and minimize isolation.

In accordance with this, The DoD Task Force on the Prevention of Suicide by Members of the Armed Forces (2010, p. 26) recommends the following:

> Incorporate postvention programs targeted at the decedent's military unit, family and community after a tragedy or loss to reduce the risk of suicide. Postvention efforts must address Service Members affected by a significant loss, especially after a fallen comrade's death in combat or in garrison when the unit is impacted. Unit-level postvention efforts must focus on effective debriefing and prevention when they are impacted by a significant tragedy or loss.

Post-suicide responses are often managed by unit leaders. Unit leaders provide support to affected personnel through the grieving process and therefore, must be closely supported during these difficult times by chaplains and mental health providers. Postvention efforts must avoid sensationalizing, romanticizing or giving undue prominence to suicide as such practices have been associated with suicide contagion and clusters. You can refer unit leaders to AFI90-505 (pp. 34-37) which provides a checklist for post-suicide and suicide attempt actions. The checklist can be accessed at: http://www.afms.af.mil/suicideprevention/index.asp

Base helping agencies serve an important post-suicide role in supporting the family, work colleagues, unit leadership, and the base community at large. Many family members and members of a military unit have commented on the significance of such interactions in their grief

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[24] Tragedy Assistance Program for Survivors (TAPS) provides a range of information and support services to survivors of military suicide. Information about this program can be found at http://www.taps.org/suicide/

and healing processes. The Traumatic Stress Response (TSR) team is commonly used for psychological first aid following traumatic exposure to suicide. The TSR team is that it offers the opportunity to seek counseling following a traumatic event without documentation. This eliminates a potential barrier to seeking counseling given that some individuals are hesitant to have a record of having received counseling services. Regardless of the mechanism used, it is imperative that all base helping agencies coordinate to meet community needs.

If the deceased was a patient at one of the mental health clinics, personnel within the impacted clinic are likely to have a difficult and painful reaction, including sadness, grief, guilt, anger, and fear. Russell Carr (2011), a Navy psychiatrist, has written about his experiences as a mental health provider with the aftermath of a suicide during his OIF deployment. This is an excellent illustration of the lessons that a careful examination of each suicide can provide. In the context of overseas deployment, where service members are in a hostile environment, far from their support systems of family and friends, and subject to strict military discipline, the complexities of processing a suicide become magnified. By presenting his observations and openly sharing his personal struggles in "second-guessing" the treatment provided to the deceased soldier, Dr. Carr effectively normalizes what providers may experience following a patient's suicide.

In cases where you find yourself treating a colleague who has lost a patient to suicide, offer the opportunity to talk through his or her reactions, if desired. Vicarious traumatization and other reactions can affect one's ability to deliver effective care to other patients. A number of resources for providers who have lost a patient to suicide are available. In communicating with colleagues who have lost a patient to suicide, be mindful that comments to colleagues, friends or family members about the deceased patient's care usually are considered non-privileged information and open to the legal discovery process. Bongar (1991) suggests that "discussions of feelings and concerns regarding possible errors in management or treatment should always be confined to the context of a psychotherapeutic or legal consultation."

A general suggestion is for the primary provider not to be involved as a responder to the base community. MTF personnel may be unsure whether to contact their patient's family following a suicide. Research suggests that supportive contact can be helpful to families and can reduce the chances that they will pursue litigation (Peterson, Luoma, & Dunne, 2002). While being careful not to discuss issues of negligence, a provider can communicate sympathy to the family, which is likely to help them cope better with their loss and increase their positive perceptions of the care given to the deceased. We encourage Air Force mental health personnel to consult with the medical-legal consultant, the Chief of Medical Services for their MTF, before contacting the family. It is advisable that at least two people talk with the family together.

Additionally, there is often high interest in the community after a suicide, and mental health staff may be contacted by the media. Refer all media inquiries to the base Public Affairs Office. Research demonstrates that news reports glamorizing suicide, discussing specific messages, or implying it is more common than it is can increase suicide rates. The AFSPP has worked with Air Force Public Affairs and the Chaplains, creating Public Affairs Guidance (PAG) and Memorial Guidance to ensure that suicide messaging does not inadvertently promote suicide. Poorly planned messaging can worsen the problem for a community.

Talking with Survivors after a Suicide

- ☐ Express sympathy for their loss
- ☐ Conceptualize the loss within the framework of mental illness, if appropriate
- ☐ Minimize any sense of blame, guilt, or responsibility, recognizing all of our limitations
- ☐ Discuss the grief process as it relates to suicide, emphasizing the mixture of emotions
- ☐ Provide professional resources should they need to talk further
- ☐ Balance recognizing the deceased's service with her/his decision to suicide

Types of Investigations Likely to Occur Following a Suicide

If a suicide decedent has had contact with the base mental health system, one or more of the following investigations is likely to occur:

1. ***Root Cause Analysis***
   Root cause analysis is an in-depth investigation conducted by the facility to identify and correct any deficiencies related to care of the deceased individual. The focus is on potential system or process problems. The MTF may send this analysis to The Joint Commission (TJC) if the suicide is determined to be a reportable sentinel event (such as suicide of an inpatient).

2. **Potentially Compensatory Event (PCE)**
   Deaths or injury (including active duty cases) that may be related to questionable or substandard healthcare will be managed in accordance with DODI 6025.13 and AFI 44-119. Appropriate Standard of Care determinations will be conducted and review/reporting by AF/SG as required.

3. ***Medical Incident Investigation (MII)***
   An MII is a comprehensive, unbiased review of a significant adverse event performed by a clinical team external to the MTF. The purpose of an MII is to find out how the system contributed to the adverse outcome, by thoroughly investigating the facts in a non-punitive way. The ultimate goal is to learn from the event and improve healthcare by recommending system changes to reduce the risk of recurrence, thereby reducing harm to patients. MIIs are approved by the AFMOA Commander in consultation with the MAJCOM Surgeon and MTF Commander. The MII is a Quality Assurance (QA) function and information from the investigation is protected for QA use only, per 10 USC 1102. Findings from the MII may support policy changes for the MTF, MAJCOM or Air Force.

4. ***Commander Directed Investigation***
   This type of investigation may be instigated by a commander at any level. The investigation team may or may not include medical/mental health personnel. The team reports its findings to the requesting commander. Many MAJCOMs require a post-suicide assessment to identify lessons learned that may help prevent future fatalities. When appropriate, the lessons learned will be distributed Air Force wide for the benefit of all. Even if the MTF was not providing care to an active duty individual who died by suicide, mental health staff can play an essential role as consultants to the individual's squadron commander during this investigation.