G. Securing Patient's Safety

G1. Education for Patient and Family

Health care professionals should provide adults and their families/caregivers/command, if appropriate, with education regarding suicide, stigma, treatment options, and management strategies.

BACKGROUND

Suicidal patients may benefit from education about the way their emotional responses, thoughts, and behaviors to negative life events may be associated with suicidal crises. Education can include information about: various available evidence-informed treatment options associated with decreases in suicide ideation, intent, and/or planning and increases in factors that prevent suicide, such as hopefulness, problem-solving, and effective interpersonal communication. Family members often struggle with conflicting feelings about the patient's suicidal behavior. Education and an opportunity to discuss their feelings can help.

Family involvement may be and often is critical to the success of discharge planning. Family involvement need not be limited to the "nuclear family." In many instances, partners, close friends, command or other identified supportive social contacts should be considered as people critical to the success of discharge to

a less restrictive environment. Family engagement should include family sessions and education about suicide, warning signs, adherence to the recommended treatment plan, possible contributing family dynamics, removal of means, and various outpatient observation, monitoring, and emergency procedures.

Family education, with appropriate patient consent, is a recommended practice when providers at any point of care first become aware that a patient is at risk of self-directed violence or engaging in suicide behaviors. Family member education, before a patient demonstrates a risk factor, may unnecessarily induce anxiety within the support system. Failure to educate family members of a patient at intermediate or high acute risk for suicide potentially diminishes the ability of the provider and the patient to successfully engage the patient's support system to assist with addressing and mitigating risk. Primary care providers may need to coordinate with behavioral health providers to accomplish family education as recommended, given the fact that such an intervention may require more time than is typically available for a primary care visit. Family education may occur within the context of a single session (e.g. intervention as part of an emergency room visit) or a series of sessions and is appropriate within both inpatient and outpatient settings.

RECOMMENDATIONS

1. The patient should be educated about conditions that are associated with their suicidal crisis, factors that increase and decrease their risk of suicide, and the risks and benefits associated with treatment options included in the treatment plan to target suicidality and associated conditions.
2. Patient and family should receive information about the resources available through the Veterans or Military Crisis Line (including phone, chat and text services).
3. The patient and family education should be done with empathy, and appropriate respect for autonomy and patient privacy. Family/unit members should be engaged with the patient consent. This education should aim to instill hope of recovery and reduce stigma and shame.
4. Strongly recommend advising all patients at intermediate to high acute risk for suicide against the use of alcohol and non-prescribed medications, and educate on the potential for drug-drug and drug-alcohol interactions that can impair decision-making and increase the risk of impulsive suicide attempts.
5. Patient and family education should be provided with the following characteristics:
    a. Tailored to the needs (e.g. language and educational level) and situational factors of the identified family or supports and patient
    b. Ensure specific focus on self-directed violence or suicide behaviors
    c. Allow plenty of time to answer patient and family member questions and establish a collaborative relationship
6. At a minimum, patient and family education should include:
    a. The nature of self-directed violence or suicide behaviors, the episodic recurrent nature of suicide risk and the applicable biological, cognitive, emotional, or psychosocial risk factors
    b. The impact of any existing psychiatric diagnoses or high risk situational stresses
    c. Risk factors associated with suicide
    d. Warning signs, reviewing any particular warning signs the patient may have demonstrated prior to any attempts or reported ideation

e. The protective role of positive family relationships and the potential harmful impact of negative family interaction on risk mitigation
f. The importance of assisting the patient with his/ her safety plan and means restriction, removing potentially lethal means of self-harm (e.g. firearms, medications, knives, or razor blades) from the person and their home environment, particularly if the person has mentioned specific means.
g. Methods for contacting the patient's provider and other medical or community support resources (e.g. hotlines) should the family member become concerned
h. The importance of encouraging the patient to comply with a collaboratively established treatment plan and follow-up care.

DISCUSSION

In an era that emphasizes patient education and involvement in treatment; educational approaches for prevention of suicidal behavior have been attempted. They are limited in number and are rarely the focus of controlled, random-assignment trials. Two general types of educational interventions for prevention of suicide have been the focus of research: 1) community-based interventions that represent a public-health approach to suicide reduction, and 2) psychosocial interventions directed to individuals identified to be at increased risk for suicide—either by virtue of a history of suicidal behavior or the presence of suicidal ideation or intentional self-harm. Psychoeducation within Community-based Primary Prevention Programs are not addressed in this CPG.

Education as part of Prevention Intervention

Bergmans and Links (2009) report on an observational study of a 20-week psychosocial/ psycho educational group intervention program developed for clients with a history of recurrent suicide attempts. Clients met weekly in small groups of 8 to 10 at the hospital for 1.5 hours for 20 weeks. The intervention program consists of 4 skill development modules focused on emotional literacy, problem solving, crisis management, and interpersonal relationships. Training modules provided a number of sub skills and educate clients to think positively about their capacity to keep themselves safe through implementation of the knowledge and skills taught within this intervention program. This pilot study of 239 individuals presenting with a history of suicide attempt(s) and one or more psychiatric disorders engaged them in a 20-week group intervention; pre- and post-intervention measures were available for a subset of the sample (n = 42 to 77); pre- versus post-intervention measures for this subset of individuals indicated significant reductions in cognitive, affective, and impulsivity deficits associated with risk for suicide and suicide-related behavior. The investigators suggest that this short-term intervention may be an important first step in engaging the client to seek longer-term help for problems associated with risk for suicide. In the randomized trial conducted by Fleischmann et al. (2008) the intervention in the experimental group received treatment as usual plus brief intervention and contact (BIC), which included patient education and follow-up. Significantly fewer deaths from suicide occurred in the BIC than in the control treatment-as-usual group (0.2% versus 2.2%, respectively; $\chi^2 = 13.83$, $P < 0.001$).

A survey conducted online by the National Alliance of Mental Illness (Cerel et al., 2006) focused on patient perceptions of their interactions with staff during emergency room care following a suicide attempt. The results of the findings were based on responses from 465 patients and 254 family members and close friends who accompanied these patients to the ER. Among the results, approximately 45% of patients did not feel staff respected them. Fewer than 42% of patients felt care staff listened or described the nature of treatment. Fewer than 75% of the family members surveyed felt staff treated them respectfully, and only 54% felt the staff explained the nature of treatment. Fifty-four percent of patients felt "punished" or "stigmatized," and 28% of family members felt "punished" or "stigmatized." Twenty-eight percent of family members and 31% of patients felt patients' injuries were not taken seriously. Twenty-nine percent

of family members and 39% of patients felt staff did not address cultural considerations. Over 14% of both groups reported that staff used confusing "jargon." Although the recommended characteristics of family education have not been formally and independently studied, they do reflect expert consensus in that they are congruent with The Joint Commission patient education standards. In addition, treatment outcomes in general depend significantly on the provider-patient relationship. Concluding that some patients who have negative experiences within their first encounter after a suicide attempt are less likely to follow through with referral seems a reasonable conclusion in at least some cases; therefore, providers must view their role as the first providers following a suicide attempt as vitally important to the patient's ongoing compliance with care.

Stanley et al. (2009) list a number of these family educational contents as important for treatment. In addition, research shows that high parental criticism is associated with self-injurious thoughts and behaviors (Shimazu et al., 2011). Although this study did not specify the role of suicide risk mitigation, the study does show the ability to address the self-directed violence risk factor of depressive disorders.

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

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

BACKGROUND

Various strategies to reduce access to lethal means in order to prevent suicide deaths of an impulsive nature have been developed and implemented in several countries. Means restriction is considered a key component in a comprehensive suicide prevention strategy and has been shown to be effective in reducing suicide rates.

Modification of the environment to decrease general access to suicide means is an important population strategy to reduce suicides. Limitation of access to lethal methods used for suicide—often entitled 'means restriction'—is an important, clinical and individual strategy for suicide prevention. Many empirical studies have shown that such means restriction is effective. Since suicide attempts are often method-specific, the probability of attempting suicide decreases when the patient is precluded from implementing a preferred method. Although some individuals might seek other alternative methods, when a lethal method is unavailable at the moment of potential action, suicide attempts might be delayed so that the suicidal impulses will pass without fatal effects.

Health care providers should routinely assess the presence and the availability (access) of lethal means including firearms and ammunition, drugs, poisons, and other means in the patient's home. (See Module A, Annotation D-3: Assessment of Access to Lethal Means, for review of the means used by Service members and Veterans in suicide). Patient, family or other caregivers should be educated about actions to reduce the associated risks, how to store and secure lethal means of self-harm appropriately and promote vigilance among families and friends of people who have attempted suicide.

RECOMMENDATIONS

1. Provide education about actions to reduce associated risks and measured to limit the availability of means with emphasis on more lethal methods available to the patient:
    a. Fire Arms (military or privately owned): For patients at highest risk, exercise extreme diligence to ensure firearms are made inaccessible to the patient. For all patients at intermediate to high acute risk of suicide,

discuss the possibility of safe storage of firearms with the patient, command, and family (e.g., lock firearms up, use trigger locks or store firearms at the military armory, at a friend's home, or local police station. Store ammunition separately.)

b. Medications: When clinically possible, include limiting access to medications that carry risk for suicide, at least during the periods when patient is at high acute risk for suicide. This may include prescribing limited quantities, supplying the medication in blister packaging, providing printed warnings about the dangers of overdose, or ensuring that currently prescribed medications are actively controlled by a responsible party.

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

Military Service Members

Individual services or commands provide limited guidance to leaders on means restriction when managing personnel in severe distress (**The War Within, Ramchand et al., 2011**). Some evidence supports the use of means reduction or enhancements to safety on all parts of the continuum in suicide prevention, from environmental controls to those targeted at the service member with an intermediate or higher risk of suicide.

Evidence for Restriction of Means

Goldney noted, "restriction of access to means is probably effective not only because of the preclusion of a lethal method of suicide per se but also because it buys time, as the final suicidal impulse nearly always dissipates with time"(2008, p.73).

Firearms – Lubin et al., 2010 reported a 40% decline in the annual number of suicides in the Israeli Army after a change of policy reducing access to firearms during weekends. This is in line with previous population studies that suggest restricting access to firearms is effective in decreasing both suicide rates due to firearms and overall suicide rates (Loftin 1991). These data clearly emphasize the effectiveness of decreasing rates of suicide is an achievement unparalleled by any other means of suicide prevention.

Prescription Medications – In September 1998, Great Britain restricted the number of tablets per packet of paracetamol and other non-opiate analgesics. This was in response to the rising numbers of paracetamol overdoses and increasing numbers of deaths and liver transplantations due to paracetamol poisoning. Before the legislation, packs of 100 tablets could be bought from pharmacies and 24 tablets from non-pharmacy outlets such as supermarkets. There was no limit on the number of packs that could be bought at one time. The legislation restricted pack sizes to 32 tablets from a pharmacy and 16 tablets from a non-pharmacy outlet. Suicide deaths from paracetamol and aspirin fell by 22% in the year after the legislation and this reduction persisted for the next two years.

Alcohol – Lifetime risk of suicide with alcohol dependence is 6%. During 2003-2009, roughly 20% of all U.S. residents who killed themselves had blood alcohol levels that met the standard definition of intoxication, a level of at least 0.08 g/dL. Alcohol abuse is the most prevalent problem and one that poses a significant health risk for the returning Veteran. A study of Army soldiers screened 3 to 4 months postdeployment to Iraq indicated that 27 percent met criteria for alcohol abuse (drinking five or more drinks per typical drinking occasion at least once per week) and were at increased risk for related harmful behaviors (e.g., drinking and driving, using illicit drugs). Despite Soldiers frequently reporting alcohol concerns, few were referred to alcohol treatment.

Hanging–Hanging is a frequently used method of suicide in many countries. In England, there are approximately 2000 hanging suicides per year. Hanging is the most commonly used suicide method in

England; it is the second most common method of suicide in Active Duty US military members. The Rand Corporation paper on suicides among the military population recommended initiatives that include policies (e.g., constructing shower-curtain rods so as to prevent fatal hangings, modify door hinges to reduce deaths by hanging). (Blue Ribbon Work Group on Suicide Prevention in the Veteran Population, 2008).

Implementation of Means Restriction in Military Settings:

Restrict access to firearms – Military personnel have access to firearms, particularly when deployed, and are more likely to own a personal firearm than are members of the general population. Restricting the access to firearms among Active Duty has been shown to decrease the suicide rate by firearms without a compensatory increase in suicide by other means. Discuss with the patient and family members locking up or securing firearms at home or in a military armory and securing ammunition in a different location. Ideally, firearms should be removed from locations were the service member lives and works. The deployed environment is a unique risk factor, with easy access to lethal weapons, and expedited redeployment to the service members' home station should be considered.

Restricting firearms among those specifically trained to use them and for whom the use of firearms may be a function of their job seems daunting or even impossible. There is precedent for such policies, both in the VHA and in DoD. One study in the VHA, for example, found that suicidal patients relied primarily on family members to restrict their access to firearms during times of suicidal crises. These patients found it acceptable for clinicians to ask about firearm ownership, distribute trigger locks, and even provide safe offsite storage of firearms (Roeder et al., 2009).

Occupational Hazards – A strategy applicable to Active Duty members is f the physical profiling system for recommending duty restrictions. Actively suicidal individuals should receive a restricted duty status (profile or limited duty). It is rare that a deployment of a person with intermediate or high acute risk for suicide would be in the best interests of the military mission. A profile change is the primary means for communicating concerns to non-medical authorities (command) so it may be documented when personnel actions (e.g., deployment, permanent change of station) or duty restrictions (carrying weapons, flying, duties requiring security clearance) are considered. When Active Duty members are assessed to be at intermediate to high acute risk for suicide, providers should strongly consider a profile, which places the Active Duty Service member in a temporary non deployable status.

Prescription Medications – Restrict prescriptions of potentially lethal medications to suicidal patients or limit to a non-lethal quantity if the benefit outweighs the risk. Common medications used in overdose include large doses of sleeping pills, barbiturates, pain medications, acetaminophen, and antidepressants (particularly tri-cyclic antidepressants (TCAs), taken under conditions of the low possibility of rescue). Call the Poison Control Hotline if you need help determining a non-lethal quantity.

Hanging – Prevention strategies should focus on countering perceptions of hanging as a clean, painless, and rapid method that is easily implemented. However, care is needed in the delivery of such messaging as some individuals could gain information that might facilitate fatal implementation.

Other methods – Methods vary in lethality. High lethal methods include the use of a firearm, hanging, jumping from significant height, drowning, and vehicular crashes at high speed. Low lethal methods include those where there is a high degree of possibility of rescue, (i.e., where there will be an amount of time sufficient for intervention to occur before death might result; or where the agent, (e.g., drugs), are of insufficient quantity and dosage to be lethal, (e.g., many over-the-counter drugs).

Alcohol and Illicit Drugs – Treat for alcohol dependence as appropriate. Primary care providers should review the alcohol screen at each clinic or periodic health visit. Military members with substance abuse problems are encouraged to seek assistance from the unit commander, senior enlisted, substance abuse counselor, or a military medical professional. Commanders must provide sufficient incentive to encourage members to seek help for problems with alcohol without fear of negative consequences. Self-identification is reserved for members who are not currently under investigation or pending action as a result of an alcohol-related incident.

However, each service mandates medical personnel notify the unit commander and the drug and alcohol program advisor when a Service member is observed, identified, or suspected to be under the influence of drugs or alcohol or receives treatment for an injury or illness that may be the result of substance use (to include suicidal behavior).

If the patient is a high or intermediate acute risk of suicide, a recommendation should be made to the command to prohibit the Service member from possessing or consuming alcohol.

G3. Safety Plan for Patient at Risk of Suicide

Establish an individualized Safety Plan for all persons who are at high acute risk for suicide as part of discharge planning, regardless of inpatient or outpatient status. The Safety Plan is designed to empower the patient, manage the suicidal crisis, and engage other resources. Discuss safety with patients at intermediate and low risk and consider offering education about safety, and a copy of a Safety Plan handout.

BACKGROUND

Historically, providers viewed treatment of underlying disorders as sufficient for addressing suicidality. Recent findings related to suicide behavior highlight the importance of focusing specifically on reducing behavior risk to address immediate safety needs and for development of new coping methods while addressing associated disorders.

Stressful events, challenging life situations, mental/substance use disorders, and other factors can precipitate a crisis of suicidal thoughts and behaviors leading directly to self-injury. Advance anticipation of challenging situations and envisioning how one can identify and break a cycle of suicidal crises can reduce risk of self-injury and enhance a patient's sense of self-efficacy. Open dialogue between patients and clinicians to establish a therapeutic alliance and develop strategies and skills supporting the patient's ability to avoid acting on thoughts of suicide (including minimizing access to lethal means) is an essential component of suicide prevention in clinical settings. Putting this thinking-through process in writing for the anticipation of a suicidal crisis and how to manage it, constitutes a patient's safety (action) plan.

Safety planning is a provider-patient collaborative process – not a "no harm" contract. The safety planning process results in a written plan that assists the patient with restricting access to means for completing suicide, problem-solving and coping strategies, enhancing social supports and identifying a network of emergency contacts including family members and friends, and ways to enhance motivation. These plans are tailored to the patient by assisting the patient with identifying his or her specific warning signs and past effective coping strategies.

Thus, suicidal crises involve experiences and thoughts that are intensely personal; comforting strategies for one patient are not necessarily helpful to another. A behavioral health provider alone cannot develop a safety plan. Formulation of a personal (individualized) safety plan is a process best accomplished with a patient and provider anticipating together likely triggers for future suicidal crises, and collaboratively planning coping strategies that make sense for a given patient.

The plan and the process of developing it should be included in the medical record, and the patient should have received a copy of the plan. "The [safety] plan should be specific…. It should list situations, stressors, thoughts, feelings, behaviors, and symptoms that suggest periods of increased risk…as well as step by step descriptions of coping strategies and help seeking behaviors." (VA Deputy Under Secretary for Operations and Management (DUSHOM) memorandum, Patients at High-Risk for Suicide, dated April 24, 2008.)

RECOMMENDATION

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

Component of Safety Plan:

The Safety Plan should consist of a written, prioritized list of coping strategies and sources of support that patients can use to alleviate a suicidal crisis.

Patients are instructed first to recognize when they are in crisis (Step 1) and then to utilize Steps 2 through 5 as needed to reduce the level of suicide risk:

1. *Recognizing warning signs of an impending suicidal crisis*
2. *Employing internal coping strategies*
3. *Utilizing social contacts and social settings as a means of distraction from suicidal thoughts*
4. *Utilizing family members or friends to help resolve the crisis*
5. *Contacting mental health professionals or agencies*
6. *Restricting access to lethal means.*

For patient at Low-Risk for Suicide

Primary care providers can initiate brief safety planning or may be involved in updating plans developed with other providers. Although individuals in the midst of ongoing stressors (such as relationship turmoil or legal proceedings) may not report suicidal ideation during assessment, their state can change quickly in response to proximate stresses. Safety planning is vital in these cases.

Primary care providers should be trained to collaboratively formulate a safety plan for those at intermediate risk of suicide when located where immediate specialty behavioral health assessment and specialty safety planning is not available.

At a minimum, in low risk patients, the provider should discuss signs that the patient can use to recognize escalating stress or risk, provide key phone numbers and resources for help, and educate about lethal means restriction. A handout can be used to reinforce the discussion.

Consider the following Example Safety Plan handout for a patient at low to intermediate acute risk:

When I am feeling overwhelmed and thinking about suicide, I'll take the following steps:

- *Take a deep breath and try to identify what's troubling me right now.*
- *Write down all of the feelings (sad, mad, lonely, helpless, scared, etc.) as a record for later.*
- *Try and do things that help me feel better for at least 30 minutes (e.g. have a bath, phone a friend, walk the dog, or listen to music).*
- *Write down individual negative thoughts and provide an alternative response that changes the perspective.*
- *If suicidal thoughts continue, I will call my emergency contact person who is_____at: _____*
- *If that person is not available, I will call the 24-hour crisis line at: _____ or the 1-800 273-TALK line.*
- *If I still feel suicidal and out-of-control, I will go to the nearest hospital emergency department.*

DISCUSSION

A short protocol that uses safety planning as a crisis-intervention tool has been developed by Barbara Stanley and Gregory Brown, including a version for Veterans called SAFE VET (Stanley and Brown, 2008), though neither the original nor the adaptation has yet been evaluated systematically. Another protocol is

the Collaborative Assessment and Management of Suicidality (CAMS) treatment that includes lethal means restriction, developing crisis response, and building interpersonal connections (Jobes et al., 2005).

Although formal, systematic, scientific reviews of the efficacy of safety planning are lacking, there is expert consensus that safety planning is a vital component of suicide prevention and that "no harm" contracts are insufficient for mitigating suicide risk.

The patient care load within a primary care clinic often makes development of meaningful safety plans challenging. Although such resource challenges are not satisfactory grounds for failure to follow safety planning recommendations, primary care providers need not conduct such safety planning alone when other competent providers are available to assist. When shared provider responsibility is present, the providers should meet together with the patient to summarize a shared understanding of the safety plan and document this action in the medical record.

G4. No-Suicide Contracts

There is no empirical evidence for the usage of "no harm" or "no-suicide" contracts. A safety plan is a preferred strategy for preventing suicide.

BACKGROUND

Historically, suicide management involved conceiving suicidality as a symptom of a mental disorder, indicating initiation of usual treatment (as for major depressive disorder) in order to terminate thoughts and behaviors of self-harm. The emphasis in this paradigm was advising a patient regarding what not to do (harm self) while awaiting the treatment for the disorder to work. Some patients were required to sign a "contract for safety" or agree to a "no harm contract" indicating they would not harm themselves while in a window of vulnerability due to an unresolved mental disorder. As treatment of mental disorders may require weeks or months, often with substantive non-response rates, dealing with suicidality itself was often insufficient or never adequately addressed.

No-Suicide contract documents have been developed to document that a patient agreed to not killing himself/herself over a specified time period. Additionally, evidence indicates that no-suicide contracts are not sufficient to protect individuals against litigation, and may possibly increase liability.

Nothing should replace a thorough evaluation of a patient's risk factors and current warning signs for suicide. A safety plan or a crisis plan is a preferred strategy that has supportive and anecdotal evidence for preventing suicide.

RECOMMENDATION

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

DISCUSSION

The use of "no-suicide" contracts between patients and health providers, in which the patient agree, often in writing, not to harm oneself, has not been demonstrated to be effective when used on their own (Goldsmith et al., 2002). Two reviews of the literature (Lewis, 2007; Rudd, Mandrusiak, & Joiner, 2006b), concluded that there is no empirical evidence to support their efficacy in reducing suicide, nor are they useful for protecting clinicians from malpractice litigation (Lewis, 2007). When a patient signs a no-suicide contract, the counselor's and staff's tendency is to be less careful in attending to her or him, when in fact

there has been no lessening of risk for suicide (Jacobs & Brewer, 2004). Additional reviews by Garvey et al. (2009), and Kelly et al. (2000) have also concluded that there is no empirical evidence for the usage of suicide contracts.

Garvey et al. 2009 conducted a literature review using different terms to describe the same concept of no-suicide to assess empirical support for the use of contracts, including medico legal implications. The majority of available literature consisted of opinion-based surveys. Overall, empirically based evidence to support the use of the contract for safety in any population is very limited, particularly in adolescent populations. An additional legal review of legal outcomes related to their use (LexisNexis search of all state and federal cases using similar search terms) reinforced that contracts are not sufficient to protect the provider against litigation, and may lead to adverse consequences for the patient/provider relationship.

Kelly et al. 2000 conducted a literature search and identified 32 articles. Of those, only 11 articles directly addressed the use of no-suicide contracts, and of those, only two were considered empirically based. Comprehensive review of all articles suggested there is no empirical evidence supporting the use or effectiveness of no-harm contracts in preventing suicide.

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

BACKGROUND

Patients at risk for suicide may have a persistent incapacitating mental disorder marked by severe and intolerable symptoms; marital, social, and vocational disability; and extensive use of psychiatric and community services. These patients may sometimes benefit from therapeutic intervention that facilitates developing skills for coping with, by utilizing case management, as well as from psychotherapy or pharmacotherapy.

Problem-solving training or other intervention for promoting resilience should be provided to help patients cope with difficulties or adjustment to stressful life events and other risk factors. A problem-solving approach is practical and designed to enhance a patient's skills to resolve stressors, obstacles, or conflicts that increase distress and the risk of suicidal behavior. Increasing one's personal effectiveness through this approach empowers healthy behaviors and reduces isolation, burdensomeness, and despondency.

For patients at high risk for suicide with a diagnosis of mental disorder, coping with the challenges should be part of psychiatric rehabilitation for the mental health condition. Psychosocial Rehabilitation involves providing the family with education, supported employment, supported education, and supported housing; some serving as case managers; or others working with peer counselors. VHA's Uniform Mental Health Services policies (VHA Handbook, 2009) now mandate psychosocial rehabilitation, expanding such services from inpatient units to outpatient programs in Primary Care settings, Outpatient Clinics, Community-Based Outpatient Clinics (CBOCs), Vet Centers, and Home-Based Care programs and in partnerships with agencies and providers in communities.

Within the military, multiple non-standardized programs with little evidence base address adaptive coping skills and may improve psychological wellness. The majority of such programs are based on the premise that Social/Occupational factors play a significant role in suicidality. Training in skills, attitudes, and behaviors may allow a Service member to interact more appropriately with their environment thereby lessening the impact of some modifiable risk factors for suicide. For example, replacing maladaptive coping skills with more adaptive coping skills may have direct impact on the quality of relationships with significant others and with commands. Skills such as: (1) anger management, (2) conflict resolution, (3) stress and anxiety management, (4) financial planning, (5) career guidance, (6) assertiveness, (7)

relationship building, (8) relaxation, (9) self care, (10) communication, and (11) mindfulness, potentially help Service members cope better with life challenges, improve life quality, and decrease suicide risk.

Programs may emphasize adaptive behavior, healthy decisions, resiliency, mindfulness, and mobilizing a Service member's resources to provide support. Additional targets of such initiative could include: (1) unemployment, (2) financial difficulties, (3) legal issues, (4) lack of supportive relationships (may be self-induced), (5) homelessness or housing instability, (6) lack of social support (may be self-induced), (7) inability to organize comprehensive care, and (8) substance abuse.

Such programs are often conducted in a group setting and may be more supportive and directive than other forms of therapy. Other formats include individual meetings, workshops, and small group counseling led by other members of the care team, not necessarily the BH clinicians. Community services, chaplains, and others may maintain similar services. They may be included in some evidence based treatment regimens.

RECOMMENDATIONS

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

Survivors of suicide attempts and other patients at high risk may need information about financial, rehabilitation, legal, and other services available to them, as well as education about common obstacles to pursuing needed services. Evaluate psychosocial function and refer for psychosocial rehabilitation, as indicated. Available resources include, but are not limited to: Chaplains, Pastors, Family Support Centers, Exceptional Family Member Programs, VA benefits counselors, occupational or recreational therapists, Vet Centers, and peer support groups.

Table B-2 Adjunctive Problem Focused Method/Services

	Domain	Service/training
1	Unemployment or lack of a job that provides adequate income and/or fully uses person's training and skills	Implement vocational rehabilitation training; comprehensive employment readiness through training, resume building, and referral
2	Financial difficulties	Social services referral and evaluation; consider housing, employment, or public assistance requirements
3	Legal issues	Consider to referral to Veteran's Justice Outreach, military base Community Services, or local community resources
4	Relationship (Lack of family or friends that are knowledgeable and actively supportive)	Family advocacy & counseling. Implement family skills training, spiritual counseling, group therapy, social engagement
5	Homelessness (Lack of safe, decent, affordable, stable housing that is consistent with treatment goals)	Address independent living skills, refer to supported housing services, and reconnection with family members HCHV
7	Lack of social support (i.e. self-induced or circumstantial, and is socially inactive or isolated)	Implement social skills training, assessment of personal support network and re-engagement
8	Inability to coordinate and locate personal services	Use of case management services
9	Patient/family and other significant social supports are not fully informed about aspects of health needs	Provide education, include in treatment planning as patient allows.
10	Requests spiritual support	Provide information /access to religious and spiritual advisors or other support
6	Substance abuse	Integrated substance abuse treatment

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

BACKGROUND

The management of the Active Duty Service member with suicidality can be complicated by many factors inherent in military service. The environment where a patient may manifest suicidality may frequently not mirror any of the care settings already described and/or immediate accessibility to a mental health provider may be limited. In these instances the care provider must determine the need for an evacuation to a more distant location where appropriately trained providers, medical support, and the ability to more adequately control the environment are available. Additional differences include the inherent quality of the relationship of Service members to their commands, which does not exist in other care settings. A final distinct difference, particularly in deployments to combat zones and in certain training environments is the fact that Service members often have readily available access to either their own, or other Service members' weapons.

One of the significant challenges in managing suicide risk in Military member is the "Clash of Cultures" between the military and the medical mindsets (Bryan 2012). Military members and leaders value ideals like mental and physical toughness in the face of adversity. The Warrior Ethos demands a sense of collectivism. That one is part of, and reliant on the whole, while highly adaptive for military operational success, results in diminished focus on the individual. The individual focus of most suicide prevention efforts must be adapted to resonate with the belief that the group is only as strong as its members in a way that capitalizes on cohesion as a protective factor. Warriors also value self-reliance and self-sacrifice in service of the unit, the mission, and the Nation. In order to achieve the military objective, this

selflessness is burnished with a fearlessness of death and significant denial about one's own mortality. Self-sacrifice and desensitization to death are important factors to understand in the management of service members at risk for suicide.

Military culture and the warrior ethos adopted stoicism as an ideal. This stoicism, while adaptive in combat, creates a significant barrier to the recognition of, and help seeking behaviors for, emotional issues (Sherman 2005). The effective management of suicide risk must take these important and adaptive qualities of military culture into consideration and adapt all communication and attitudes to resonate with the warrior ethos. The challenge is always how best to capitalize on the strengths of military culture while protecting against the potential for marginalization of a member who is at risk for suicide.

The following apply both to Active Duty Service members managed by DoD and to activated Reserve and National Guard members who may be receiving care from either the Veterans Administration Health Care System or from the DoD.

RECOMMENDATIONS

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

DISCUSSSION

The odds-ratio for suicide increased across all military Departments in 2007 among those who deployed to OIF or OEF (Hyman, Ireland, et al., 2012). This may be accounted for by (Bryan et al., 2010) factors affecting suicidality and risk management challenges in war zones. Deploying Service members may be more at risk for suicidal ideation and completed suicide due to experiencing "trauma, violence, combat exposure, and habituation to the fear of death" (Bryan et al., 2010 p713f). Insomnia, agitation, and hyper arousal compound reactions to these stressors in the context of all members carrying weapons and fewer behavioral health resources. Those without a sense of belonging in their units may be at special risk as well.

Special precautions are indicated regarding sharing of information and involvement of command, either in-garrison or while deployed, when it is determined that a Service member is at risk for suicide.

Service members have the same rights as others to Protected Health Information (PHI) with some exceptions with regard to the Service member's command element. All PHI shared with command should only be disclosed in accordance with service specific and DoD policies and regulations.

PHI may be disclosed to a Service member's Commander when military readiness is jeopardized.

Disclosures may include sharing information to:

- Determine the member's fitness for duty
- Report on casualties in any military operation
- Avert a serious and imminent threat to health or safety of a person, such as suicide, homicide, or other violent action
- Indicate whether prescribed medications might impair duty performance
- Inform whether diagnosed condition might impair a member's performance of duty or harm a mission
- Indicate when member is in a substance abuse treatment program
- Respond to a command-directed mental health evaluation
- Report an injury that indicates a safety problem or a battlefield trend
- Report that the member requires hospitalization
- Carry out required or occupationally specific activities IAW applicable military regulations or procedures.

Providers must take reasonable steps to limit the disclosure of PHI to the minimum necessary to accomplish the intended purpose. Medical conditions that do not affect the member's fitness for duty/mission or are not necessary to assure the proper execution of the military mission are not revealed to the unit. For example, commanders would not be advised of a member's self-referral to mental health if none of the issues listed above are evident. Each service prescribes a formal way to document communication with commanders. For example, the Army may document duty limitations in a medical profile, whereas the Navy may put a Sailor on a limited duty profile for a temporary condition. These mechanisms do not preclude direct conversation, and when safety issues are imminent, it is recommended that both direct communication and appropriate service-specific documentation are utilized. An example of specific communication would include a comment such as "No access to weapons until cleared by a qualified mental health provider," or "Please monitor that Service member is compliant with treatment plan and notify provider of any concerns that Service member is not following through with the recommended plan." A final distinction has to do with the unique legal considerations related to limited privilege, limits of confidentiality and the differences in military and civilian legal codes.

Command elements can be a powerful ally to facilitate a safety plan. On rare occasions, poor leaders may create a barrier to ideal care. This practice is not indicated except in extreme situations.

The practice of unit watch is not recommended for patients who meet criteria for hospitalization due to imminent risk. Unit watch may be necessary to ensure the safety of a Service member who meets criteria for hospitalization until the Service member can be safely transported to an inpatient psychiatric setting (e.g., deployment, field training exercises, training aboard ship, etc.

Providers should determine the utility of a command element to be a useful ally in safety planning for a Service member. This should include determining the ability of the command to become part of the social supports for the Service member. Adequate direction, discussion and education are often needed to communicate exactly how a command can help the Service member recover and regain the ability to return to full duty without restrictions.

For Active Duty component Service members and activated Reserve and Guard members, the command should always be involved in the treatment plan of a suicidal patient. This is true even in instances where the command is identified as one of the factors contributing to the suicidality.

Continuous command involvement is indicated for Service members and may include:

- Command-directed mental health evaluations
- Implementing medically-directed duty restrictions (Profile)
- Restrictions from weapons
- Suspending security clearance and access to classified areas, as indicated.