MODULE C: TREATMENT OF THE PATIENT AT RISK FOR SUICIDE

The treatment plan for a patient at high risk for suicide should be based on the balance of potential benefits and harm of specific medical treatment as well as the potential benefits of psychotherapies and psychosocial interventions. After assessing evidence quality for suicide prevention distilled from surveillance of 16,500 English language post-2005 studies, with a final analysis of 35 relevant randomized controlled studies and 38 systematic reviews, the Working Group concluded, "there is a lack of strong evidence for any interventions in preventing suicide and suicide attempts". The dearth of quality research available on effective suicide prevention practices is mainly due to the difficulty conducting randomized controlled trials (RCTs) in high risk for suicide population and the low base rates of suicide and suicide attempts, even in groups at higher risk for suicide.

In formulating recommendations in this guideline, the working group evaluated the empirical evidence-base, considering RCT as the highest level of the evidence-based hierarchy. Although therapy provided in clinical trial settings differs from therapy practiced in day-to-day care, the recommendations can only represent the techniques and protocols as they were studied and reported in RCTs.

The recommendations are based on the best available evidence in suicide prevention in the civilian context. Results of studies currently under way may be informative regarding the usefulness of interventions in the military and identify relative efficacy of different evidence-based strategies of risk reduction and potential differences in patient-based outcomes.

ANNOTATIONS

Annotation H. Determine Treatment Plan

Establish a treatment plan for patients at risk for suicide addressing the patient's potential (risk) for suicide, fostering the therapeutic alliance, and addressing mental health or medical disorders, and a range of available treatment alternatives from outpatient follow-up to hospitalization with constant observation and assurance of safety.

BACKGROUND

Developing of a treatment plan for a patient with suicidal thoughts or behaviors should be based on the balance of potential benefits and harm of specific medical treatment as well as the potential benefits of psychosocial interventions, including specific psychotherapies. Many patients with suicidal thoughts, intent, or behaviors will benefit most from a combination of these treatments. Treatment should address the modifiable potentiating factors identified in the initial suicide assessment.

Treatment should be a collaborative process between the patient, clinical team and, if the patient consents, others such as family members, unit members/ command, community organizations or other resources available to the patient. The clinician should continue to make re-assessments of suicide risk during the course of treatment. In general, therapeutic approaches should target the suicide risk and the specific psychiatric conditions and associated symptoms such as depression, anxiety, aggression, pain, and sleep disturbance. Treatment goals of psychosocial interventions may be broader and longer term, including achieving improvements in interpersonal relationships, providing training in coping skills and addressing psychosocial functioning.

RECOMMENDATIONS

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

Annotation I. Psychotherapy

BACKGROUND

Focal psychotherapies are effective for the treatment of a range of common psychiatric and behavioral problems. Most evidence-based psychotherapy interventions for prevention of suicide can be considered broadly as treatment designed to influence dysfunctional cognitions, emotions, and behaviors through a goal-oriented, systematic procedure. Much of the evidence base for reducing suicide risk has concerned cogni¬tive behavioral approaches. Cognitive-behavioral therapy (CBT) can be seen as an umbrella term that encompasses many different therapies sharing a conceptual foundation in behavior learning theory, cognitive theory, emotional processing theory, and interpersonal relationship theory approaches. The objective is typically to identify and monitor thoughts, assumptions, beliefs, and behaviors that are related and accompanied by debilitating, inaccurate and dysfunctional emotions. This is done in an effort to replace them with more realistic and useful ones. For the prevention of suicide, the primary goal of CBT is to teach suicidal patients that death is not the only option.

CBT includes a variety of approaches and therapeutic systems. The vast majority of interventions that have been evaluated in clinical trials involve a combination of the following core therapeutic components:

- Cognitive (irrational negative thoughts, core beliefs and cognitive distortions, problem solving deficits)
- Emotional (avoidance of unpleasant experiences that was activated prior to the suicide attempt)
- Behavioral (reduced activity, impulsive behavior)
- Interpersonal (poor communication and impaired social function)

Therapeutic techniques vary among cognitive and behavioral approaches according to the types of issues addressed. The interventions include various activities such as Socratic questioning, keeping a positive diary, positive self-verbalization, increasing tolerance of distress, mindfulness training, using existing coping skills, learning new coping skills, changing cognitions related to loss of control, skills training through modeling or role playing, removing obstacles to social support, and psychoeducation as an important component of all interventions. However, very few studies have dismantled these individual components to assess the relative efficacy of each one independently.

The treatment interventions for prevention of suicide have been packaged in various ways, and the majority of interventions included in the RCTs were grouped into four main categories based on the components most emphasized or the specific names used in the published literature: 1) Cognitive-Behavioral Therapy (CBT), 2) Problem Solving Therapy (PST), 3) Dialectical Behavior Therapy (DBT), and 4) Interpersonal therapy (IPT). All of these four categories include the components described above in different combinations.

Cognitive-Behavioral Therapies (CBT) emphasize the modification of core beliefs and schemas related to perception of self, the world, and the future. The approach involves changing problematic behaviors through cognitive restructuring (challenging automatic or acquired beliefs, such as beliefs about safety or trust) but also include relaxation techniques and discussion/narration of the potentiating factors (circumstances at the time of the episode, motives and reasons for self-harm).

Another form of behavioral therapy emphasizes skills-training interventions. This approach is premised on an assumption that dysfunctional behaviors stem from underlying skills deficits. Their goal is to decrease suicidal behaviors by increasing adaptive coping strategies such as distress tolerance, emotion regulation, and interpersonal skills. Another skill training intervention is **Problem Solving Therapy (PST)** that emphasizes the emotional and maladaptive ways that individuals react to stressful conditions when facing of significant problems. The goal of problem solving is to increase the person's understanding of the links between his/her current distress and his/her current problems, the ability to define his/her problems, and to teach specific strategies for problem solving. PST is based on the principle that the most adaptive response to significant problems is to engage in problem solving. However, in the face of significant problems, many individuals may be overwhelmed, and react in emotional and maladaptive ways that can lead to depression, other mental health conditions, or suicide.

Problem solving interventions are included in several studies as a pragmatic approach that involves patients learning and practicing problem solving as a coping skill. Safety planning is one example of a structured problem solving approach to help the patient cope with a crisis situation.

Several studies evaluated the effectiveness of skills training for reducing suicidal behavior in individuals with personality disturbance using manual-assisted cognitive therapy (MACT).

Dialectical Behavior Therapy (DBT) was initially developed by Linehan (1993) after having found that cognitive behavior therapy (CBT) is problematic for chronically suicidal individuals such as those suffering from personality disorders. DBT places more emphasis on managing the patient's multiple, severe problems, suicidal behavior, and extreme emotional sensitivity by providing structured, staged treatment and multiple sources of support for both patient and provider. DBT assumes that emotion dysregulation is the core disorder in Borderline Personality Disorder and a main causal pathway for suicide-related behaviors. Lack of adequate coping skills for dealing with emotional distress may lead to an attempt to escape through suicide. DBT also uses mindfulness techniques to increase self-awareness and strategies from other therapeutic approaches to help the individual move toward accepting that change is possible and to learn new coping skills necessary to begin to make such changes. Some trials have used self-learning reading material that follows the DBT approach.

Interpersonal therapy (IPT) focuses on impaired social functioning and addresses interpersonal difficulties that lead to psychological problems. The goal of this treatment is to provide new interpersonal learning experiences to overcome grief due to loss, interpersonal disputes, role transitions, and interpersonal skill deficits. IPT that is delivered in a group setting provides opportunities to resolve interpersonal conflicts by addressing the "here-and-now" interpersonal transactions. Relational information provided through the transactions in the group allows for a shift in the patient's self-schema.

Psychodynamic therapies have not been directly targeted at the problem of suicide. Recent trials have been conducted to evaluate specific forms of **psychodynamic therapy**, titled transference focused psychotherapy and schema-focused therapy as an integrative approach that combines aspects of CBT, experiential therapy, attachment theory, and psychodynamic theory. **Mentalization-Based Therapy** (MBT) is a psychodynamic approach that emphasizes the relational aspect of personality disturbance, with treatment strategies focusing on the attachment relationship and on restructuring the individual's self-image and understanding of others. According to MBT, borderline pathology, including suicidal behaviors, stems from a disorganized attachment system resulting in impaired relationships and emotional instability.

Although not targeted specifically to suicide or suicidal behaviors, other psychosocial treatments (e.g., treating alcohol and other substance use disorders that are themselves associated with increased rates of suicide and suicidal behaviors) may be helpful in reducing symptoms and improving functioning in individuals with psychiatric disorders. For patients at risk for suicide, specific psychosocial interventions such as intensive care plus outreach, brief psychological interventions and follow-up; or family, couples/group therapies may be useful despite limited evidence for their efficacy.

The following overarching principles should guide providers in selecting the appropriate type of evidence-based therapy for patients at risk for suicide:

- The benefits and risks of evidence-based psychotherapies for suicide prevention should be evaluated, discussed amongst providers, and documented in treatment planning for all patients who have survived a suicide attempt and others at high risk for suicide.
- The goal of therapy and the identification of the problem areas upon which therapy will focus should be based on the way the individual's prior experiences influences current cognitions, emotions, behavior and relations.
- The selection of individual specific therapy between effective evidence-based treatment options should be based on the patient's diagnosis and preference, the provider training and experience, comfort in pursuing the technique, and available resources in the care setting.

Annotation J. Suicide-Focused Psychotherapy Addressing the Suicide Risk

BACKGROUND

Specific forms of cognitive therapy have been shown to decrease the risk of suicide. A provider using the cognitive therapy model identifies the suicidal behavior as the primary problem rather than as a symptom of a psychiatric disorder. Similar to cognitive therapy protocols for other problems, the provider pursues evidence of cognitive distortions in a patient's core beliefs and schemas that fuel suicidal behavior. The provider can then address these

distortions by evaluating cognitive processes that will lead the patient to the conclusion that death is not the only solution.

Evidence-based cognitive therapy (CT) for suicide prevention can be utilized by providers to treat suicidal patients regardless of non-psychotic psychiatric diagnosis and can be used in conjunction with other forms of treatment that the suicidal patient is receiving.

There is some evidence that cognitive therapy and skills training can be used to address patient's problems associated with self-harm behaviors and suicidal thoughts regardless of the psychiatric disorder. Suicidal patients may have deficits in problem solving such that dying by suicide may be perceived as the only solution to their perceived life problem(s). While a range of theories and psychotherapies has been studied, some research supports structured, problem-solving approaches that specifically target and treat suicidal ideation and behavior (independent of diagnosis).

Providers should recognize the benefit of evidence-informed practices in teaching patients about effective problem solving. Problem solving training can be integrated into other CBT interventions, or offered as a stand-alone treatment.

RECOMMENDATIONS

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

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

When the self-harming behavior or suicide risk is associated with a psychiatric illness then that illness needs to be identified and treated and the treatment plan needs to be modified to specifically address the risk of suicide.

BACKGROUND

Evidence supports the efficacy of psychotherapy in the treatment of specific psychiatric disorders associated with increased suicide risk. Treatment of the underlying disorders and psychiatric symptoms is important to support the prevention of suicide. If the self-directed violence behavior or suicide risk is attributable to a psychiatric illness then that illness needs to be identified and treated and treatment plan need to be modified to specifically address the risk of suicide.

Annotation K1. Psychotherapy for Co-occurring Mental Disorders Associated with Suicide Risk

RECOMMENDATIONS

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

Annotation K2. Psychotherapy for Borderline Personality Disorder Associated with Suicide Risk

2. Dialectical Behavioral Therapy (DBT) for patients with Borderline Personality Disorder (BPD) or other personality disorders characterized by emotional dysregulation and a history of suicide attempts and/or self-harm. [I]
3. Specific psychotherapies based on cognitive or behavioral approaches or skills training (i.e., CBT for Borderline Personality Disorder, MACT, Acceptance Based Emotion Regulation Group Intervention) for patients with BPD who are at high risk for suicide. [I]
4. Specific psychodynamic psychotherapies (i.e., MBT, brief psychodynamic interpersonal therapy) for patients with BPD who are a high risk for suicide. [I]

Annotation K3. Psychotherapy for Suicide in Schizophrenia Associated with Suicide Risk

RECOMMENDATIONS

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

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

BACKGROUND

As documented throughout this guideline, substance use disorders are a prevalent and potent risk factor for suicide attempts and suicide. The recommendations for management and treatment made throughout this guideline generally apply to individuals with substance use disorders and should be followed.

RECOMMENDATIONS

1. Ongoing management of suicidal patients with SUD should include treatment by a licensed mental health practitioner.
2. In addition to suicidality-focused interventions, treatment should be provided for an underlying SUD condition (e.g., addiction). Ensure that management of suicide risk is coordinated or integrated with treatment for substance use disorder and comorbid conditions
3. Intervention strategies in patients in whom suicide risk is associated with using substances should emphasize safety, relapse prevention, and addressing the substance use.
4. In the effort to limit access to lethal means, pay special attention in this population to restriction of lethal means as firearms, and prescribed medication (dosage and quantities).

Annotation L. Pharmacotherapy to Reduce Risk of Suicide

RECOMMENDATIONS

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

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

When self-harm behavior or suicide risk is attributable to a psychiatric illness, that illness needs to be identified and treated and the treatment plan modified when appropriate to specifically address the risk of suicide.

RECOMMENDATIONS

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

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

Closely monitor patients for changes in thoughts of suicide or suicidal behaviors after antidepressant treatment has been initiated or the medication dose is changed.

RECOMMENDATIONS

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

See VA/DoD CPGs for Management of Major Depressive Disorder and Bipolar Disorder

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

Closely monitor patients for changes in thoughts of suicide or suicidal behaviors after an antipsychotic is added to treatment for a mood disorder.

BACKGROUND

Atypical antipsychotics may be used as treatment augmentation in the management of MDD and treatment of bipolar depressive disorders. Aripiprazole, quetiapine, and olanzapine in combination with fluoxetine include depressive

disorders in their label indications. Their labels also include the same box warning as antidepressants for an increased risk of suicidal thinking and behaviors. There is no evidence to support this increased risk in adults, albeit atypical antipsychotics have not been as extensively studied as antidepressants.

RECOMMENDATIONS

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

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

Providers should consider treating patients with a unipolar depression disorder with lithium in an effort to reduce the risk of suicide.

RECOMMENDATIONS

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

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

Providers should consider treating patients with a bipolar disorder with lithium in an effort to reduce the risk of suicide.

RECOMMENDATIONS

1. Lithium should be considered for patients diagnosed with bipolar disorder who do not have contraindications to lithium as it has been shown to reduce the increased risk of suicide associated with this illness. [B]
2. Lithium should be avoided or used in caution in patients with impaired renal functions, taking concurrent medications that increase or decrease lithium concentrations or other risk factors for lithium toxicity.
3. When prescribing lithium to patients at risk for suicide, it is important to pay attention to the risk of overdose by limiting the amount of lithium dispensed, and to the form in which it is provided.

See VA/DoD CPG for Management of Bipolar Disorder

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

Providers should consider treating patients with schizophrenia with clozapine who have a history of suicide attempt, high risk for suicide, or who are symptomatic after two adequate trials with other antipsychotics.

RECOMMENDATIONS

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

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

Closely monitor patients for changes in thoughts of suicide or suicidal behaviors after an antiepileptic drug is initiated for any indication.

RECOMMENDATIONS

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

Annotation M7. Use of Anti-Anxiety Agents in Suicidal Patients

Anxiety is a significant and modifiable risk factor for suicide. The use of anti-anxiety agents may have the potential to decrease this risk.

RECOMMENDATIONS

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

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

RECOMMENDATIONS

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

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

Consider ECT for rapid resolution of suicidal symptoms in patients with Major Depressive Disorder, Manic Episodes, Bipolar I Depression, PTSD, and Acute Schizophrenia.

RECOMMENDATIONS

1. ECT is recommended as a treatment option for severe episodes of major depression that are accompanied by suicidal thoughts or behaviors indicating imminent risk for suicide, considering patient preferences.
2. Under certain clinical circumstances and, considering patient preference, ECT may also be considered to treat suicidal patients with schizophrenia, schizoaffective disorder, or mixed or manic episodes of bipolar disorder.
3. The decision of whether to initiate ECT treatment should follow evidence-based recommendation for the specific disorder, and be based on documented assessment of the risks and potential benefits to the individual, including: the risks associated with the anesthetic; current co-morbidities; anticipated adverse events; and the risks of not having treatment.
4. Since there is no evidence of a long-term reduction of suicide risk with ECT, continuation or maintenance treatment with pharmacotherapy or with ECT is recommended after an acute ECT course.
5. ECT should be performed by experts in centers that are properly equipped and experienced in the treatment.
6. In general, the following conditions increase the indications to use ECT:
    a. A history of prior good response to ECT
    b. Need for rapid, definitive treatment response
    c. Risks of other treatments outweigh the risks of ECT
    d. History of poor response to medication treatment
    e. Intolerable side effects to medication treatments
    f. Patient preference.
7. The risk-versus-benefits ratio must be considered in patients with relative contraindications such as [B]:
    a. Space occupying lesions
    b. Elevated intracranial pressure
    c. Cardiovascular problems to include recent myocardial infarction, severe cardiac ischemic disease, or profound hypertensive illness.
    d. Degenerative skeletal disease
    e. Monamine Oxidase Inhibitors should be discontinued two weeks prior to ECT to prevent possible hypertensive crisis
    f. Lithium: patients may develop neurotoxic syndrome with confusion, disorientation, and unresponsiveness
    g. Retinal detachment
    h. Pheochromocytoma
    i. High Anesthesia Risk: American Society of Anesthesiologists level 4 or 5.