Air Force Guide for Managing Suicidal Behavior

Strategies, Resources and Tools

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Questions about this guide and its use should first be directed to your MAJCOM Behavioral Health Consultant due to variability in implementation across commands

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MEMORANDUM TO AIR FORCE MENTAL HEALTH PROFESSIONALS

FROM: AFMOA/CC

SUBJECT: Management of Suicidal Behavior

In recent years, the Air Force has implemented broad-based initiatives to prevent suicide in the Air Force community. Since the initiation of this broad-based approach, the Air Force has seen some of its lowest suicide rates over the past several years. Nevertheless, suicides and suicide attempts still occur. Suicidal behavior not only impacts the lives and well-being of the individual, family, and friends, but it can also seriously impair the ability of affected Air Force units to accomplish their missions. Mental health professionals at our military installations are at the front lines assisting unit commanders and First Sergeants in the care of personnel, and I understand the immense challenges you face when suicidality is part of the clinical picture. It is essential that Air Force mental health professionals have current information, applicable skills, and the best resources for managing suicidal patients.

I am pleased to present you with the *Air Force Guide for Managing Suicidal Behavior: Strategies, Resources, and Tools* to help you deliver high-quality, evidenced-based care to suicidal individuals. As a guide, it explicitly does not represent a mandate or requirement; but rather, it is a set of recommendations that is intended to help you provide quality care. Experts both within and outside the Air Force recognize this guide as state of the art, a product without equal in the military or civilian community. I highly encourage its use by all Air Force outpatient mental health providers, nurses, technicians and support staff.

For further information or questions, contact Lt Col Rick Campise at DSN 297-4285 or rick.campise@pentagon.af.mil.

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TABLE OF CONTENTS

Multiple surveys indicate that training on suicide assessment and intervention in mental health training programs is variable and often inadequate.

Bonger &Harmatz (1989, 1991)
Ellis & Dickey (1998)

Preface

We developed this guide in an effort to help to Air Force mental health staff navigate one of the most difficult and complex aspects of clinical practice: suicidal behavior. In each clinical encounter, we potentially face the most serious of consequences for our patients as well as potential legal threats to the Air Force and ourselves, yet mental health professionals typically receive minimal *formal* training in managing suicide and generally feel insufficiently prepared to handle it. This guide pulls together state-of-the-art knowledge and best practices for the clinical management of suicidal behavior to make providing this care easier for mental health providers, nurses, technicians and clinic staff.

This document is a *clinical guide*. As a guide, it explicitly does not represent a mandate or requirement; rather, it is a set of recommendations that is intended to help you provide quality care. The ultimate responsibility for patient care decisions rests with 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 defined as what a typical, similarly trained provider in a similar community setting would do in a given circumstance. A jury or medical incident investigation board ultimately determines this standard. As a guide, this document was developed to *reflect* those practices that have been judged to be the "standard of care," but does not (and, by definition, cannot) define it. This guide should not be used as a static or definitive "statement" of the standard of care in Medical Incident Investigations, or legal investigations and proceedings. Clinic leaders, however, may incorporate relevant information from this guide into local clinic operating instructions (OIs). Local OIs *are* the appropriate benchmark on which clinical performance should be judged when standard-of-care determinations are made.

The guide was structured around a set of 18 recommendations, organized within eight topical chapter headings. You will find these recommendations listed on page 10. Note that the scope of the recommendations is the *management* of suicidal behavior, not *treatment* per se (i.e., medications and dosages, how to do cognitive behavioral therapy for suicide, etc.). Following each recommendation, we present further discussion on strategies, tools, and resources for meeting that recommendation. Additionally, a set of appendixes contains a flow chart diagramming a process of care for management of suicidal behavior in mental health clinics (see Appendix A), suicide assessment and tracking tools, templates, and examples. We leave the use of specific strategies, tools, or resources to the discretion of individual professionals and clinics, based on their unique needs, resources, and preferences.

We highly recommend creating a clinic OI reflecting local procedures and policies related to suicide management. You can find a template for an OI in Appendix B.

Suicide is the #1 sentinel event for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Introduction

No patient behavior generates more stress and fear among clinicians than suicide and suicidal behaviors (Pope & Tabachnick, 1993). While completed suicide is fortunately rare, many mental health professionals 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, Bauer, Kinney, & Hamada, 1988; Chemtob, Bauer, Torigoe, & Hamada, 1988). Furthermore, suicidal symptoms, risk factors, and even self-injurious behavior in which there is a secondary (interpersonal) gain are quite common in mental health and substance abuse settings. In recent times, criteria for inpatient care have become increasingly restrictive, and providers have worked to provide quality care for individuals at higher risk for suicide on an outpatient basis (Jobes, 2000). Encouragingly, there is increasing evidence that outpatient management of suicidal patients can be appropriate, safe and, often, preferable to inpatient care (Rudd, Joiner, Jobes, & King, 1999).

"Suicidality," broadly defined, can range from internal thoughts to external behaviors related to taking one's own life. This includes overt actions that are potentially self-injurious, whether or not there is true intent to die. It also includes self-reported suicidal thoughts, verbal or written suicide threats, and preparatory or rehearsal activities related to suicide. Clearly, it also encompasses an individual's actions that intentionally result in his or her own death.

When managing suicidal behavior, Air Force mental health professionals have two tasks. First, they are responsible for conducting a timely and competent assessment of risk, and providing or facilitating appropriate care. Secondly, they support unit leadership in managing personnel at increased risk for suicide, as well as the impact these situations can have on the organization and mission. Historically, mental health professionals have received variable levels of formal training on the first task (Bonger & 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 purpose and scope of this guide is to help privileged mental health professionals, as well as nurses, technicians, and administrative staff, provide high-quality, evidence-based care to suicidal individuals, as well as consultation and support to units. Currently, no standardized training program for managing suicidal behavior exists within the Air Force Medical Service (AFMS). Individual mental health practitioners are left to evaluate for themselves the literature, assessment tools, and strategies. Although the decisions and actions of providers and staff will be evaluated as to whether the standard of care was met in the event of a patient's suicide, there is no Air Force written guidance to help mental health professionals meet this standard. We intend this guide to fill the gap by recommending tools, strategies, and resources to help behavioral health personnel provide high-quality care to patients, effective support to commanders and First Sergeants, and minimize risk to their professional careers.

In the development of this guide, we utilized several sources of information:

- Empirical findings from well-designed research studies
- Professional guidelines and codes of ethics
- Sound psychometric principles applied to assessment instruments
- Expert opinion, including suicidologists and Air Force mental health professionals
- Recognized organizational standards (i.e., Air Force Instructions and JCAHO standards)
- Lessons learned from Air Force suicide events and civilian malpractice litigation

Additionally, due to issues unique to military settings, we obtained input from line commanders and First Sergeants and incorporated it into development of the guide. 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 mental health providers and staff in meeting or exceeding this standard.

This guide applies to outpatient specialty mental health care settings, including Life Skills Support Centers (LSSC), Family Advocacy Programs (FAP) and Alcohol and Drug Abuse Prevention and Treatment (ADAPT) clinics. Mental health related services that have a truly unique mission, such as the Behavioral Analysis Service at Air Force Basic Military Training, may find that some sections do not apply.

Suicide Management Recommendations

Assessment of Suicide Risk

1: Formally assess suicide at every initial evaluation, and as clinically indicated at follow-up contacts.

2: Use appropriate measures to assess suicidality.

A Decision-Making Framework

3: Determine suicide risk level based on assessment information and match to appropriate suicide-specific interventions.

Outpatient Management Strategies

4: Specifically target suicidal symptoms and risk factors in the formal outpatient treatment plan.

5: Take steps to safeguard the environment; limit accessibility to means of self-harm.

6: Establish processes for ongoing monitoring of suicide risk.

7: Use management strategies that are uniquely applicable to active duty members.

Documentation Strategies

8: When documenting a suicide risk assessment, include both current and historical risk factors, observations from the session, rationale for actions taken or considered but not taken, and follow-up plans, including a response plan when there is evidence of increased suicidality.

Coordinating with Inpatient Care

9: Establish a process for coordination when patients are hospitalized.

10: Reassess a patient's needs (including suicidality) following inpatient or partial hospitalization before assuming or reassuming responsibility for outpatient care.

Clinic Support and Peer Consultation

11: Use a high-interest log as a clinic tracking procedure for suicidality and share information between relevant specialty mental health clinics.

12: Consult professional peers regularly regarding suicidal patients and document the consultation.

Ensuring Continuity of Care

13: Use a standardized follow-up and referral procedure for all previously suicidal patients dropping out of treatment prematurely.

14: Ensure clinical coverage when the primary provider is unavailable.

15: Establish a procedure for ensuring continuity of care during provider and patient transitions.

Links with the Community

16: Establish a written plan for after-hours evaluations. Ensure other relevant agencies and individuals (i.e., Security Forces, First Sergeants, etc.) are aware of the plan.

17: Mental health providers and staff are the primary resource within the base community regarding mental health issues; as such, they should serve as consultants to unit leadership regarding the management of at-risk personnel.

18: Use community support resources in managing suicidal behavior.

Summary of Empirical Findings on Clinical Management of Suicide

Historically, clinical management of suicidality has been based more on "art" than on science. Typically, training programs in the mental health disciplines teach suicide management through supervised clinical experience, and often the approaches taught are based on the supervisor's experience or on publicized malpractice claims rather than on empirical science. Admittedly, the research literature on clinical management of suicidality is limited. A recent review identified only 25 randomized or controlled studies targeting suicidality (Rudd et al., 1999).

The following is a summary of conclusions based on the limited empirical findings that all mental health providers should know as they work with suicidal patients. We integrated this literature into the development of this Air Force guide, and we discuss each of these findings in more detail later in the guide.

- Multiple attempters appear to be a unique group, as compared with ideators and single attempters. They present a more severe clinical picture and, accordingly, are at higher suicide risk (Rudd et al., 1996). **It is important, therefore, to carefully assess multiple attempt status and incorporate it into plans for treatment intensity and duration, and consider it in military retention decisions.**

- Treatment of major depressive disorder does not appear to necessarily reduce suicidal behavior or suicide attempts. For example, Khan, Warner and Brown (2000) analyzed data from clinical trails on 7 new antidepressants and found that rates of suicide attempts and completions were not significantly different between drug-treated and placebo control groups. Additionally, a comparison of three psychotherapy approaches for adolescent depression showed significant between-groups effects on depression symptoms but not on suicidality (Brent et al., 1997). Therefore, **it is best to directly target suicidal behavior for treatment** (Jobes, 2000).

- In civilian community studies, the vast majority (64 percent) of individuals who committed suicide saw their general medical provider within a month before their death (Appleby et al., 1999; Andersen, Andersen, Rosholm, & Gram, 2000; Luoma, Martin, & Pearson, 2002). Air Force data show similar trends. In CY 2001, 33 percent of those who completed suicide visited a military treatment facility (MTF) in the month prior to their death, and 56 percent saw a doctor within 3 months of their death. **It is, therefore, important to include primary care managers (PCM) in suicide management efforts**.

- The strongest predictor of completed suicide during the five years following discharge from inpatient care, especially for those who have chronically elevated risk, is a reduction in the intensity of care (Appleby et al., 1999). High-risk patients are also disproportionately represented in treatment dropouts (Rudd, Joiner, & Rajab, 1995). There is evidence, however, that simply maintaining contact with treatment-refusing patients through a follow-up letter or phone call leads to reduced suicide rates over a five-year period, as compared to no contact (Motto & Bostrum, 2001). There is clear evidence that **chronic-risk individuals (multiple attempters) are likely to benefit from on-going monitoring or treatment. Clinic processes to ensure follow-up and contact may be helpful.**

- Short-term cognitive behavioral and problem-solving approaches as core interventions are effective at reducing suicidal ideation, depression, and hopelessness over periods up to a year (see review in Rudd et al., 2001). Several studies of short-term treatment were done with the highest-risk patients (i.e., multiple attempters). Therefore, we can conclude **that even some high-risk suicidal patients may be safely and effectively treated on an outpatient basis** (Linehan, Armstrong, Suarez, Allmon & Heard, 1991; Rudd et al., 1996). Indeed, considering patient preference and stigma issues, there is an increasing movement in the field to emphasize **outpatient care as *preferable* to inpatient care** (Jobes, 2000).

Common Errors in the Management of Suicidality

To avoid repeating errors that have resulted in poor outcomes, mental health professionals may find it helpful to know about the types of suicide management actions, or inactions, that have led to legal malpractice findings, Health Services Inspections (HSI) findings, and, in some situations, disciplinary actions by the military or by state licensing boards.

HSI Findings Related to Suicide

A review by the Air Force Investigation Agency (AFIA) of suicide-related findings from HSIs over 15 months revealed several concerns. Most noteworthy were findings that 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** (OPS 7.1.4; 7.2.5; 7.3.2). This suggests that there is room for improvement related to assessing and managing suicidal risk even at the most rudimentary level. 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 (OPS 7.1.4). You will find a sample client information sheet in Appendix J. The final concern stemming from HSI inspections was **a failure to use approved abbreviations for suicidal/homicidal risk assessments** (OPS 7.2.5; 7.3.2). Non-approved abbreviations can result in miscommunications among healthcare providers that can lead to inappropriate decisions and inadequate care.

Common Failure Scenarios for Suicide Management

In a key article on outpatient standards of care for the suicidal patient, Bonger, Maris, Berman & Litman (1992) present 12 common failure scenarios for suicide management. They are…

Failure to:

- properly evaluate the need for psychopharmacological intervention or use of unsuitable pharmacotherapy
- specify criteria for hospitalization and failure to implement hospitalization
- maintain an appropriate clinician–patient relationship
- perform supervision and consultation
- evaluate for suicide risk at intake
- evaluate for suicide risk at management transitions
- secure records of prior treatments or inadequate history taking

- conduct a mental status exam
- formally diagnose the patient's condition
- establish a formal treatment plan
- safeguard the environment
- adequately document clinical judgments, rationales, and observations

Lessons Learned from Civilian Malpractice Suits

We can learn important lessons from malpractice suits in civilian courts, to ensure that Air Force mental health providers 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 (Jobes & Berman, 1993). We recommend the following practices, derived from malpractice suits, for the optimum protection of providers and the government. These are covered in more detail throughout the guide.

Foreseeability
- Conduct a risk assessment
- The risk assessment must be thorough
- Consider using assessment instruments
- Consider using psychological testing
- Make an overall clinical judgment of suicide risk
- Seek and document consultation
- Adequately document assessment information

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

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

Assessment of Suicide Risk

1: Formally assess suicide at every initial evaluation, and as clinically indicated at follow-up contacts.

The goal of a suicidality evaluation is to assess the risk of a suicidal act reasonably and consistently, in order to guide appropriate intervention, management, and treatment. As a low base-rate event, we are not able to predict suicide. Suicide risk can be assessed for all patients using a screening question with further evaluation for those who screen positive. Clinics can utilize all levels of staff (providers, nurses, technicians) to accomplish screening. Evaluation, however, falls within the scope of practice of privileged providers.

Screening

We recommend using one or more screening questions at the initial visit for all patients seen in a mental health setting (including Life Skills Support Centers, ADAPT programs, and Family Advocacy programs). A single question, such as the following, can be used:

> **"Over the past two weeks, how often have you had thoughts about wanting to commit suicide"[1]**
>
> **0=Never; 1=Rarely; 2=Sometimes; 3=Frequently; 4=Always**

Alternatively, a general mental health monitoring instrument that includes a suicide risk screening question can be used. In this regard, the OQ-45.2 (Lambert et al., 1996) is an example of a useful outcome/tracking tool that is commonly used in Air Force clinics. It is available for a one-time, minimal, per-provider licensing fee (see www.oqfamily.com). If you select this instrument as part of the initial intake paperwork, you can use the suicide question (# 8: "I have thoughts of ending my life") as the suicide screening question. When patients mark "0 = Never" or "1 = Rarely" to either the above question or to OQ-45 question #8, make a clinical judgment in determining whether you should readdress suicidal ideation during the clinical interview. Since patients may be more willing to disclose thoughts and feelings after developing rapport with a provider, we recommend further inquiry about suicidal thoughts and feelings, especially if the presenting problem is associated with increased risk (e.g., depression, relationship difficulties, legal problems or other significant stressors, alcohol or drug problems, etc.). **Ensure that you reconcile discrepancies between sources of information (written, verbal, collateral information) and document that reconciliation**.

Assessment

When patients mark the suicide screening question with "2 = Sometimes," "3 = Frequently" or "4 = Always" with regard to current and historical risk factors, further assessment is necessary. Explore and document the following areas:

[1] Adapted from the National Depression Screening Project

- **Intent**: Differentiate between *ideation or desire* to commit suicide and *active planning or behavioral preparation*.
- **Meaning of suicidal thoughts and behavior, and motivation for suicide**: Identify predisposing and precipitating factors; specifically assess "perceived burdensomeness" to others and feelings of helplessness and hopelessness.
- **Specifics of the plan and rehearsal**: Assess when, where, how, and availability; evaluate whether there is adequate knowledge to use the plan; assess how lethal the plan is; include efforts to prevent rescue; there is notable increased risk when the individual has practiced the plan, so it is important to ask if they have conducted a "dry run."
- **Overt suicidal/self-destructive behavior**: Include prior suicidal behavior, in both the recent and distant past, with focus on whether the intent to die was present.
- **Physiological, cognitive, and affective states**: Consider acute and chronic psychopathology (Axis I and II).
- **Coping potential and protective factors**: Consider such factors as social support, evidence of past problem solving, and investment in current treatment.
- **Impulsivity and self-restraint**: Use both objective and subjective information.
- **Substance abuse or dependence**
- **Significant psychosocial stressors**: Include areas such as relationship, legal, financial, and occupational problems.
- **Static risk factors***

***Static Risk Factors**

Age: In the general population, risk escalates with age, particularly after age 60. In the ADAF population, there are no differences between age groups
Sex: Risk greater for males
Previous Axis I or II psychiatric diagnosis
Previous history of suicidal behavior
History of family suicide
History of physical, emotional, or sexual abuse

Ask questions about suicide directly and straightforwardly with the goal of gathering information and understanding the "functional role" that the prospect of suicide holds for the individual. Recommended questions include:

"Have you thought about suicide as a means of coping?"
"What are these thoughts like for you? What would be the goal of attempting suicide?"
"Have you ever made a suicide attempt? Did you mean to die?"
"What most makes you want to die?"

Suicide-specific assessment instruments can assist providers with clinical risk assessment. You will find a list of recommended measures in the next section of this guide.

It is important to establish a baseline for an individual's suicide risk during the assessment to determine the appropriate level of intervention. **Research indicates that individuals with two or more suicide attempts (with intent to die) are most appropriately classified as being at chronic risk** (Rudd, Joiner, & Rajab, 2001). Brief interventions, both inpatient and outpatient, can target acute exacerbation of suicidality and return patients to their baseline risk level. For patients

with low baseline risk, further treatment may be unnecessary when the acute exacerbation is resolved. Patients with high baseline risk (chronic risk) will likely need ongoing monitoring and treatment (Jobes, Jacoby, Cimbolic & Hustead, 1997).

Seek out collateral sources of information and incorporate them into the assessment. Commanders, First Sergeants, family members, supervisors, and others who have personal knowledge of the patient and his or her situation can provide valuable information otherwise unavailable to the evaluating provider. Discussing with the patient the potential benefits of including others in the evaluation can help establish a collaborative relationship that can facilitate high quality care. Ask the patient about others in his or her life who might be able to offer more information for a comprehensive evaluation. Also obtain treatment history, including past mental health records, when applicable, using appropriate consent forms for release of information.

A full mental health evaluation, including a mental status exam, is recommended for suicidality assessments. In some situations, an "emergency evaluation" may focus on determining the presence of imminent dangerousness and the necessity of hospitalization. **In these situations, however, it is recommended that the patient return again to complete the full evaluation and formulate an appropriate treatment plan**.

We suggest that each clinic identify circumstances in which a referral would be appropriate and document this in the clinic OIs. For example, an ADAPT program might establish a policy that patients judged to be at moderate or higher risk for suicide be referred to LSSC for further assessment and management of suicidality.

Thorough documentation of the suicide assessment is essential (see *Documentation Strategies* on page 26 of this guide).

2: Use appropriate measures to assess suicidality.

Objective assessment instruments are useful for augmenting interview data when assessing risk and determining appropriate care. Rudd, Joiner, & Rajab (2001) suggest the following advantages to using objective measures:

- They provide more objective data than clinical interviews.
- They can help clarify the nature of suicidal thoughts, feelings, and behaviors.
- They are a potentially less threatening mechanism for a patient to express thoughts and feelings.
- They have known reliability and validity.
- They can measure subtle changes over time.

It is notable, however, that virtually no data support the idea that psychometric instruments can improve our prediction of suicidal acts.

As with all assessment instruments, data from suicidality measures should be integrated with other sources of information and should not be used alone to determine treatment decisions. In addition, as stated earlier, it is important to reconcile discrepancies between sources of information in the clinical documentation.

Recommended Instruments for Assessing Suicidal Ideation and Behavior

A broad range of suicide-specific assessment instruments is available to assist providers in assessing risk for suicide. Instruments vary in their reliability and validity, however. You will find a table in Appendix C with information on these instruments based on a comprehensive review by Brown (2001). Three instruments, discussed below, are specifically recommended because they meet the accepted psychometric standards of quality assessment tools, they are available free of charge, and some have been tested in Air Force clinics. The Beck Scale for Suicidal Ideation is an exception, in that it must be purchased from the publisher, however, it is included because of its excellent psychometric properties and its standing as the most widely used suicide risk assessment instrument nationally.

We recommend the following measures:

Suicide Status Form-II (SSF-II; Jobes et al, 1997): One initial screening question, followed by 12 items to be completed collaboratively with the patient, plus 12 questions to be completed by clinician via interview. The manual for the Collaborative Assessment and Management of Suicidality (CAMS), available at Air Force Suicide Prevention Program Website (website address will be inserted when available Nov 02), offers guidance for use of this instrument. Reliability and validity data are good. Air Force-specific data are available (Jobes, Wong, Drozd, & Kiernan, 2002).

(See Appendix D); The author grants permission for Air Force mental health personnel to reprint both instruments; no fee for use.

Suicide Tracking Forms-I (STF-I; Jobes, Luoma, Jacoby, & Mann, 2000): One initial screening question, followed by six questions to be completed collaboratively with the patient. To be used for ongoing monitoring of risk during treatment.

(See Appendix E); The author grants permission for Air Force mental health personnel to reprint both instruments; no fee for use.

Beck Scale for Suicidal Ideation (Beck, Kovacs, & Weissman, 1979): 21-item scale. The first five questions serve as a screening instrument. It has good to excellent reliability and validity data.

Available for purchase from the Psychological Corporation, 1-800-872-1726, or www.psychcorp.com; $1.33 per administration.

3: Determine suicide risk level based on assessment information and match to appropriate suicide-specific interventions.

Nomenclature

Clear communication about an individual's suicidal status requires common terminology. Patients can misinterpret inconsistent or imprecise words, and there is potential that level of risk can be miscommunicated within the health care system when standard terminology does not exist (Rudd et al., 2001). Suicide-related terminology is complex and it continues to be debated in the field of suicidology. Currently, there is no agreed upon terminology. O'Carroll and colleagues (1996) suggest a standard nomenclature where behavior is classified as *instrumental suicide-related behavior*, in which a secondary (interpersonal) gain is driving an individual's actions, or *suicidal acts*, in which the goal is to die. Although the key distinguishing factor is intent to die, either can cause injury or death. This terminology avoids some of the confusion inherent in commonly used terms such as *suicidal gesture* and *parasuicidal*.

Determining Level of Risk

Joiner, Rudd and Rajab (1997) conclude from their factor-analytic work that suicide symptomatology and indicators fall into two factors. The factors have been labeled 1) *suicidal desire and ideation* and 2) *resolved plans and preparation.* Although suicidal symptoms and indicators from both factors are important, **those that fall into the resolved plans and preparation factor are indicative of greater risk**. The following table shows symptoms and indicators in each factor.

Suicidal desire and ideation (SDI)	**Resolved plans and preparation (RPP)**
➢ Reasons for living	➢ Sense of courage to make an attempt
➢ Wish to die	➢ Sense of competence to make an attempt
➢ Frequency of ideation	➢ Availability of means for an attempt
➢ Wish not to live	➢ Opportunity to make an attempt
➢ Passive attempt	➢ Specificity of plans for an attempt
➢ Desire for attempt	➢ Preparations for an attempt
➢ Expectancy of attempt	➢ Duration of suicidal ideation
➢ Lack of deterrents to attempt	➢ Intensity of suicidal ideation
➢ Talk of death and/or suicide	

The following is a framework for determining level of risk using these two factors (Joiner, Walker, Rudd, & Jobes, 1999). **Of particular note is the fact that the same symptoms represent higher risk for multiple attempters than for non-multiple attempters**. For example, baseline-risk for multiple attempters is *mild* and the presence of any suicidal symptom or indicator increases risk level to at least to *moderate*. See the following tables for the criteria of each risk level.

RISK LEVEL CRITERIA FOR MULTIPLE ATTEMPTERS

Risk Level	Multiple attempters fit this risk level if the following findings are present:
No significant risk	Never
Mild	No other symptoms or indicators from SDI or RPP factors (see table on page 19) or other risk factors[2]
Moderate	Any symptom or indicator from either the SDI or RPP factors or other positive risk factor[2]
Severe	Two or more positive findings[2] including SDI or RPP symptoms or indicators
Extreme	Severe symptoms or indicators of the RPP factor

RISK LEVEL CRITERIA FOR NON-MULTIPLE ATTEMPTERS

Risk Level	Non-multiple attempters fit this risk level if the following findings are present:
No significant risk	No identified SDI or RPP suicidal symptoms or indicators (see table on page 19) and few other risk factors[2]
Mild	Suicidal ideation of limited intensity or duration, but no or mild symptoms or indicators from the RPP factor and few other risk factors[2]
Moderate	Moderate to severe symptoms or indicators from the RPP factor, **OR** no or few symptoms or indicators from the RPP factor, but moderate to severe symptoms or indicators from the SDI factors, and at least two other positive risk factors[2]
Severe	Moderate to severe symptoms or indicators from the RPP factor and at least one other risk factor[2]
Extreme	Severe symptoms or indicators from the RPP factor and two or more other risk factors[2]

Research indicates that persons with two or more suicide attempts are at significantly higher risk for suicide, even when there is no acute crisis (see Rudd et al., 2001). Therefore, it is helpful to place patients into four categories:

- **Minimal Risk**: Baseline risk for non-multiple attempters; no acute crisis, significant stressors, or suicidal symptomatology
- **Acute Risk**: Presence of acute crisis, significant stressors, or symptomatology
- **Chronic High Risk**: Baseline risk for multiple attempters; no acute stressors or symptomatology
- **Chronic High Risk with Acute Exacerbation**: Acute risk category for multiple attempters

This categorization is important because a lower threshold for intervention (e.g., hospitalization) is indicated for chronic risk patients relative to those at acute risk.

[2] Other risk factors include acute and chronic psychopathology, history of impulsivity and poor self-restraint, substance abuse or dependence, and significant psychosocial stressors. Do not include static risk factors (see page 16) in these criteria.

It is also notable that "protective factors," such as strong social support and good problem-solving skills, do not necessarily decrease risk for individuals who are at chronic risk (i.e., multiple attempters). For these people, it is more appropriate to base intervention decisions on level of cognitive impairment rather than on presence or absence of protective factors. In contrast, individuals who are not chronic can be considered at lower risk if protective factors are present.

Matching Risk Level to Clinical Response

Once you determine a patient's level of suicidal risk, you can formulate and activate an appropriate intervention plan. The plan will generally include adequate supervision and monitoring, activation of protective factors (e.g., increased support), and modification of specific high-risk factors (e.g., removing access to a weapon). We suggest you consider the following interventions for specific risk classifications:

If Risk Is…	Consider…
Severe or extreme	Immediate evaluation for hospitalization Monitoring at all times Involvement of family, commander, and police, if necessary
Moderate	Recurrent evaluation for hospitalization Increased frequency of outpatient visits and/or telephone contacts Active involvement of family, friends, First Sergeant, or unit Re-evaluation of suicide risk at least weekly Frequent re-evaluation of treatment goals 24-hour availability of crisis services Evaluation for medication Frequent input from family, supervisor, First Sergeant, etc., on risk indicators
Mild or less	Recurrent risk assessment as indicated by circumstances or clinical presentation

Adapted from Rudd et al., 2001

Outpatient Management Strategies

4: Specifically target suicidal symptoms and risk factors in the formal outpatient treatment plan.

Historically, outpatient treatment planning for suicidal patients has focused on major psychiatric conditions, and suicidality has been viewed as a symptom. Current "best practices" in the field include *potential self-harm* on the problem list and include specific interventions in the treatment plan aimed at ensuring safety and stability. Treatment plans for suicidal patients that exclusively target a psychiatric diagnosis (e.g., cognitive-behavioral therapy to target depression) are insufficiently specific and may fail to fully address the multi-dimensional nature of suicidal risk (for example, a patient may move toward less depression, but remain suicidal).

Once you have established a treatment plan, ensure that you follow it, or document your rationale for deviating from it. Providers have been found negligent for failing to follow a documented treatment plan (Baerger, 2001). Depending on individual need, treatment and management strategies may range from intense outpatient clinical treatment, to focused management of suicidal behaviors, to periodic monitoring of risk, to specific recommendations for an individual's commander or family. Even when suicidal risk is mild, it is wise to include interventions in your treatment plan to address that risk (e.g., "periodic monitoring of risk related to occasional, vague suicidal ideation"). It is important to update the treatment plan as indicated based on changes in the patient's clinical status.

One way of specifically targeting suicidal symptoms in the treatment plan is to use a "commitment to treatment" contract. This type of contract specifies the behaviors that you believe will facilitate progress in treatment and outlines a **Crisis Response Plan** that the patient will use when suicidal thoughts or urges occur. Negotiate the content of the contract with each patient so that it includes behaviors to which the patient is willing to commit. Have the patient write out and sign the contract (we do ***not*** recommend a generic, pre-printed contract). The following is an example of an individualized "commitment to treatment":

I agree to make a commitment to the treatment process. I understand this means I agree to active involvement in all aspects of treatment including:

- **Attending sessions (or letting you know when I cannot make it)**
- **Voicing my opinions, thoughts, and feelings honestly and openly, whether negative or positive**
- **Being actively involved during sessions**
- **Completing homework assignments**
- **Experimenting with new behaviors and new ways of doing things**
- **Taking medication as prescribed**
- **Implementing my crisis response plan**

I also understand that, to large degree, my progress depends on the amount of energy and effort I make. If it is not working, I'll discuss it with my therapist. In short, I agree to make a *commitment to living*.

(Adapted from Rudd et al., 2001)

An important part of this process is explicit negotiations around a behavioral plan for what the patient will do to cope instead of using suicidal behavior (the Crisis Response Plan). It is insufficient to simply have the patient promise not to act on suicidal thoughts until the next session. The crisis response plan can be written concretely, to include a definition of when it is to be used (e.g., when suicidal thoughts occur), and specific, concrete steps the patient should use to ensure safety and deactivate the suicidal mode. It may be helpful to provide the plan on a card that they can carry in a wallet or purse. You can find a sample card in Appendix F. If an acutely suicidal patient will not commit to adequate treatment or to following a crisis response plan that the provider believes will address risk, the likelihood of imminent risk is high and hospitalization may be necessary.

The "commitment to treatment" contract is different in several key ways from the commonly used "no-suicide contract" (in which the patient promises not to harm himself or herself). First, the "commitment to treatment contract" is a clinically derived intervention. Its purpose is to engage the patient in a positive activity (i.e., treatment) that is likely to result in clinical improvement. It is a document that can be referred to throughout the course of treatment as a way of helping the patient stay on a progressive track. This is in contrast to the "no-suicide contract," which, after initially being signed, is usually only looked at again following a completed suicide when the provider is attempting to defend his or her actions. As such, its purpose is legal rather than clinical. In some clinical settings, the use of a "no suicide contract" has been considered a "must" in order to free the provider from blame in the event of a bad outcome. Unfortunately, this may be a misguided belief. It is notable that forensic experts generally do not recommend use of "no-suicide contracts" as they potentially pose an increased liability rather than serve as protection (D. A. Jobes and M. D. Rudd, personal communication, May 13, 2002). Some have suggested that "no suicide contracts" can communicate the message that the therapist cares about the patient's life and well-being. Unfortunately, there is also potential for it to provide a subtle message to patient that "I think you are out of control." This message from a therapist can negatively impact rapport and does not support self-efficacy.

5: Take steps to safeguard the environment; limit accessibility to means of self-harm.

In situations where patients are at increased risk for suicide, yet hospitalization is not indicated (i.e., when the patient does not meet admission criteria), it is appropriate for providers to take steps to limit the 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 possible dangers of keeping the firearm available and recommending it be removed from the patient's access. The Security Forces will generally secure personal firearms in their armory. 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 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 will be important to try to get cooperation and collaboration with patients in this regard so as not to increase risk by acting against the patient's wishes. Commanders can also 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.

6: Establish processes for ongoing monitoring of suicide risk.

Clinics and providers can benefit from establishing a standard process for all providers to use in monitoring suicidal risk. Having a "usual and customary practice"[3] documented not only will ensure consistent care for all patients, but will increase protection for providers in the event of a patient's suicide.

Clinic procedures can establish criteria indicating which patients are to be assessed at every visit. The recommended criterion is all patients who are at ***mild*** risk or higher, according to the framework presented on page 20 of this guide.

The Collaborative Assessment and Management of Suicide (CAMS; Jobes et al., 2000) is a strategy for monitoring risk that is growing in popularity in Air Force clinics and which has clearly impressed JCAHO inspectors. While there are only preliminary empirical data on this relatively new strategy (Jobes, Wong, Drozd, & Kiernan, 2002), it shows promise as a systematic means for monitoring and managing suicidal behavior. Given the limited data on CAMS, we do not specifically endorse it, however, you may be interested in learning more about it, especially as more data emerges. You can find the CAMS manual at the Suicide Prevention Program Website (website address will be inserted when available in Nov 02).

7: Use management strategies that are uniquely applicable to active duty members.

We recommend the use of two strategies that are specifically applicable to the active duty population: the Limited Privilege Suicide Prevention (LPSP) program and the physical profiling system. Both are covered by AFIs and can help the medical, legal and line communities appropriately manage individuals who are at increased risk for suicide. While we are highlighting

[3] "Usual and customary practice" is a term used by attorneys reflecting what one routinely or typically does in practice in relation to specific clinical issues. Providers are most protected legally when these practices are documented in the clinic OIs. Of course, providers must follow these policies and procedures to be protected.

these two strategies in this section, note that other recommendations specifically applicable to active duty members (e.g., communication with commanders) are discussed in other sections of this guide.

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 AFI 44-109, *Mental Health, Confidentiality and Military Law,* the objective of the LPSP program is "to identify and treat those Air Force members who, because of the stress of impending disciplinary action under the Uniform Code of Military Justice (UCMJ), pose a genuine risk of suicide." 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 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 remain protected. Mental health personnel should be thoroughly familiar with the policies and procedures of the LPSP program, as outlined in AFI 44-109.

Another strategy applicable to active duty members is use of **the physical profiling system for recommending duty restrictions** (see AFI 48-123, Chapter 10 and Attachment 13). Clearly, actively suicidal individuals are inappropriate for an S-1 profile. For example, it would be rare that a deployment would be in the best interests of a suicidal person or the Air Force mission. A profile change using Air Force Form 422 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. When individuals are judged to be at moderate risk for suicide or higher, you might strongly consider an S-4T profile (temporarily not world-wide qualified).

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 genuine 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. (See AFI 44-156, *Medical Evaluation Boards and Continued Military Service*; AFI 44-123, *Medical Examinations and Standards,* especially Attachment 2, paragraphs 2.12 and 2.20; and DoDI 1332.38, *Physical Disability Evaluation*, Enclosure 5).

Documentation Strategies

8: When documenting a suicide risk assessment, include both current and historical risk factors, observations from the session, rationale for actions taken or considered but not taken, and follow-up plans, including a response plan when there is evidence of increased suicidality.

Thorough documentation in the clinical record is essential both for continuity of patient care and protection of the provider and the government in the event of a post-suicide investigation or litigation. **Clinical records are most complete when they document the domains that were assessed related to suicide, relevant findings, treatment planning specific to suicide risk factors, and the rationale for decisions made**. Baerger (2001) recommends documenting the following content *as often as is clinically indicated*:

- The patient's actual statements (quotes if possible) regarding the increase or alleviation of suicidal thoughts
- The content of discussions about risk and safety
- Any contemporaneous information provided by concerned family members
- Any attempts to obtain prior treatment records
- All increases in treatment intensity or frequency
- Any special precautions taken, or arrangements made
- Any attempts to have the patient voluntarily admit himself or herself to a hospital
- All reasons why hospitalization was rejected as an alternative
- Evening, weekend, and emergency arrangements that were made

It is recommended that you include a risk assessment section in every initial note and all follow-up notes for patients who are at moderate risk for suicide. This section might include the following:

Category	Indicators of Risk	Level of Risk	Treatment Response
▪ Minimal risk ▪ Acute risk ▪ Chronic high risk ▪ Chronic high risk with acute exacerbation	▪ Ideation ▪ Intent ▪ Means and access ▪ Past suicidality ▪ Physiological state ▪ Cognitive state ▪ Affective state ▪ Static risk factors ▪ Impulsivity ▪ Substance abuse	▪ Mild ▪ Moderate ▪ Severe ▪ Extreme	▪ Use of self-regulation strategies ▪ Use of crisis response plan ▪ Adherence to medication ▪ Adherence to other treatment ▪ Increase or decrease in ideation ▪ Other acceptable interventions

Furthermore, when patients are evaluated in the clinic and then referred out, it is appropriate to document all follow-up contact done to determine if they sought care via the referral.

You can find sample risk-assessment sections of an intake note and a follow-up note in Appendix G. Follow-up entries can be much briefer than intake documentation but should note the status of each active risk factor, until they are resolved. These examples are in marked contrast to the commonly used brief notations such as "No evidence of suicidal ideation," or "Vague ideation, but no plan or intent." While this level of documentation records the provider's opinion, it does not provide clear evidence that you reasonably and thoroughly assessed suicidal risk, and how this assessment informed your decisions. Providers should not fall prey to the erroneous (but common) belief that minimal documentation gives better legal protection than detailed notes.

Standardized tools, such as the suggested overprint in Appendix H or the Suicide Status/Tracking Forms in Appendix D and Appendix E can provide a systematic means for documenting risk assessment and interventions.

It is appropriate to include information on suicide risk and interventions in the outpatient medical record as well as the mental health records to ensure continuity of care. Changes in clinical status must also be documented in both records.

Remember (as the lawyers say)…

If it isn't DOCUMENTED, it didn't happen

Coordinating with Inpatient Care

9: Establish a process for coordination when patients are hospitalized.

When multiple facilities are involved in a patient's care, coordination and collaboration are always in the best interest of the patient. Unfortunately, for a variety of reasons, communication between inpatient and outpatient facilities is often poor and may be difficult to achieve, especially when the inpatient unit is not at a military treatment facility. It is recommended that clinic staff make every effort to maintain contact with inpatient psychiatric staff when active duty members are hospitalized. It is particularly helpful when the outpatient provider who will be providing follow-up care participates in the discharge planning process.

Clearly, the 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. First, 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 of the coordination issues in advance so these issues are not having to be addressed with each individual case. A template for an MOU can be found in Appendix I. Second, Air Force clinics may find it helpful to obtain "release of information" consent documents from the most frequently used inpatient facilities so that signatures can be obtained *prior* to hospitalization. Third, it may also be helpful to get the TRICARE office involved, since information sharing pathways are often better established through administrative/financial channels. Fourth, if you continue to experience difficulties obtaining status reports or being involved in discharge plans, it may help to change the person who is seeking the information. Sometimes health professionals are more comfortable sharing information with individuals from their own profession (e.g., psychiatrist to psychiatrist, nurse to nurse, etc.). Finally, some Air Force providers have gone as far as to obtain privileges in civilian facilities for the specific purpose of being able to participate in discharge planning. It is always in the best interest of patients to seek treatment records from the inpatient facility upon discharge.

10: Reassess a patient's needs (including suicidality) following inpatient or partial hospitalization before assuming or reassuming responsibility for outpatient care.

One of the times of highest risk for increasing suicidal behavior is following a reduction in intensity of care (e.g., transitioning from inpatient to outpatient treatment [Appleby et al., 1999]). Clinic staff and providers should 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 status and needs following discharge can be used to determine whether a revision of the treatment plan is needed. If the patient is determined not to be 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.

11: Use a high-interest log as a clinic tracking procedure for suicidality and share information between relevant specialty mental health clinics.

In accord with AFI 44-102, facilities must maintain a high-risk log for tracking high-interest patients. While the AFI uses the term "high-risk log," we recommend using the term "high-interest log" so it can encompass 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. In many facilities, a common log can be used for the various specialty mental health clinics (i.e., ADAPT, FAP, LSSC). For some MTFs, however, it is more practical for each clinic to maintain a separate log. In this situation, it is important that when one clinic enters a patient on the high-interest log who is also being seen in another military mental health clinic, they inform the other clinic. We recommend that local OIs document this process to ensure that this coordination occurs.

Enter all patients who have significant risk factors for suicide on the log, and maintain them there until the risk factors have resolved. Inform patients about the high-interest log and related procedures as part of informed consent (see Appendix J). 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 providers aware of those individuals. Front desk staff should notify primary providers when these patients cancel appointments. Providers should make a reasonable effort to contact patients who cancel as well as patients who "no show" for scheduled appointments. If you cannot reach high-interest active duty patients following a no-show, notify their commander or First Sergeant and recommend active outreach.

When you enter patients on the high-interest log, 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, contacting their commander if you are unable to reach them directly. Emphasize their responsibility to attempt to contact the clinic if they are unable to attend.

Since the high-interest log 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 high-interest patients. We recommend a system for flagging clinic charts to remind both front-desk staff and providers of high-interest status.

AFI 44-102 requires that appropriate on-call and emergency department (ED) personnel be notified of *high-risk* cases (note that this does not necessarily include high-interest cases that are not high-risk). One way to accomplish this is to flag relevant records in the Composite Health Care System (CHCS) for patients on the high-interest log to alert ED and on-call providers of high-interest status. Flagging of CHCS records potentially protects patient privacy more than distributing a list of names, since in that ED staff will only be aware of high-interest status when the individual presents for care. Mental health professionals should also consider notifying a patient's PCM when they determine that a patient is at increased risk for suicide (chronic or acute). Since there is evidence that a substantial proportion of people who complete suicide visit their

general medical provider within 30-90 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. The PCM should also be notified when the elevated risk is resolved. It is appropriate to discuss with patients the need for informing their PCM and to request their consent.

We recommend that clinic staff discuss each patient on the high-interest log at least every week regarding suicidal status, progress with the treatment plan, case management decisions and whether high interest status is still warranted. Patients should be removed from the high-interest log when suicidality has resolved.

12: Consult professional peers regularly regarding suicidal patients and document the consultation.

Providers are advised to make a practice of regularly consulting with peers regarding the management of suicidal patients. Within a facility, this can be accomplished through informal "curbside consults" or formal "case conference" meetings. Another mechanism is to conduct peer review of all cases on the high-interest log. 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 should 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 should always be documented for both quality assurance and legal purposes.

Ensuring Continuity of Care

13: Use a standardized follow-up and referral procedure for all previously suicidal patients dropping out of treatment prematurely.

Clinics are advised to adopt a "usual and customary practice" for handling patients who drop out of treatment before termination is mutually agreed upon. For example, encourage patients who notify the clinic that they do not wish to continue in care to return to treatment, either at the clinic or through another source of care (e.g., private sector care, primary care, etc.). Document these discussions in the clinical record.

It is also helpful for clinics to have a standard policy for handling established patients who do not keep scheduled appointments or who fail to schedule follow-up appointments as planned. For example, a policy might require providers or technicians to make (and document) three attempts to contact the patient by telephone, in order to address barriers to continuing treatment and encourage returning to care. To protect privacy, messages left on telephone answering machines can generally include the rank and name of the provider (rather than titles like "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. Appendix K contains a sample. It is important to formally close cases when patients have dropped out of treatment.

While standard procedures in these areas apply to all patients, you might consider taking extra steps in high-risk or high-interest cases. For example, it is prudent to contact the patient's PCM when high-risk patients withdraw from treatment prematurely. (Note: Clearly inform patients of this practice in the informed consent process; see Appendix J). Additionally, it may be wise to use registered mail for proof of receipt when sending "no-show" letters to these patients.

In accord with AFI 44-102, 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 their initial appointment.

14: 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 OIs. Ensure that patients are aware of the procedures for obtaining after-hours care, and document that this has been covered with patients. We recommend a written handout outlining procedures. You can find a sample handout in Appendix L.

In accord with AFI 44-102, Family Advocacy and LSSCs 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. The flagging system discussed on page 29 of this guide is one method for doing this.

15: Establish a procedure for ensuring continuity of care during provider and patient transitions.

Take special care when high-risk individuals are facing pending transitions, such as base reassignment and 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. Give careful consideration (and document) whether it would be advisable for actively suicidal patients to be more stable before a permanent change of station (PCS) occurs. This emphasizes the importance of using the physical profiling system to reflect the patient's psychiatric status and limitations (see recommendation 7). If a PCS is not advisable given the patient's condition, 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 should arrange a hand-off with a mental health provider at the receiving facility and this should be documented. 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 should be documented).

It is recommended that clinics 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. Also, consider establishing processes to ensure ongoing monitoring and appropriate care through the transition period.

Links with the Community

16: Establish a written plan for after-hours evaluations. Ensure other relevant agencies and individuals (i.e., Security Forces, First Sergeants, etc.) are aware of the plan.

After-hours mental health evaluations pose a potential danger to on-call personnel that should be thoughtfully addressed in local policy. The Occupational Safety and Health Administration (OSHA, 1998) 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."

When conducting after-hours mental health evaluations, do so in accordance with the 2 Dec 02 AF/SG2 memo, *After Duty Hours Mental Health Evaluations*. If an MTF has an ED, this will likely be the safest and most appropriate venue for conducting after-hours suicide risk assessments. If there is no ED, the MTF will generally handle suicide risk assessments similarly to other acute medical emergencies, using community resources. Do not perform evaluations where medical support and security is 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. Mental health personnel are not necessary for transport of potentially suicidal individuals. It is important to consider the safety of both the patient and escorts when formulating plans, and Security Forces personnel may be necessary. The on-call mental health provider can be a consultant to advise the unit on safety precautions.

The presence of established procedures, coordinated and communicated **in advance of a crisis**, can ensure collaboration and cooperation between mental health personnel and unit leadership when managing individuals perceived to be at possible risk for suicide.

17: Mental health providers and staff are the primary resource within the base community regarding mental health issues; as such, they should serve as consultants to unit leadership and other medical staff regarding the management of at-risk personnel.

Consulting with Commanders

When unit leadership has expressed concern about an active duty individual's suicide risk, it is generally not indicated for clinical personnel to return individuals to duty without *ongoing* contact or follow-up with the leadership and/or the patient. Unit leaders commonly feel unequipped to

handle distressed or even mildly suicidal individuals. Furthermore, there is often concern about the impact of these individuals and their problems on the unit and its mission. Mental health personnel are the primary mental health resources on an installation and are most helpful when they are available for both consultative and patient-care roles.

For instance, when you accomplish an emergency commander-directed evaluation to assess suicidal risk, and the assessment indicates non-imminent risk for suicide, communicate this information to the individual's commander (both verbally and in writing). If clinical care is indicated, it is appropriate to communicate general information about the treatment plan. However, if the patient does not desire treatment and involuntary hospitalization is not indicated, the provider can benefit all parties by inquiring as to what support is acceptable to the patient, and what support is needed or desired by the commander and First Sergeant regarding management of this individual. 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 (Motto & Bostrum, 2001), 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). Examples of non-treatment assistance that you can offer to commanders include:

- Collaboration to develop a means for ongoing monitoring of risk in the workplace
- Consultation with unit leadership about possible responses to the patient's disruptive behavior
- Regular contact with the First Sergeant or supervisor to discuss the individual's behavior
- Collaboration to increase support and decrease factors contributing to the individual's suicidality
- Telephone check-ups

It is important for providers to make genuine efforts to communicate to patients the degree to which communication and collaboration with commanders and other significant people may be in their best interest. Nevertheless, mental health professionals should protect patient privacy within the limits of Air Force instructions (e.g., AFI 44-109), the law, and commanders' legitimate need to know. Providers should be cautious in issues of dual relationship, as well. When meeting with the patient, the provider should clearly spell out the nature of his or her role as consultant to the commander.

AFI 44-109 states, "there is no patient-psychotherapist privilege when a psychotherapist or assistant to a psychotherapist believes that a patient's mental or emotional condition makes the patient a danger to any person, including the patient." Therefore, in these situations, mental health personnel may communicate necessary information obtained in clinical sessions to commanders, family, or others. It is important to be aware, however, of state requirements that may be relevant off base and with non-active duty patients.

Since thirty-three percent of active duty members who commit suicide are under investigation of some type, it is especially important that mental health professionals consult with commanders regarding support for these individuals. Airmen under investigation can easily feel isolated from their family, friends, and other support systems when they need them most, and Air Force policy has provisions for helping them find this support. The LPSP program (see page 24) and the 'hand-off" responsibilities of investigative agencies and commanders following member interviews are

two such policies. It may be helpful to remind commanders of these policies and to direct them to AFI 44-109 and the Chief of Staff policy letter on investigative interview "hand-offs." When you perform a suicide-risk assessment for someone referred as part of an investigative interview handoff, we recommend you follow-up with the individual 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. Alternatively, providers can contact commanders and First Sergeants 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 First Sergeant, while not risking patient/therapist rapport by communicating without the patient's awareness.

Consultation Regarding Civilian Employees

When commanders or other unit personnel contact mental health professionals regarding non-beneficiary civilian employees who are potentially suicidal, it is appropriate to assist the unit in dealing with these patients. Assistance might include, but is not limited to, advising that the employee be monitored at all times, screening to assess the degree of suicidality and the urgency of care, and assisting in obtaining appropriate care. In acute situations, apply the policies established by your local MPF regarding eligibility of contract and civilian employees. Though there may be exceptions, per DoD requirements, MTF providers should generally not provide on-going clinical care to non-beneficiary employees.

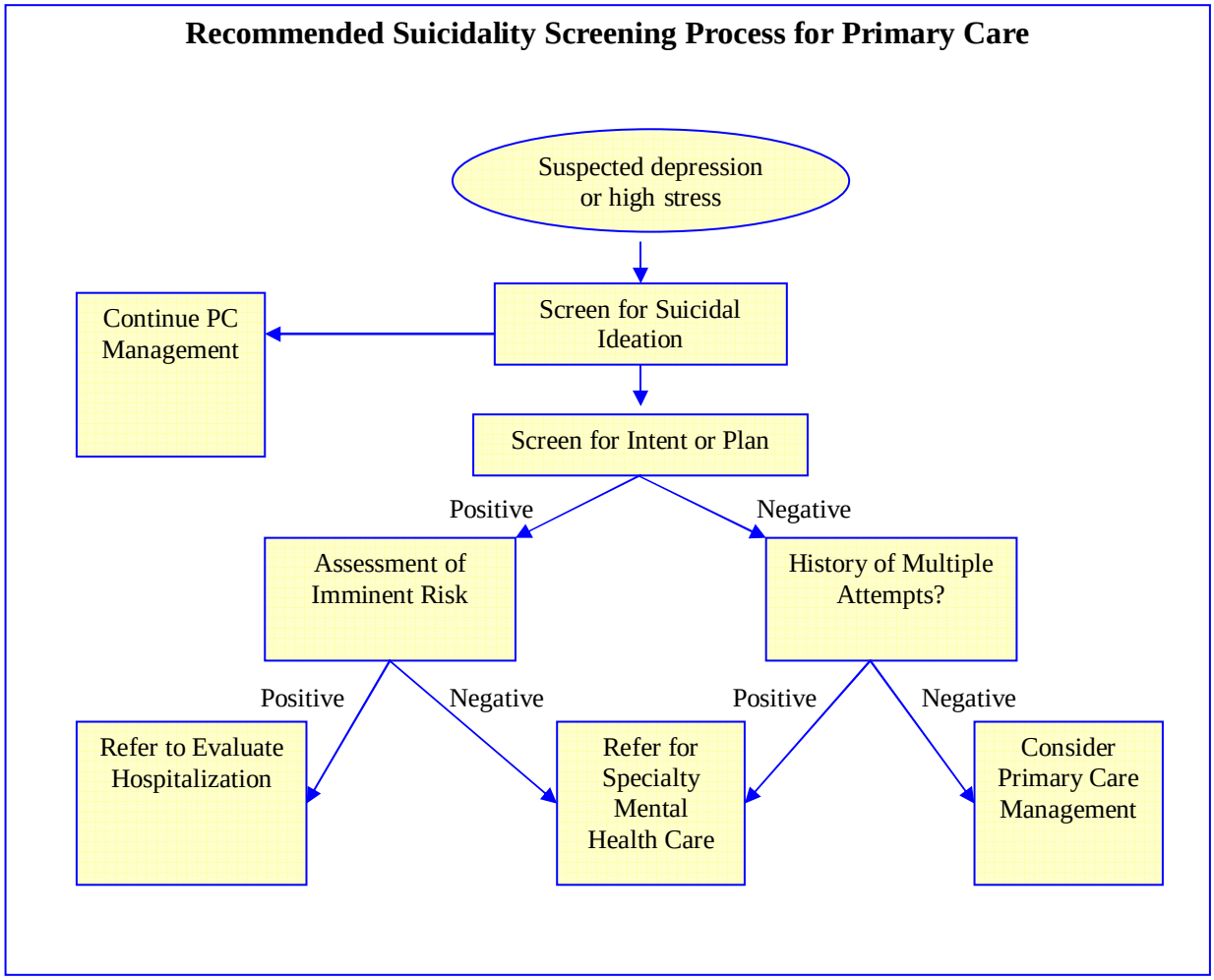
Consulting with Other Medical Staff

Mental health providers can also help other MTF providers and clinics improve their processes of care for patients who may be at increased risk for suicide. Given the fact that many suicidal patients will have contact with a medical provider but not with the mental health system, active collaboration between mental health and medical staff is important.

We recommend you provide other providers and medical clinics (including the emergency department) with concrete guidance on who to screen for suicidality and when to refer to specialty mental health care. Certainly, individuals who are acutely or chronically suicidal are appropriate for referral to the LSSC or a network mental health provider. That said, it is important to emphasize to non-mental health staff that suicidal ideation is common with major depressive disorder and, in absence of other risk factors, does not *necessarily* warrant a mental health referral. Many patients with depression can be appropriately and effectively treated in primary care, even when suicidal thoughts are present. As a consultant to other providers and clinics, mental health providers can recommend screening questions and criteria for referral.

We recommend medical clinics use a multi-level screening process as diagramed at the end of this section. It begins with a screening question such as the one on page 15 of this guide whenever depression or significant stressors are suspected. The question is: "*Over the past two weeks, how often have you had thoughts about wanting to commit suicide*." If the patient responds with "*sometimes,*" "*frequently,*" or "*always,*" follow-up questioning is indicated to assess whether risk is imminent. Questions about intent and plan are recommended for further screening in this regard. The primary care provider (PCP) can assess intent with "*Do you think you would act on those thoughts?*" and assess plans with "*Do you have a plan for killing yourself?*" If the patient gives a positive response to either of the intent or plan questions, further assessment will need to be done, either by the medical provider or through an emergency mental health evaluation, to determine whether there is a need for hospitalization. PCPs can be directed to the *DoD/VA Suicide Prevention Identification and Assessment in the Primary Care Setting Toolkit* (downloadable at http://www.qmo.amedd.army.mil/HOME.HTM) for further guidance on suicide assessment or you can provide them with material from the assessment section of this guide. If a patient screens positive for plan and intent but was not hospitalized, a referral to mental health is indicated. If a patient denies intent or plan, the PCP should assess multiple attempter status by asking: "*Have you ever made a suicide attempt before? How many times?*" If there have been more than one genuine suicide attempt in the past, the PCP should refer to mental health, even with ideation as the only current risk factor. This is due to the chronic risk of multiple attempters. If the patient with suicidal ideation is not a multiple attempter and responds negatively to the intent and plan

screening questions, the patient may be appropriate for management in primary care, especially if a clinic has integrated a behavioral health consultant who can assist. Of course, you can encourage colleagues seek consultation anytime they feel uncertain about suicidality.



18: Use community support resources in managing suicidal behavior.

Try to connect patients to sources of support in the community, to augment ongoing mental health care and/or maintain and enhance functioning following completion of treatment. This may involve incorporating family, friends, or the unit into treatment planning, or including structured community support services, such as the Family Support Center and the Chapel. Managing distress in the community is a shared responsibility, and collaborative use of all community resources will best serve individuals. Furthermore, involvement by more than one helping agency increases the likelihood that an individual will find people with whom he or she can establish trust and rapport, and increases the chance that emerging needs or crises will be recognized and attended to early. Inform patients about the services offered by the base helping agencies and actively involve them in referral decisions. The Integrated Delivery System (IDS) at each installation maintains a listing of community resources and services.

It is also important to ensure that commanders and First Sergeants are aware of the protective nature of social support. Encourage them to use the formal and informal networks of support within the unit to assist distressed individuals and to promote help-seeking.

When a Suicide Occurs

A suicide in a base community is a traumatic event, with far-reaching implications. Base helping agencies serve an important role by immediately responding with support for the family, work colleagues, unit leadership, and the base community at large. The Critical Incident Stress Management (CISM) team is commonly used following a suicide for initial response and follow-up. One advantage to using the CISM team is the protection given by AFI 44-153 to individuals seeking counseling following a traumatic event (i.e., no documentation in the medical record for up to four one-on-one education/prevention sessions with a CISM team member). Regardless of the mechanism used for the response, it is imperative that all base helping agencies coordinate to meet community needs.

When the deceased was a patient of the one of the mental health clinics, clinic personnel are likely to have a difficult and painful reaction, which may involve sadness, grief, guilt, anger, and fear. Offer the primary provider (and others needing it) an opportunity to talk through his or her reactions, if desired. It is important to be aware, however, of the fact that comments made to colleagues, friends or family members about the deceased patient's care are usually considered non-privileged information and are open to the legal discovery process. Bonger (1991), therefore, 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." The American Association of Suicidology's Clinician Survivor Task Force provides a number of resources and contacts (www.suicidology.org). It is generally best for the primary provider not to be involved as a responder to the base community, when possible.

Providers and other 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 it is likely to increase the family's positive perceptions of the care given to their deceased family member. We encourage Air Force mental health professionals to consult with the medical-legal consultant, the chief of medical services for their MTF, and peers before contacting the family. Furthermore, it is sometimes advisable that at least two people talk with the family together.

Talking with Family Members 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 in the family, recognizing all of our individual limitations
- Discuss the grief process as it relates to suicide, emphasizing the mixture of emotions experienced (often significant anger)
- Remind them of availability of professional resources should they need to talk further

There is often high interest in the community when a suicide occurs, and mental health staff may be contacted by the media. Remember to refer all media inquiries to the base Public Affairs Office.

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

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

JCAHO Sentinel Event Investigation: MTFs are required to report any "unexpected occurrence or variation involving death, serious physical or psychological injury, or the risk thereof" (AFI 44-119) to the JCAHO Sentinel Event Program. The goal of this program is to reduce injuries suffered by patients in healthcare organizations. Sentinel event information is protected from disclosure.

Medical Incident Investigation (MII): An investigation usually conducted by a team of external Air Force mental health professionals, appointed by the MTF commander and/or MAJCOM, to promote safety and improve care. Part of the MII will be a determination of whether the providers and system met the standard of care. The MII is a Quality Assurance (QA) function and information from the investigation is protected for QA use only. Findings from the MII may dictate policy change recommendations for the MTF, MAJCOM or Air Force.

Commander Directed Investigation: An investigation of the suicide instigated by a commander at any level. The investigation team may or may not include medical/mental health personnel. The investigation team will report the findings to the requesting commander.

Each MAJCOM is required to have a post-suicide assessment process to examine lessons learned from each completed suicide that may help prevent future fatalities. The lessons learned from these assessments when appropriate 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 commits suicide, mental health personnel can play an essential role as a consultant to the individual's squadron commander. This commander will be required to report on the suicide up the chain of command to the MAJCOM commander. This can be a difficult, taxing responsibility for the commander, and mental health assistance may be welcomed.

Resources and Recommended Readings

A. Managing and Treating Suicidal Behavior

Bonger, B., Maris, R. W., Berman, A. L., & Litman, R. E. (1992). Outpatient standards of care and the suicidal patient. *Suicide and Life Threatening Behavior*, 22, 453-478.

Joiner, T. E., Walker, R. L., Rudd, M. D., & Jobes, D. A. (1999). Scientizing and routinizing the assessment of suicidality in outpatient practice. *Professional Psychology: Research and Practice*, 30, 447-453.

Rudd., M. D., Joiner, T. E, Jobes, D. A., & King, C. A. (1999). The outpatient treatment of suicidality: an integration of science and recognition of its limitations. *Professional Psychology: Research and Practice*, 30, 437-446.

Rudd, M. D., Joiner, T., & Rajab, M. H. (2001). *Treatment of Suicidal Behavior: An Effective, Time Limited Approach*. Guilford Press: New York.

Risk Management Foundation, Harvard Medical Institutions (1996). *Guideline for identification, assessment, and treatment planning for suicidality.* www.rmf.harvard.edu/rmlibrary/clinical-guidelines/suicide/body.html

B. Assessment and Assessment Instruments

Range, L. M., & Knott, E. C. (1997). Twenty suicide assessment instruments: evaluation and recommendations. *Death Studies*, 21, 25-59.

Brown, G. K (2001). *A Review of Suicide Assessment Measures for Intervention Research with Adults and Older Adults.* http://www.nimh.nih.gov/research/adultsuicide.pdf.

Goldston, D. B. (2000). *Reviews of Measures of Suicidal Behavior: Assessment of Suicidal Behaviors and Risk Among Children and Adolescents.* http://www.nimh.nih.gov/research/measures.pdf

C. Bibliotherapy for Suicidal Patients

Ellis, T. E. & Newman, C. F. (1996). *Choosing to Live: How to Defeat Suicide Through Cognitive Therapy*. New Harbinger: Oakland, CA.

D. Resources for After a Suicide

Resources for clinicians who have lost a patient to suicide. American Association of Suicidology website. www.suicidology.org

Dunne, E. J. (1992). Postvention. In B. Bonger (Ed.) *Suicide: Guidelines for Assessment, Management and Treatment*. Oxford University Press: New York.

E. Literature on Suicide in the Air Force

Centers for Disease Control (1999, November 26). Suicide prevention among active duty Air Force personnel – United States, 1990 – 1999. *Morbidity Mortality Weekly Report*, 48(46), 1053-1057.

Staal, M. A., & Hughes, T. G. (2002). Suicide prediction in the US Air Force: Implications for practice. *Professional Psychology: Research & Practice*, 33, 190-196.

Staal, M. A. (2000). The assessment and prevention of suicide for the 21st century: The Air Force's community awareness training model. *Military Medicine*, 166, 195-198.

F. General Suicide Textbooks

Maris, R. W., Berman, A. L., & Silverman, M.M. (2000). *Comprehensive Textbook of Suicidology*. New York: Guilford Press.

Jacobs, D. G. (Ed.). (1999). *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco: Jossy-Bass.

G. Military Guidance Related to Suicide Management

AFI 44-102, *Community Health Management*

AFI 44-109, *Mental Health, Confidentiality and Military Law*

AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*

AFI 44-153, *Critical Incident Stress Management*

AFI 44-154, *Community Training: Suicide and Violence Awareness Education*

AFPAM 44-160, *The Air Force Suicide Prevention Program*

AF/CC Memo, 25 Nov 02, *Policy for Investigative Interview Hand-Offs*

AF/CVA Memo, 2 Jul 01, *Limited Privilege in the Suicide Prevention Program*

AF/SG2 Memo, 2 Dec 02, *After Duty Hours Mental Health Evaluations*

DoD/VA *Suicide Prevention Identification and Assessment in the Primary Care Setting Toolkit*

DoD Instruction 6490, *Requirements for Mental Health Evaluations of Members of the Armed Forces*

DoD Directive 6490.1, *Mental Health Evaluations for Members of the Armed Forces*

DoD Directive 6490.4, *Requirements for Mental Health Evaluations of Members of the Armed Forces*

HQ AFMOA/SGOF Memorandum, USAF Family Advocacy Program Standards, July 1998

H. Suicide Related Websites

The appearance of website addresses or hyperlinks does not constitute endorsement by the U.S. Air Force of this Website or the information, products, or services contained therein. For other than authorized activities such as Air Force Suicide Prevention Program sites, the U.S. Air Force does not exercise any editorial control over the information you may find at these locations.

Aeschi Working Group	www.aeschiconference.unibe.ch
Air Force Suicide Prevention Program	website address will be inserted
American Association of Suicidology	www.suicidology.org
American Foundation for Suicide Prevention	www.afsp.org
International Association for Suicide Prevention	www.suicide-parasuicide.rumos.com/en/links/menta_health_assoc/IASP.htm
National Institutes of Mental Health, Suicide Research Consortium	www.nimh.nih.gov/research/suicide.cfm
National Strategy for Suicide Prevention	www.mentalhealth.org/suicideprevention
Suicide Prevention Advocacy Network	www.spanusa.org

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Baerger, D. R. (2001). Risk management with the suicidal patient: lessons from case law. *Professional Psychology: Research and Practice*, 32, 359-366.

Beck, A. T., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal intention: The Scale for Suicide Ideation. *Journal of Consulting and Clinical Psychology*, 47(2), 343-352.

Bongar, B. (1991). *The suicidal patient: Clinical and legal standards of care*. Washington, DC: American Psychological Association.

Bongar, B., & Harmatz, M. (1991). Clinical psychology graduate education in the study of suicide: Availability, resources, and importance. *Suicide and Life-Threatening Behavior*, *21*, 231–244.

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Brown, G. K (2001). *A Review of Suicide Assessment Measures for Intervention Research with Adults and Older Adults.* http://www.nimh.nih.gov/research/adultsuicide.pdf.

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