



Defense Health Agency

ADMINISTRATIVE INSTRUCTION

NUMBER 6025.06

August 9, 2022

DAD-MA

SUBJECT: Suicide Risk Care Pathway for Adult Patients in the Defense Health Agency

References: See Enclosure 1

1. PURPOSE. This Defense Health Agency-Administrative Instruction (DHA-AI), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (y), establishes the Defense Health Agency's (DHA) procedures to screen and comprehensively assess patients in the Defense Health Agency (DHA) (who, hereafter, are referred to collectively as "patients"), for suicide risk; manage and treat patients at-risk for suicide using evidence-based and evidence-informed practices; track at-risk patients during periods of increased risk; train the DHA workforce on suicide risk care procedures; measure outcomes for suicide risk care in the DHA; and report suicide deaths and attempts identified in Active Duty Service members (ADSM) and Reserve Component Service members on active duty for a period of more than 30 days, who, hereafter, are referred to collectively as "ADSMs." For purposes of this guidance, this policy applies to adult patients, defined as the term used under applicable state law the Military Medical Treatment Facility (MTF) delivering care resides and is inclusive of any minors who may be able to consent for behavioral health care under applicable state law on their own.

2. APPLICABILITY. This DHA-AI applies to:

a. The DHA and DHA Components (i.e., Activities under the authority, direction, and control of the DHA, including Direct Reporting Markets (DRM), DHA Small Markets and Stand-Alone Medical Treatment Facility Organizations (SSO), DHA Regions (DHAR), and MTF;

b. All personnel assigned, allocated, detailed to, or otherwise used to perform duties and functions associated with MTF operations, including the delivery of clinical/health care services and MTF business operations.

3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to References (a) through (c), that DHA Components implement the procedures in this DHA-AI to provide standardized and comprehensive suicide risk care, which includes standardized language pursuant to Reference (d), to DHA patients.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3. The procedures outlined in this DHA-AI support suicide risk reduction in patients receiving care in the DHA, including all DRMs, SSOs, DHARs, and MTFs, by establishing standardized strategies to manage and treat patients at risk for suicide. This DHA-AI provides healthcare guidance for at-risk patients along an evidence-based pathway, as well as guidance for an DHA -wide system of tracking at-risk patients.

6. PROPONENT AND WAIVERS. The proponent of this publication is the Deputy Assistant Director (DAD), Medical Affairs (MA). When Activities are unable to comply with this publication the activity may request a waiver that must include a justification, including an analysis of the risk associated with not granting the waiver. The activity director or senior leader will submit the waiver request through their supervisory chain to the DAD-MA to determine if the waiver may be granted by the Director, DHA or their designee.

7. RELEASABILITY. **Cleared for public release**. This DHA-AI is available on the Internet from the Health.mil site at: <https://health.mil/Reference-Center/Policies> and is also available to authorized users from the DHA SharePoint site at: <https://info.health.mil/cos/admin/pubs/SitePages/Home.aspx>.

8. EFFECTIVE DATE. This DHA-AI:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with Reference (c).

/S/
RONALD J. PLACE
LTG, MC, USA
Director

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ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5136.01, “Assistant Secretary of Defense for Health Affairs (ASD(HA)),” September 30, 2013, as amended
- (b) DoD Directive 5136.13, “Defense Health Agency (DHA),” September 30, 2013, as amended
- (c) DHA-Procedural Instruction 5025.01, “Publication System,” April 1, 2022
- (d) Office of the Undersecretary of Defense for Personnel and Readiness Memorandum, “Standardization of Common Suicide-Related Definitions,” Dec 29, 2021¹
- (e) United States Code, Title 10, Section 1073c
- (f) DHA-Procedural Instruction 6490.02, “Behavioral Health (BH) Treatment and Outcomes Monitoring,” July 12, 2018
- (g) U.S. Department of Veterans Affairs: The Assessment and Management of Suicide Risk Work Group, “VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide, Version 2.0 - May 2019
- (h) DHA Administrative Instruction 6025.04, “Standardization of Depression and Suicide Risk Screening in Primary Care During and Subsequent to the Coronavirus Disease 2019 Pandemic,” January 25, 2022
- (i) DoD Instruction 6490.08, “Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members,” August 17, 2011
- (j) DoD Manual 6025.18, “Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs,” March 13, 2019
- (k) DHA-Procedures Manual 6025.13, “Clinical Quality Management in the Military Health System, Volume 1: General Clinical Quality Management” August 29, 2019
- (l) DoD Instruction 6490.04, “Mental Health Evaluations of Members of the Military Services,” March 4, 2013, as amended
- (m) DHA-Procedural Instruction 6025.27, "Integration of Primary Care Behavioral Health (PCBH) Services into Patient-Centered Medical Home (PCMH) and Other Primary Care Service Settings within the Military Health System (MHS)," October 18, 2019
- (n) Defense Health Agency, “Behavioral Health Coding and Documentation Handbook, Version 3.0, September 2021²
- (o) DHA-Procedural Instruction 6040.07, “Medical Coding of the DoD Health Record,” March 8, 2021
- (p) DoD Instruction 6040.42, “Management Standards for Medical Coding of DoD Health Records,” June 8, 2016
- (q) DoD Instruction 6400.09, “DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm,” September 11, 2020
- (r) DoD Instruction 6025.18, “Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs,” March 13, 2019
- (s) DoD Instruction 8580.02, “Security of Individually Identifiable Health Information in DoD

¹ This reference will be provided upon request by contacting dha.ncr.j-3.mbx.bhgmt-suicide-support@mail.mil.

² This reference can be found at <https://info.health.mil/sites/hro/CMT/BH/SitePages/Library.aspx>.

- Health Care Programs,” August 12, 2015
- (t) DoD Instruction 5400.11, “DoD Privacy and Civil Liberties Programs,” January 29, 2019, as amended
 - (u) DoD Instruction 6000.14, “DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS),” September 26, 2011, as amended
 - (v) DHA-Procedural Instruction 6025.10, “Standard Processes, Guidelines, and Responsibilities of the DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS) Military Medical Treatment Facilities (MTFs),” October 9, 2018
 - (w) DoD Instruction 6490.16, “Defense Suicide Prevention Program,” November 6, 2017, as amended
 - (x) Posner, K. (2018). Columbia Suicide Severity Rating Scale (C-SSRS), Columbia University Medical Center, Center for Suicide Risk Assessment
 - (y) U.S. Department of Veteran Affairs: MIRECC, “Self-Directed Violence Classification System”³

³ This reference can be found at: <https://www.mirecc.va.gov/visn19/clinical/nomenclature.asp>

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness through the Assistant Secretary of Defense for Health Affairs, and in accordance with Reference (e), the Director, DHA will:
 - a. Oversee implementation of this DHA-AI to ensure consistent application across the DHA.
 - b. Support the development, dissemination, and implementation of educational materials and standardized training for the procedures outlined in this DHA-AI, and:
 - (1) Establish training on the procedures set forth in this DHA-AI, and patient educational materials, to DHA healthcare providers.
 - (2) Establish procedures to require that education and training on the procedures outlined in this DHA-AI, are conducted throughout the DHA.
 - c. Support the Military Departments, DRMs, SSOs, DHARs, and MTFs in the execution of this DHA-AI.
2. DAD-MA. The DAD-MA will:
 - a. Oversee development of data collection, analysis, and accountability mechanisms to support suicide risk care.
 - b. Monitor MTF compliance with the guidance outlined in this DHA-AI.
 - c. Collaborate with DHA Health Information Technology Division to ensure MHS GENESIS supports all suicide risk care evaluation, communication, and documentation requirements.
 - d. Recommend and track performance of process and outcome measures relevant to the procedures in this DHA-AI, in accordance with Reference (f).
 - e. Update this instruction, as necessary and as part of continuous process improvement, with respect to suicide risk care procedures..
 - f. Ensure the development of educational materials and standardized training for the procedures outlined in this DHA-AI.

g. Designate a point of contact to develop educational materials and training aimed at developing an understanding of the fundamentals of screening for suicide risk, including when to refer a patient to a BH provider.

h. Establish DHA -wide standardized procedures for screening, evaluations, assessments, tracking, and any other procedures related to suicide risk care in the DHA.

i. Work with Health Informatics to ensure the electronic health record system, MHS GENESIS, supports all suicide risk screening and assessment, communication, documentation, and reporting requirements. This includes a standardized system capable of recording and storing suicide risk screening and assessment results, facilitating communication between providers, and displaying suicide risk screening and assessment results when available.

j. Ensure standard clinical results communication and documentation systems are in place to collect data and measure compliance with this DHA-AI.

3. DIRECTOR, EDUCATION AND TRAINING (J-7). The Director, J-7 will support the dissemination of core education and training guidelines on the Suicide Risk Care Pathway to behavioral health (BH) professionals, healthcare providers, trainees, and students within the DHA as part of internship, residency, fellowship, and Continuing Medical Education programs.

4. DRM, SSO, AND DHAR DIRECTORS. The DRM, SSO, and DHAR Directors will:

a. Ensure MTF compliance with the processes and procedures regarding suicide risk care as outlined in this DHA-AI.

b. Implement corrective actions, to include training and evaluation as required, to achieve the goals outlined in this DHA-AI.

c. Identify future DRM, SSO, and DHAR leads to support full implementation and compliance with this DHA-AI.

d. Implement suicide risk care requirements within the MTFs, DRMs, SSOs, and DHARs, as outlined in this DHA-AI.

e. Monitor and implement the required suicide risk care-specific education and training activities outlined in this DHA-AI within the MTFs, DRMs, SSOs, and DHARs.

f. Monitor and evaluate effectiveness of suicide risk care offered through MTFs, including performance improvement initiatives defined by DAD-MA.

g. Coordinate with DAD-MA to ensure the information shared by DAD-MA is comprehensively communicated to the MTF leadership.

h. Recommend updates to this DHA-AI to the DHA BH Clinical Community, as necessary and as part of continuous process improvement, with respect to suicide risk care procedures..

5. MTF DIRECTORS. MTF Directors will:

a. Ensure compliance with and oversee the implementation of the processes and protocols related to suicide risk care outlined in this DHA-AI.

b. Ensure dissemination of this DHA-AI to all MTF level healthcare providers, and ensure all MTF healthcare providers are informed of the guidance and procedures, as well as the requirements to follow the guidance and procedures, set forth in this DHA-AI.

c. Ensure all healthcare providers are trained on the suicide risk care processes and procedures in this DHA-AI.

d. Ensure standard operating procedures are developed to track the MTF's patients with current suicide risk.

ENCLOSURE 3

PROCEDURES

1. OVERVIEW

a. This DHA-AI establishes a standardized Suicide Risk Care Pathway for adult patients in the DHA who are at risk for suicide. The procedures set forth in this DHA-AI include general guidance for DHA providers (including Primary Care Behavioral Health (PCBH) providers) working in primary care and other non-BH care settings, as well as more comprehensive guidance for Specialty BH providers working in BH care settings (including Unit-Aligned Outpatient Behavioral Health). Effective suicide risk care is reliant upon appropriate training, multi-disciplinary collaboration, clear communication, and evidence-based practices.

b. The DHA Suicide Risk Care Pathway is a unified structure of care that supports suicide risk reduction by defining and establishing standardized procedures to promote identification, treatment, and tracking of patients at risk of suicide in alignment with Reference (g). This new Pathway covers key BH care functions, including risk screening and comprehensive risk assessment, safety planning, evidence-based and evidence-informed treatment, and means safety considerations. Providers are encouraged to continue to use their clinical judgment and to consider the specific needs of individual patients when providing care for suicide risk. Reference (g) outlines additional clinical considerations for providers.

2. GENERAL INFORMATION AND GUIDELINES

a. The Suicide Risk Care Pathway establishes procedures and clinical actions to be followed by DHA healthcare providers treating adult patients at risk for suicide. Specifically, DHA providers will:

(1) Use an electronic (e.g., MHS GENESIS, Behavioral Health Data Portal) version of the Columbia Suicide Severity Rating Scale (C-SSRS) screener to identify risk or, in Primary Care settings, use screeners identified in Reference (h) or its equivalent;

(2) Conduct comprehensive risk assessments as outlined in Section 4 of this Enclosure and Reference (g);

(3) Use standardized risk level determination using the Acute Risk Stratification Table (Appendix 1), in accordance with Reference (g) and paragraph 4 of this Enclosure;

(4) Use a safety plan (Appendix 2) for all patients with intermediate acute or high acute risk (Appendix 1), in accordance with this DHA-AI and Reference (g);

(5) Implement and use an at-risk tracking list and established tracking teams, as described in paragraph 7 of this Enclosure; and

(6) Utilize standardized documentation using the standard suicide terminology from References (d) and (g) and found in this DHA-AI's Glossary.

b. All healthcare providers to whom this DHA-AI applies will receive educational materials and training aimed at developing an understanding of the fundamentals of screening for suicide risk, including when to refer a patient to a BH provider. This training will be provided by DAD-MA's designee. Appropriate referrals include a patient who indicates suicidal ideation on a routine depression screen, a patient who presents with suicidal warning signs, and a patient who presents for care with an injury that might have been self-inflicted (Reference (g)).

c. All healthcare providers will conduct a "warm hand-off" to a BH consultant in primary care or a Specialty BH provider for any patient who reports or endorses any of the suicide warning signs listed below (2.c.(1)-(3)), which indicate potential imminent risk (Reference (g)). Note that suicidal ideation alone does not necessarily suggest imminent risk or warrant a warm hand-off, but it does require thorough exploration. In the event BH or PCBH resources are unavailable to providers who encounter a client with any of the below suicide warning signs, the provider will coordinate a warm hand-off to the nearest emergency department and ensure direct observation by healthcare staff is established. All clinical actions taken by providers will be recorded in the patient's medical record.

(1) Communicating suicidal intent verbally, electronically, or in writing;

(2) Suicidal ideation paired with seeking access to lethal means, such as firearms;
and/or

(3) Suicidal ideation paired with preparatory behaviors, such as putting affairs in order prior to death.

d. All healthcare providers will communicate with ADSMs' commanders about suicide risk in accordance with Reference (i) or its equivalent. Providers will also communicate with other healthcare providers or appropriate individuals, internal or external to the DoD, when such communication is, in good faith, believed to be necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, in accordance with Reference (j).

e. While face-to-face contact is preferred for suicide risk care, healthcare providers may use telemedicine in accordance with Enclosure 4 of Reference (k) when clinically appropriate.

f. Reference (g) reflects a summary of the evidence-based literature and is intended to support clinical judgement. This DHA-AI attempts to balance the need for standardized clinical practices across DoD treatment facilities and support for clinician judgment and autonomy in clinical decision-making concerning the complex topic of suicide risk.

g. Specialty BH providers will act in accordance with Reference (l), or its equivalent, when completing a command-directed BH evaluation for suicidal ideation or suicide-related behaviors.

3. RISK SCREENING GUIDELINES. Suicide risk screening requirements vary by healthcare setting and fall into two categories: healthcare settings other than BH specialty care and BH specialty care settings.

a. Health Care Settings Other than BH Specialty Care. Healthcare settings other than BH Specialty Care include, but are not limited to, Primary Care, emergency departments, inpatient medical and surgical wards, urgent care clinics, acute care clinics, substance use disorder (SUD) clinics that do not fall directly under BH, and specialty medical clinics other than BH, and will adhere to the guidance set forth in Reference (m) and the following:

(1) When clinically indicated, healthcare providers will screen patients for suicide risk using the past-month screener version of the Columbia Suicide Severity Rating Scale (C-SSRS), which can be found in MHS GENESIS. Examples of indicators that would prompt screening for suicide risk include, but are not limited to: a recent suicide attempt, current suicidal ideation, a positive depression screen, current evaluation or treatment for a BH condition, recent psychiatric hospitalization, command-directed referral due to safety concerns, and recent serious psychosocial stressors.

(2) Primary Care Providers will also follow suicide risk screening procedures outlined in Reference (h) or its equivalent.

(3) Interpretation and triage for the past-month screener version of the C-SSRS are as follows:

(a) For all patients, Items 1, 2, and 7 should be completed. The screen is negative if the patient responds “No” to all C-SSRS screener items. Providers do not need to follow up on negative screens. For patients who respond “Yes” to Items 1, 2, and/or 7 only, providers will complete the remaining C-SSRS items and follow up to determine whether further clinical attention or management is required. Providers will document their decision-making regarding suicide risk screening and follow-up questioning in the medical record.

(b) For patients who respond “Yes” to at least one of Items 3, 4, 5, 6, or 8, the screen is positive. Positive screens warrant immediate clinical follow-up and, unless clinical judgment indicates otherwise, providers will initiate a referral to BH for a clinical evaluation and comprehensive risk assessment. Providers will document their referral in the medical record.

(4) When a patient screens positive for suicide risk based on the criteria in this Enclosure, healthcare providers will determine whether that patient has any safety concerns that require immediate management. If a patient requires immediate management for safety concerns, providers will conduct a warm hand-off to emergency services personnel or BH, as indicated. When indicated, healthcare providers will maintain direct observation of the patient

until the warm hand-off to emergency services personnel or BH has been accomplished. Safety concerns that require immediate management include, but are not limited to:

(a) Suicidal ideation with intent to die by suicide paired with access to lethal means; and/or

(b) An inability to independently maintain safety (i.e., keep oneself safe without external support or assistance).

(5) Healthcare providers will document in the patient's medical record all relevant details of administered screening procedures, determination of immediate safety concerns, and any additional information deemed clinically relevant. Healthcare providers will consult References (n) through (p) for Current Procedural Terminology (CPT) codes and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) or equivalent diagnosis codes.

b. BH Specialty Care Settings. BH specialty care settings, which include outpatient BH clinics, SUD clinics, and BH departments, will adhere to the following guidelines:

(1) For initial intake BH clinical encounters in BH Specialty Settings, BH providers will screen each patient for suicide risk using the lifetime screener version of the C-SSRS. The lifetime C-SSRS screener may be completed via the BH Data Portal; Reference (f), MHS GENESIS, verbal administration by a BH provider, or a paper survey. Any "yes" responses on the lifetime C-SSRS screener will be explored clinically to assess whether the symptoms are current and the results will be documented in the medical record.

(2) For follow-up (i.e., non-intake) encounters, BH providers will screen each patient for suicide risk using the past-month screener version of the C-SSRS. The past-month C-SSRS screener may be completed via BH Data Portal or a paper survey. Alternatively, clinicians can elect to apply the past-month C-SSRS screener as a set of interview prompts. For each patient, Items 1, 2, and 7 should be completed. The screen is negative if the patient responds, "No," to all C-SSRS screener items. Providers do not need to follow up on negative screens. For patients who respond, "Yes," to Items 1, 2, and/or 7 only, providers will follow-up to determine whether further clinical attention or management is required. For patients who respond, "Yes," to at least one of Items 3, 4, 5, 6, or 8, the screen is positive. Positive screens warrant immediate clinical follow-up and, unless clinical judgment indicates otherwise, a clinical evaluation and comprehensive risk assessment. The results of the screening and any associated provider decisions will be clearly documented in the medical record. If paper survey was utilized, it should either be documented or scanned into the medical record.

(3) BH Providers will conduct a clinical evaluation and comprehensive risk assessment whenever clinically indicated, including for any patient whose responses to a C-SSRS screener or clinical interview indicate current method, current plan, current intent, and/or recent suicide attempt or preparatory behavior, in accordance with paragraph 4 of this Enclosure.

(4) Once a clinical evaluation and comprehensive risk assessment have been completed and the patient has been assigned an acute risk level (i.e., low, intermediate, or high) that is documented according to the guidelines below, further screening is not required at every follow-up BH visit. For these patients with acute risk levels, BH providers may conduct screenings as clinically indicated, and will monitor patients' assigned risk levels by regularly asking patients about relevant concerning symptoms, behaviors, risk/protective factors, life circumstances, ability to keep oneself safe, and any other clinically relevant information. The patient's risk level, as defined in Appendix 1, will be updated and documented in their medical record following each BH encounter.

4. CLINICAL EVALUATION AND COMPREHENSIVE RISK ASSESSMENT CONDUCTED BY BH PROVIDERS

a. BH providers will conduct clinical evaluations and comprehensive risk assessments in clinically-appropriate settings. If indicated, providers should take care to restrict patient access to lethal means (e.g., firearms, sharps, tubing or cordage, toxic substances, medications) during these procedures and as necessary throughout the encounter.

b. If a patient presents with evidence of a high acute risk level, as defined in Appendix 1, direct observation of the patient will be facilitated until the patient's risk level has been confirmed and an appropriate disposition has been undertaken. If a lower level of risk is confirmed for the patient, direct observation may be discontinued, as clinically indicated.

c. Once a patient's suicide risk level has been determined in accordance with Appendix 1, the BH provider will perform disposition, management, and/or treatment procedures consistent with the patient's current suicide risk level, in accordance with paragraph 6 of this Enclosure.

d. For patients who require clinical evaluations and comprehensive risk assessments due to warning signs, risk indicators, command-directed evaluation, and/or C-SSRS screener results, BH providers will conduct a clinical evaluation and comprehensive risk assessment that includes all of the following REQUIRED components and some or none of the following OPTIONAL components, as indicated:

(1) Required. BH providers will review the pertinent medical records and the patient's responses to the lifetime C-SSRS screener in their evaluation, but will not determine the patient's suicide risk level solely on the basis of responses to the C-SSRS screener. Providers will determine the patient's risk level based on their complete clinical evaluation in accordance with clinical judgment and guidance based on, but not limited to, the following considerations:

- (a) Current suicidal ideation;
- (b) Prior suicide attempts;

- (c) Current psychiatric conditions and/or symptoms;
- (d) Prior psychiatric hospitalization;
- (e) Recent key biopsychosocial stressors, such as, but not limited to, significant relationship conflict or loss, loss of job, financial problems, risk of losing housing or homelessness, trauma exposure, social isolation, or legal or disciplinary issues;
- (f) Availability of or access to firearms (in accordance with Reference (q)); and
- (g) Key risk and protective factors including, but not limited to, sex, age, social/family support, adverse childhood experiences, or pertinent co-morbidities.

(2) BH providers will consult additional sources as needed to determine a patient's suicide risk level. Additional sources may include, but are not limited to, the following:

- (a) The ADMSM's administrative records; and
- (b) The patient's commander, supervisor(s), family members, friends, colleagues, other providers, and/or other individuals in the patient's life. Providers will consult individuals in the patient's life as necessary, in accordance with References (r) through (v) and/or patient's authorization.

e. BH providers will use information obtained during the clinical evaluation and comprehensive risk assessment to determine the patient's current suicide risk level according to the "Essential Features" columns of the Acute Risk Stratification Table provided in Appendix 1. If the provider determines that the patient has no identifiable suicide risk, the provider may document, "No Risk Detected," in the medical record. The, "No Risk Detected," categorization is generally reserved for patients who report no suicidal ideation or recent suicide attempts or preparatory behaviors, no significant underlying BH conditions, and have a favorable balance of risk and protective factors.

f. BH providers will assign the high acute risk level to all patients who have safety concerns that require immediate management, and will follow management and disposition procedures, as clinically indicated, and in accordance with this DHA-AI.

g. BH providers will document the current suicide risk level, and the clinical basis for this determination, in the patient's medical record, on the same day as the clinical evaluation and comprehensive risk assessment. Providers will document any late-night determinations of risk by early the next morning. The provider will include, if applicable, any evidence of safety concerns for the patient, the sources consulted by the provider, and any additional information that the provider deems clinically relevant. When documenting in patients' medical records, standard terminology will be used. See the Glossary for standard terminology and their definitions.

(1) The following are accepted terms: suicide (i.e., death by suicide), suicide attempt, suicidal ideation, suicidal intent, preparatory behavior, and low/intermediate/high acute risk level.

(2) The following are terms that will not be used: committed suicide, completed suicide, successful suicide, failed attempt, suicide gesture, suicide threat, manipulative act, and nonfatal suicide.

h. BH providers will consult relevant MHS coding guidelines for appropriate CPT codes and relevant DoD guidance for ICD-10-CM or equivalent diagnosis codes (i.e., References (n) through (p)).

i. BH providers will notify commanders of ADSMs at risk for suicide, in accordance with Reference (i) or its equivalent. In general, BH providers will notify commanders of ADSMs with an intermediate acute or high acute risk level, as defined in Appendix 1, or when there is a serious risk of self-harm by the Service member. BH providers will undertake command notification within the context of balancing the roles and responsibilities they have to both patients and unit mission readiness, pursuant to Reference (i) or its equivalent. Ultimately, ensuring Service member safety and well-being should be the overriding priority.

5. SAFETY PLANNING CONDUCTED BY BH PROVIDERS

a. When suicide risk at an intermediate acute or high acute level (in accordance with Appendix 1) is identified for the first time during a clinical encounter, or when clinically indicated, the BH provider will develop a safety plan collaboratively with the patient (Reference (g)). The BH provider may also review and/or update any existing safety plan found in the patient's medical record. An example of a safety plan containing all required items in accordance with this DHA-AI can be found in Appendix 2; other formats may be used, but they must contain the elements outlined in paragraph 5.d. (1) – (6) of this Enclosure. The provider will document the contents of the safety plan in the patient's medical record and ensure that the patient has either an electronic or physical copy of the plan to take with them at the end of the clinical encounter.

b. BH providers will consult relevant MHS coding guidelines for appropriate CPT codes and relevant DoD guidance for ICD-10-CM or equivalent diagnosis codes for proper documentation of a safety plan in the medical record (i.e., References (n) through (p)).

c. BH providers will collaboratively review and/or update a patient's safety plan, as clinically indicated, such as when the patient experiences any significant change in suicide risk level or clinical status.

d. BH providers will include the following components in all safety plans (Reference (g)):

(1) Personal Warning Signs. Warning signs of a suicidal crisis include, but are not limited to: feelings of worthlessness or hopelessness, thinking about death, and researching suicide methods. These signs will vary from patient to patient and can be unique to each individual.

(2) Self-Management Coping Strategies. Skills the patient can utilize on their own to distract themselves and/or to cope with stress include, but are not limited to: exercising, watching television, playing with a pet, or journaling;

(3) Social Support. Supportive individuals in the patient's life who can be counted on for distraction and/or support (e.g., friends, family members, colleagues);

(4) Professional Support. Professional individuals who can be contacted for support and/or assistance (e.g., BH provider, Primary Care provider, chaplain), and whose contact information is known;

(5) Crisis Line / Emergency Services. Resources, including crisis intervention services, that can be consulted and utilized during a suicidal crisis (e.g., Veteran/Military Crisis Line: 988 or 1- 800-273-8255 or text 838255 (continental U.S.); 00800 1273 8255 or Defense Switched Network 118 (Europe); 0808 555 118 or Defense Switched Network 118 (Korea); and local police and emergency transportation services (e.g., 911));

(6) Means safety. Ways to improve the safety of the environment (e.g., safe storage of firearms and other lethal means, safe disposal of excess or unused medications), consistent with Reference (q), and in accordance with paragraph 8 of this Enclosure.

6. MANAGEMENT OF SUICIDE RISK IN BH CARE SETTINGS - DISPOSITION, TREATMENT, DISCHARGE PLANNING

a. Disposition by Risk Level. BH providers will use both clinical judgment and information from the Acute Suicide Risk Stratification Table (Appendix 1) that correspond to the patient's current suicide risk level to inform their clinical disposition and management decisions. Providers will document their decisions in the patient's medical record on the same day that the decisions were made. Providers will document any late-night decisions by early the next morning.

b. Treatment by Risk Level. BH providers will use clinical judgment, Algorithm C (Appendix 3), and the Acute Suicide Risk Stratification Table (Appendix 1) to inform their treatment plan decisions. Reference (g) provides recommendations for psychotherapy and pharmacotherapy treatments. Providers will document their treatment plan, as well as the rationale for that plan, in the patient's medical record.

c. Command Notification. When notifying command of an ADSM with suicide or self-harm risk, BH providers are reminded to provide the minimum amount of information to the commander concerned as required to satisfy the purpose of the disclosure, in accordance with Reference (i) or its equivalent. In general, providers will notify commanders of ADSMs with an intermediate acute or high acute risk level, as defined in Appendix 1, or when there is a serious risk of self-harm by the Service member. BH providers will consider command notification within the context of balancing the roles and responsibilities they have to both patients and unit mission readiness. BH providers' recommendations to command could include, but are not limited to: modifying the Service member's daily activities to lower the risk of harm; soliciting potential changes in activities from the Service member to increase safety; or discussing the safe storage of lethal means, such as firearms, to decrease suicide risk. Ultimately, ensuring the Service member's safety and well-being should be the overriding priority.

d. Unit Watch. BH providers are not authorized to recommend any type of unit watch, or "buddy watch," in lieu of a medically necessary hospitalization. Unit watch is not an authorized medical disposition for ADSMs who are at a risk level that warrants a monitored clinical setting (see Appendix 1 for setting considerations). ADSMs will only be released to outpatient care when they can be reasonably expected to self-manage safety issues, seek help when appropriate, and participate in outpatient treatment. However, in certain operational conditions where hospitalization or medical evacuation may not be immediately available, unit commanders, in close consultation with BH providers, may have to establish a time-limited plan for buddy or command supervision to ensure ADSM safety until definitive medical care can be provided.

e. Management of No-Shows/Missed Appointments. When patients at an intermediate acute or high acute risk level miss a scheduled appointment without prior communication (i.e., "no-show"), providers must call the patient on the same day, preferably during the appointment time, to determine reason for no-show, screen for current BH symptoms and suicide risk status, and arrange for appropriate follow-up. If the patient is unable to be reached, the BH provider will use their clinical judgment and document their decision-making in the medical record regarding the need for further action, such as contacting an ADSM's commander to facilitate appropriate follow-up or, in the case of civilian patients, contacting local law enforcement for a wellness check.

f. Discharge Planning from In-Patient BH Treatment Settings

(1) A standard discharge plan from an inpatient BH setting for patients with suicide risk will include three components: a referral plan, a safety plan, and a discharge summary. The patient's primary BH provider will identify and provide referrals to the patient with consideration for the patient's suicide risk level and other relevant clinical issues as well as the commander's and/or family's ability to support the treatment plan. The safety plan will be developed collaboratively by the BH provider and the patient, as described in paragraph 5 of this Enclosure. It is recommended to include the following in the discharge summary: reason(s) for hospitalization, pertinent findings from the clinical evaluation and comprehensive risk assessment, relevant procedures and treatments provided, discharge diagnoses, level of suicide

risk at discharge, referral information for outpatient care, medications prescribed, and other relevant clinical and psychosocial information.

(2) The discharge plan must consist of referral information with follow-up plans to include outpatient or partial hospitalization follow-up within 7 days of discharge (optimally within 72 hours).

7. TRACKING OF AT-RISK PATIENTS IN BH TREATMENT SETTINGS

a. Leadership in BH settings will develop and follow a set of standard operating procedures to create and maintain an “at-risk tracking list” to track patients with clinically significant current suicide risk. Tracking is based on clinical judgment, in addition to comprehensive risk assessment, and the criteria listed in paragraph 7.b. of this Enclosure. The tracking process is intended to facilitate coordination of care for patients and allow for close monitoring of patients by their BH providers via regular tracking meetings. Command may also be consulted or contacted, as appropriate, following applicable guidelines for communication with commanders (Reference (i) or its equivalent), such as when military personnel on the at-risk tracking list miss their scheduled appointments. The treating BH provider will ensure that the patient’s tracking status is accurately reflected in the patient’s medical record, using standardized documentation, as applicable, in accordance with Reference (d).

b. BH providers will place all patients with a high acute risk level, as defined in Appendix 1, and all patients discharged from a psychiatric or BH hospitalization or residential treatment (including SUD treatment) within the previous 30 days on the at-risk tracking list.

c. BH providers should consider placing patients on the at-risk tracking list who meet any of the following criteria:

(1) Intermediate acute risk level, as defined in Appendix 1;

(2) A history of suicide attempt within the previous 60 days;

(3) Medical evacuation from theater for a BH reason within the previous 30 days; or

(4) A combination of current suicidal ideation and other clinically relevant indicators that may be associated with suicide risk, such as serious co-morbidities, deteriorating clinical functioning, discharge from a partial hospital or intensive outpatient program within the previous 30 days, or a complex medication regimen that includes four or more psychotropic medications.

d. BH leadership will coordinate review of the at-risk tracking list and maintain, securely and in accordance with relevant DoD issuances (References (r) through (v)), a list containing the following elements to enable the tracking of at-risk patients:

- (1) Patient's name;
- (2) Patient's BH care provider(s) and case manager(s);
- (3) Patient's Primary Care provider and/or Primary Care case manager;
- (4) For ADSMs, the name of patient's command representative;
- (5) Date patient placed on tracking list;
- (6) Reason patient placed on tracking list;
- (7) Patient's relevant diagnosis or diagnoses;
- (8) Patient's suicide risk level;
- (9) Profile or limited duty status for military personnel;
- (10) Date patient was removed from tracking list, when applicable; and
- (11) Reason patient was removed from tracking list, when applicable.

e. The at-risk tracking list will be reviewed on a regular basis according to the established standard operating procedures to determine when to remove patients from the list based on review of clinical status, clinical judgment, and command input where appropriate and applicable. For example, a patient may be considered for removal from the at-risk tracking list when they no longer meet any of the criteria in paragraphs 7.b. and 7.c. of this Enclosure, have demonstrated adherence to a pre-determined amount and length of treatment, and have exhibited clinical stability.

8. REDUCING ACCESS TO LETHAL MEANS IN BH TREATMENT SETTINGS

a. Lethal means are methods of self-injury that, when used, can lead to death. Examples of lethal means include firearms, sharps, tubing or cordage, toxic substances, and medications. For more information on lethal means, see Reference (q).

b. BH providers of patients with an intermediate acute or high acute risk level will inquire about patients' access to lethal means in a straightforward, compassionate, and non-judgmental manner. Providers will discuss reducing access to lethal means in the context of helping to keep patients safe from suicide as opposed to it being a punitive action. Some patients, for example, may demonstrate resistance to limiting or removing their access to lethal means primarily out of concern for their personal freedom or autonomy. Concerns about having firearms removed from

a patient's possession pose unique challenges when working with military personnel. Providers will follow guidance in accordance with Reference (q) in these situations. Providers will advise patients on methods to reduce access to lethal means (i.e., “lethal means safety”), such as using gun locks and safes, storing ammunition separately from firearms, storing firearms unloaded, safely disposing of excess or unused medications, and reducing quantities of medications stored in one’s household.

c. BH providers working with patients at an intermediate acute or high acute risk level who are not currently hospitalized and who have access to firearms will use their clinical judgment to determine whether to consult command (when patients are ADSMs) and/or family members about the possibility of removing firearms from the patient’s home and/or work environments (Reference (q)).

9. REPORTING. In accordance with relevant policies and Reference (w) or its equivalent, leadership at each MTF will develop and follow procedures to report suicide deaths, suicide attempts, and any other mandated-reporting suicide events among ADSMs via the DoD Suicide Event Report surveillance system.

10. TRAINING

a. All healthcare providers (other than BH providers) working at MTFs will complete suicide risk care core training that includes risk screening and guidance on referrals to BH, within 90 days of issuance of this policy or within 90 days of initially assuming clinical duty at the MTFs, as well as every 3 years thereafter. Core training requirements include procedures and requirements of this DHA-AI including evidentiary basis from the Clinical Practice Guideline, fundamentals of screening/assessing suicide risk, and guidance on referring to BH specialty providers for further assessment. Training is projected to take approximately one hour. This training can be accessed via the Joint Knowledge Online system.

b. BH providers working at MTFs will complete training focused on the core requirements established in this DHA-AI, including screening, assessment, and safety planning, within 90 days of issuance of this policy or within 90 days of initially assuming clinical duty at the MTFs, as well as every 3 years thereafter. Core training requirements include procedures and requirements of this DHA-AI including evidentiary basis from the Clinical Practice Guideline, screening and assessment of suicide risk, and safety planning to mitigate risk. Training is projected to take approximately one to two hours. This training can be accessed via the Joint Knowledge Online system.

APPENDIX 1

ACUTE RISK STRATIFICATION TABLE

1. The overall level of an individual’s suicide risk may increase or decrease based upon warning signs, risk factors, protective factors, life events and many other factors. Consequently, risk levels must not be interpreted as fixed, and once a patient is identified as at-risk, ongoing monitoring of their risk level is imperative (Reference (g)).

Risk Level	Features, Warning Signs, and Risk Factors	Action
High Acute Risk	<p><u>Essential Features:</u></p> <ul style="list-style-type: none"> - Suicidal ideation with intent to die by suicide - Inability to maintain safety, independent of external support/help <p><u>Common warning signs:</u></p> <ul style="list-style-type: none"> - A plan for suicide - Recent attempt and/or ongoing preparatory behaviors - Acute major mental illness (e.g., major depressive episode, acute mania, acute psychosis, recent/current drug relapse) - Exacerbation of personality disorder (e.g., increased borderline symptomatology) <p><u>Common Risk Factors:</u></p> <ul style="list-style-type: none"> - Access to means - Acute psychosocial stressor (e.g., job loss, relationship dissolution, substance abuse relapse) 	<ul style="list-style-type: none"> - Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors - These individuals may need to be directly observed until they are transferred to a secure unit and kept in an environment with limited access to lethal means (e.g., keep away from sharps, cords or tubing, toxic substances) - During hospitalization, co-occurring conditions should also be addressed
Intermediate Acute Risk	<p><u>Essential Features:</u></p> <ul style="list-style-type: none"> - Suicidal ideation to die by suicide - Ability to maintain safety, independent of external support/help <p>These individuals may present similarly to those at high acute risk, sharing many of the features and warning signs. Differences exhibited by patients at intermediate acute risk may be lack of intent based upon an identified reason for living (e.g., children), ability to abide by a safety plan, and maintain their own safety. Preparatory behaviors are likely to be absent.</p>	<ul style="list-style-type: none"> - Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g., acute psychosis) - Outpatient management of suicidal thoughts and/or behaviors must be intensive, and include (but not limited to): frequent contact, regular reassessment of risk, and a well-articulated safety plan - BH treatment must also address any co-occurring conditions

<p>Low Acute Risk</p>	<p><u>Essential Features:</u></p> <ul style="list-style-type: none"> - No current suicidal intent AND - No specific and current suicidal plan AND - No recent preparatory behaviors AND - Collective high confidence (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety <p>Patients at Low Acute Risk may have suicidal ideation, but it will generally be with little or no intent or specific current plan. If a plan is present, the plan is typically general and/or vague, without any associated preparatory behaviors (e.g., “I’d shoot myself if things got bad enough, but I don’t have a gun”). These patients will generally be capable of engaging in appropriate coping strategies, and if categorized as Low Acute Risk, should exhibit the willingness and ability to utilize a safety plan in a crisis situation. If not, consideration of a higher risk level is warranted.</p>	<ul style="list-style-type: none"> - Can be managed in Primary Care - Outpatient BH treatment may be indicated, particularly if suicidal ideation and co-occurring conditions exist
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APPENDIX 2

SAMPLE SAFETY PLAN

My Safety Plan

If I am experiencing a medical or mental health emergency, I can call 911. If I am unable to reach my safety contacts or if I am in crisis, I can call the Military Crisis Line at 1-800-273-8255 (press 1).

This plan lists coping strategies to assist me in reducing my risk for suicide. If I am headed toward a crisis or if I am having thoughts of suicide, I may take the following actions to deescalate the situation and keep myself safe.

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. Thinking that I'm worthless
2. Getting angry about small things with my wife and daughter
3. Drinking every night

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. Play fetch with the dog
2. Listen to music with my headphones and concentrate on the music
3. Look through my hope box

Step 3: People and social settings that provide distraction:

1. Go out with John for coffee or food
2. Call my Aunt Janice – 111 111 1111
3. Take my kids to a movie

Step 4: People whom I can ask for help:

1. John – 999 999 9999
2. Shawn (co-worker) – 777 777 7777
3. My mom – 555 555 5555

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

1. Dr. Jane Doe – 333 333 3333
2. BH Clinic – 222 222 2222
3. DSTRESS Line – 877 476 7734

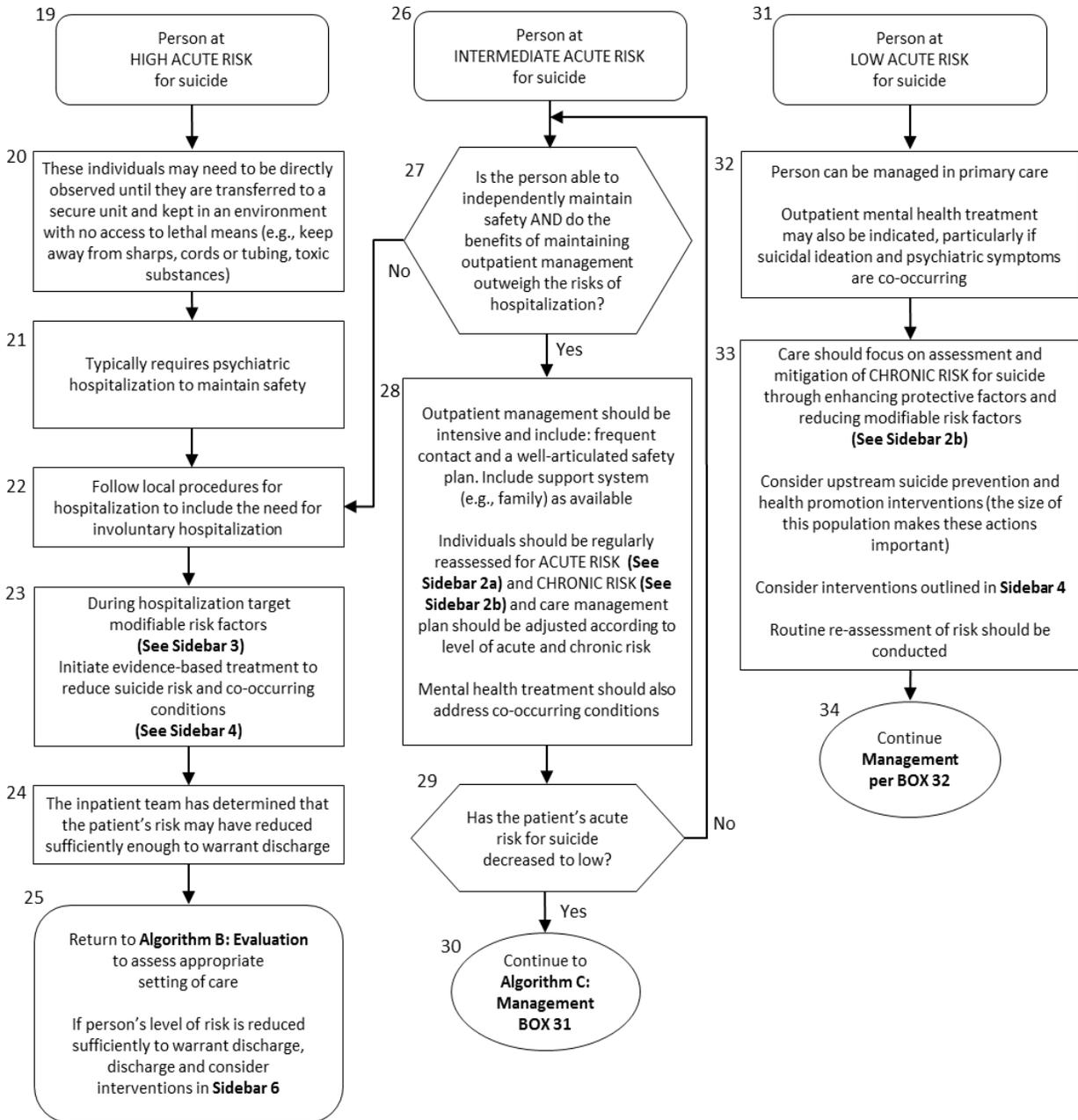
Step 6: Making my environment safe:

1. Ask John to keep my guns and gun safe
2. No alcohol at home
3. Tell my wife when I'm feeling bad so she knows to check on me

The one thing that is most important to me and worth living for is: my wife and kids

APPENDIX 3

ALGORITHM FOR MANAGEMENT OF PATIENTS AT ACUTE RISK FOR SUICIDE



GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ADSM	Active Duty Service Member
BH	behavioral health
CPT	Current Procedural Terminology
C-SSRS	Columbia Suicide Severity Rating Scale
DAD	Deputy Assistant Director
DHA	Defense Health Agency
DHA-AI	Defense Health Agency-Administrative Instruction
DHAR	Defense Health Agency Region
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
J-7	Education and Training
MA	Medical Affairs
MHS	Military Health System
MTF	military medical treatment facility
PCBH	Primary Care Behavioral Health
SSO	Small Market and Stand-Alone Military Medical Treatment Facility Organization
SUD	substance use disorder

PART II. DEFINITIONS

BH provider. A provider licensed to provide BH care services, including psychiatrists, psychologists, social workers, substance abuse treatment counselors, psychiatric nurses, marriage and family therapists, and BH case/care managers working in BH care settings. Most BH clinical decisions outlined in this DHA-AI will be made by or approved by privileged BH providers (Reference (k)).

BH care settings. For purposes of this DHA-AI, suicide risk care falls into two categories: BH specialty care settings and healthcare settings other than BH specialty care. Specialty BH settings include outpatient BH clinics, SUD clinics, and BH departments. healthcare settings other than BH Specialty Care include other healthcare settings where BH providers provide specialty care, such as primary care, emergency departments, SUD clinics that do not fall

directly under BH departments, and specialty medical clinics other than BH, such as Traumatic Brain Injury/polytrauma, or oncology clinics.

healthcare provider. Any member of the uniformed services, civilian employee of the DoD, or contract employee authorized by the DoD to perform healthcare services (Reference (k)).

lethal means. Lethal means are methods of self-injury that, when used, can lead to death, such as sharps, tubing or cordage, toxic substances, medications, and firearms (Reference (q)).

PCBH provider. A licensed independent BH provider who is integrated into primary care clinics to assist primary care managers in treating the patient population.

preparatory behaviors. Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note) (Reference (x)).

safety planning. A plan for safety developed collaboratively between patient and provider (Reference (g)).

suicide. Death caused by self-directed injurious behavior with an intent to die as a result of the behavior (References (d) and (w)).

suicide attempt. A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior (References (d) and (w)).

suicidal ideation. Thinking about, considering, or planning suicide (References (d) and (w)).

suicidal intent. There is past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and in the absence of suicidal behavior (Reference (y)).

suicide risk assessment. The clinical process involving administration and review of screening instruments such as the C-SSRS (Reference (x)), face-to-face clinical interview, review of medical records, physical examination (by the psychiatrist, another physician, or a medically trained clinician), mental status examination, diagnostic testing, and/or history taking from collateral sources to determine a patient's level of risk for suicide (Reference (g)).

suicide risk screening. The use of a screening tool, such as the C-SSRS, to determine the need for a more in-depth assessment for suicide risk (Reference (g)).

warm hand-off. The transfer of a patient's care from provider (or provider's representative) to provider (or provider's representative) via a direct communication in which the receiving provider acknowledges and confirms receipt of care.