

Suicide Risk Assessment & Management

2024 VA/DoD Clinical Practice Framework

Version 3.0
Executive Guide



The Clinical Imperative: Escalating Risk

General Population

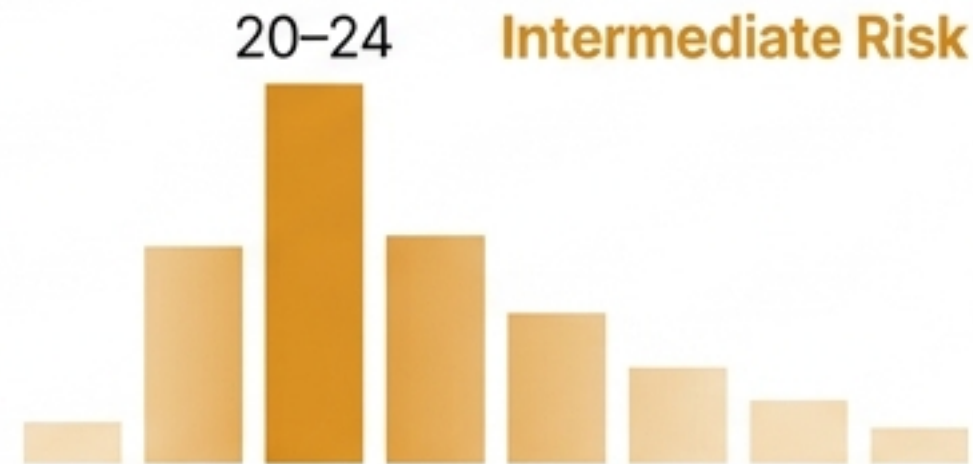
18.0 per 100k



55.0% of deaths involve a firearm.

Active Duty

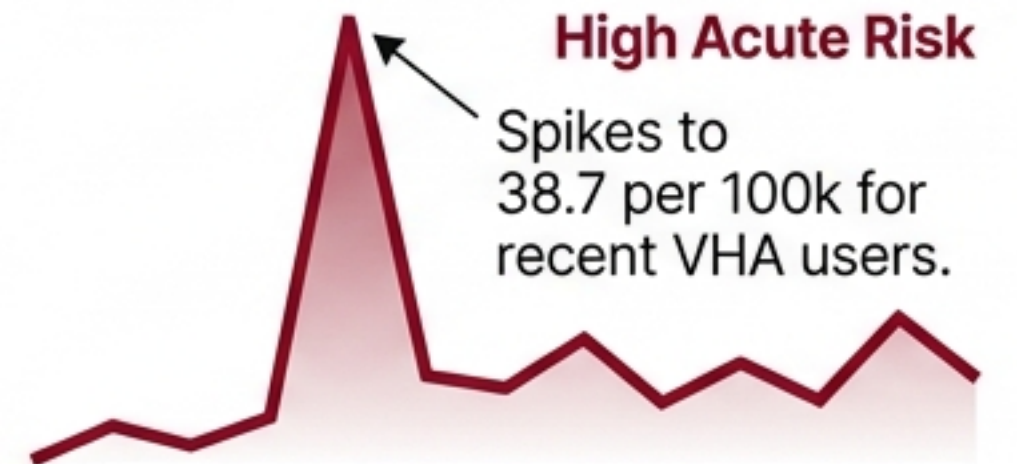
17.1 – 27.1 per 100k



67.1% of active-component deaths involve a firearm.

Veterans

30.1 per 100k



44.3% higher risk for recent **VHA users** compared to non-users.

The 2024 Paradigm Shift: Rigor in the GRADE Methodology



A downgrade in recommendation strength reflects an absence of definitive RCT mortality data, not necessarily evidence of ineffectiveness. These remain valid clinical options subject to shared decision-making.

The Clinical Decision Pathway



Module A: **Identification**

Detecting warning signs
and executing validated
screening.



Module B: **Assessment**

Determining **Acute vs.**
Chronic risk **severity** to
dictate immediate action.



Module C: **Management**

Deploying targeted safety
planning, lethal means
safety, and specialized
treatments.

Module A | The Warning Signs Taxonomy

Left Pane | Indirect Signs



Substance use escalation



Hopelessness / Purposelessness



Reckless behavior



Sleep disturbances



Severe mood changes



Feeling trapped

Right | Direct Signs



Suicide-related communication
(e.g., suicide note, expressing a wish to die)



Seeking access to or recent use of lethal means



Preparatory behaviors
(e.g., giving away possessions)

Any direct warning sign triggers immediate transition to Comprehensive Risk Assessment (Module B).

Module A | Validated Screening Execution



Insufficient evidence to recommend blanket suicide risk screening programs (Recommendation 1).



i When screening is indicated, validated tools are strictly advised (Recommendation 2).



General Population

- C-SSRS Screener
- Suicide Cognition Scale-Revised
- PHQ-9



At-Risk Populations

- Beck Suicide Intent Scale / Beck Scale for Suicidal Ideation
- C-SSRS Screener

Module B | The Acute Risk Stratification Engine

HIGH

Core Features

Suicidal ideation with intent **TO DIE** + Inability to independently maintain safety. Often features a specific plan and access to lethal means.

Action Required

Immediate transition to Module C (Hospitalization / Direct Observation)

INTERMEDIATE

Core Features

Suicidal ideation + Ability to maintain safety independent of external help. Lacks preparatory behaviors.

Action Required

Enhanced outpatient care, frequent contact, safety planning

LOW

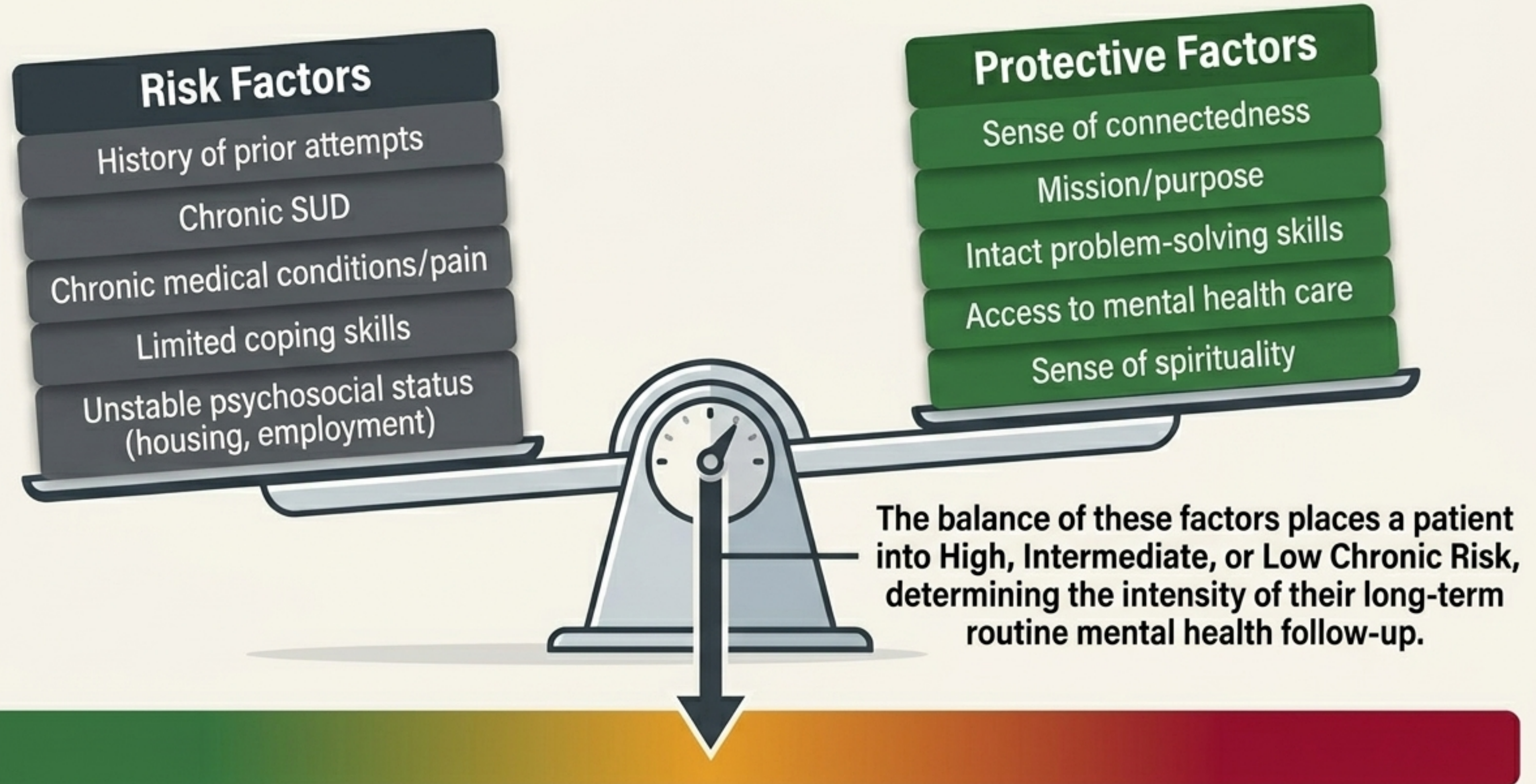
Core Features

Possible ideation but **NO current intent, NO specific plan, NO preparatory behavior.** Collective high confidence in patient safety.

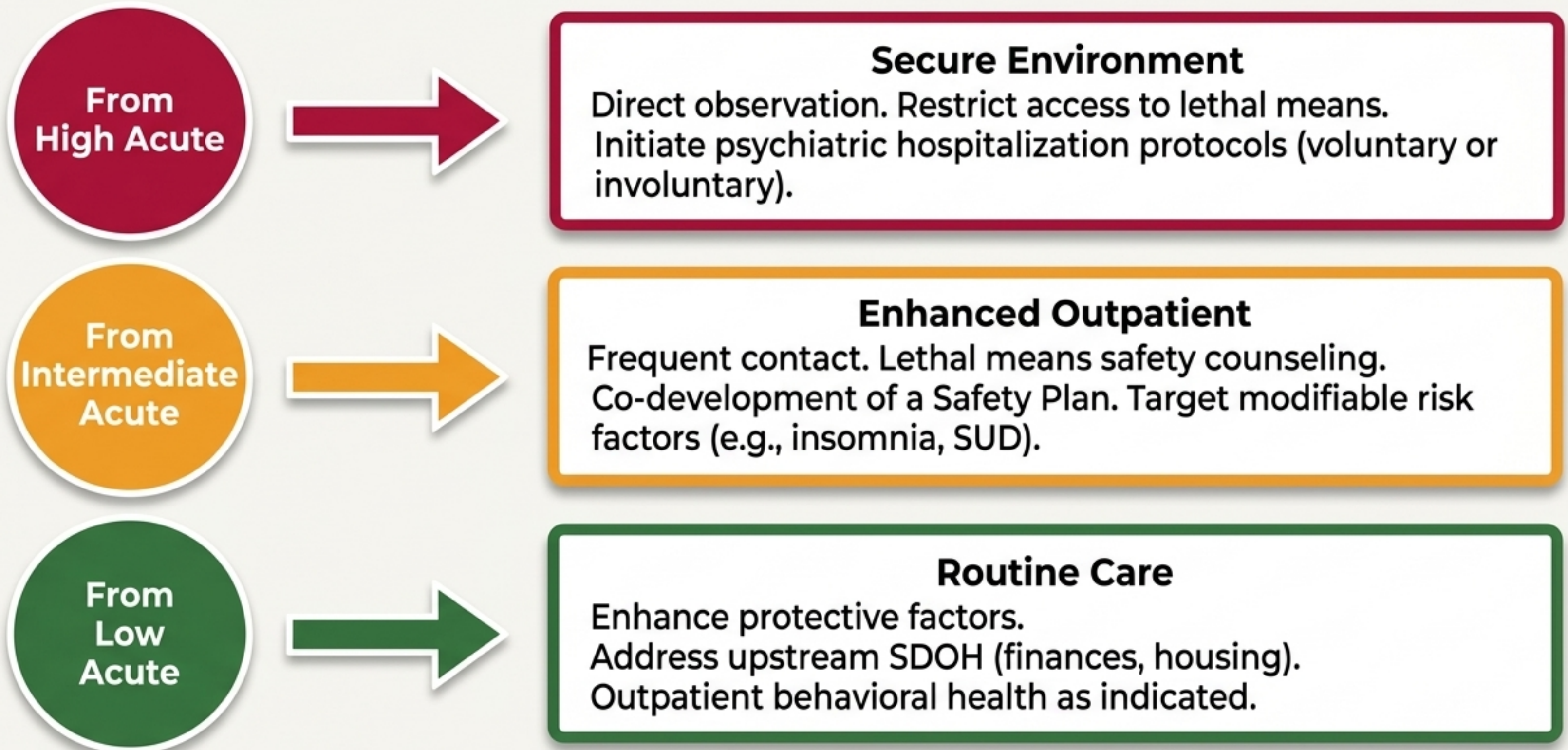
Action Required

Focus on chronic risk mitigation

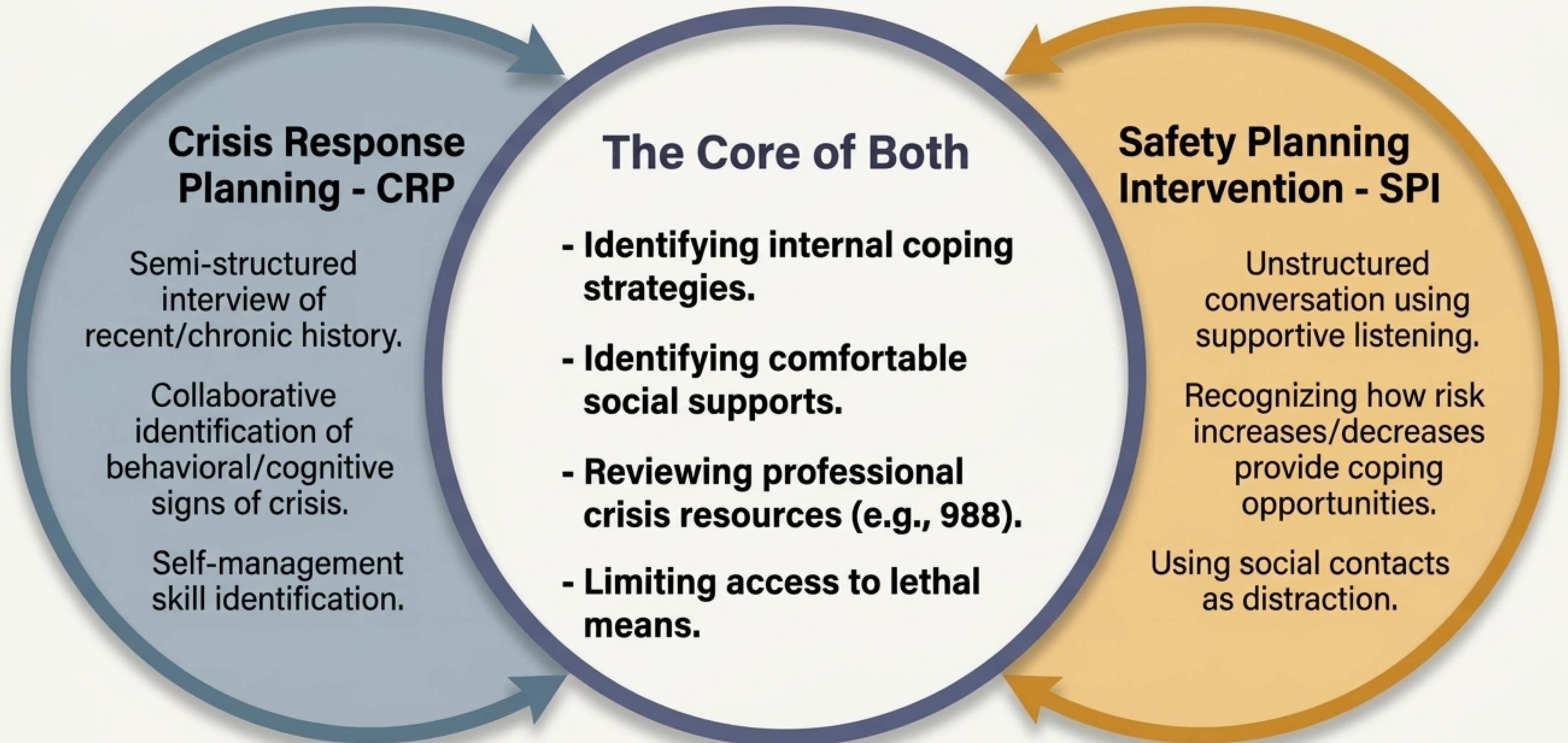
Module B | Establishing Chronic Risk Baselines



Module C | Management Dispatch Protocol

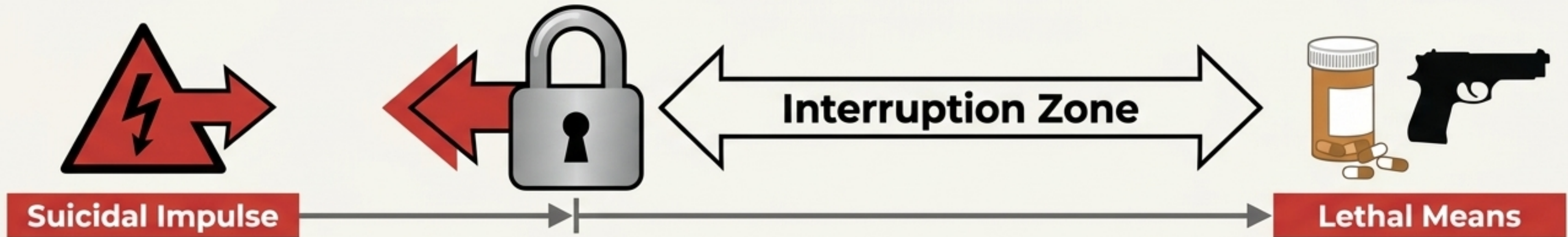


Module C | The Anatomy of a Safety Plan (SPI vs. CRP)



Module C | Lethal Means Safety (LMS)

LMS is an intentional, collaborative, and voluntary practice to reduce suicide risk by limiting access to lethal means (Recommendation 21).



Mechanism 1: Time

Delaying the ability to act on a temporary suicidal crisis allows the intense acute impulse to crest and subside.

Mechanism 2: Distance

Creating physical barriers (e.g., gun safes, limiting medication quantities) requires complex executive function, which is often impaired during a crisis, interrupting the behavioral loop.

Module C | Evidence-Based Targeted Treatments

Non-Pharmacologic Interventions

CBT-Based Psychotherapy: Recommended to reduce risk in patients with a history of behavior within the past 6 months (Recommendation 5).

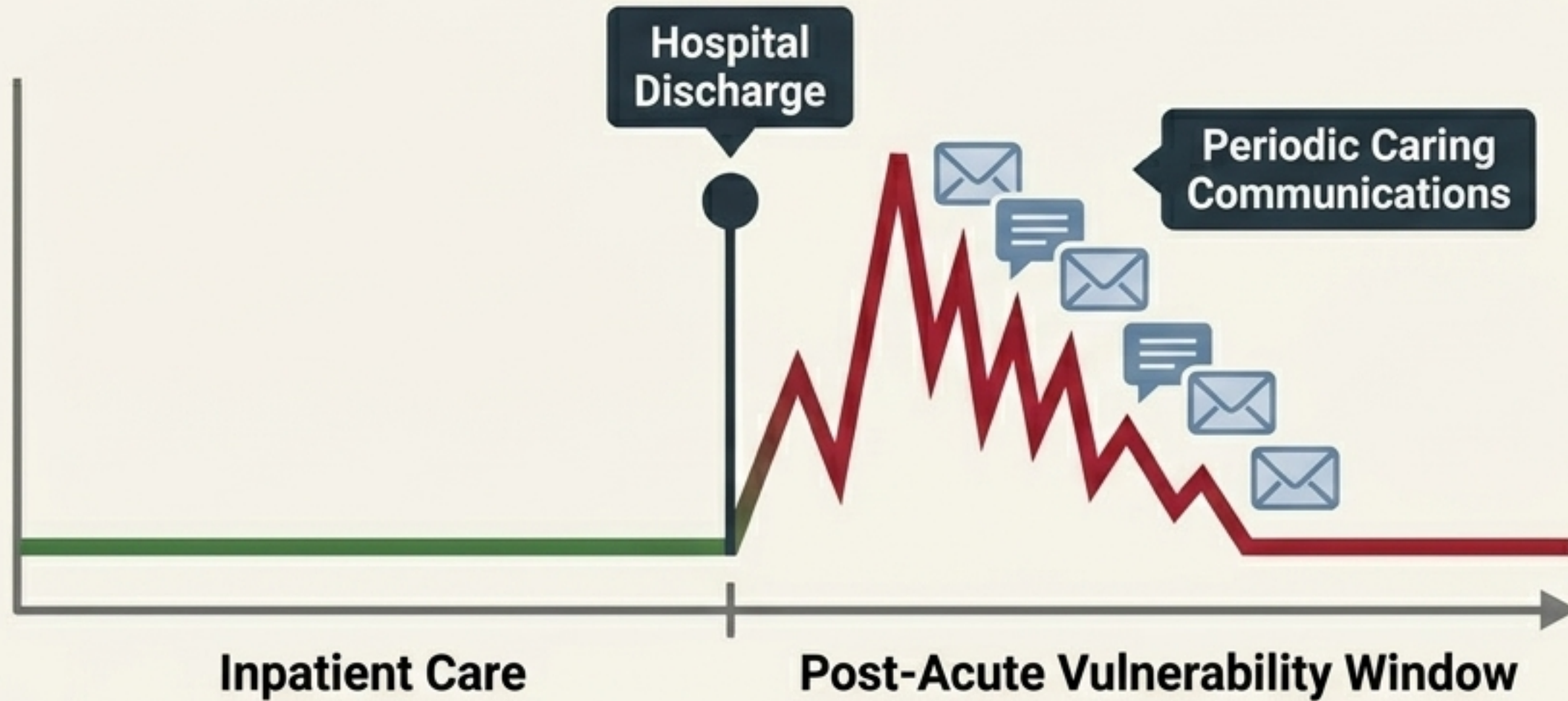
Digital Interventions: Suggest use of self-guided digital tools (apps/web) with CBT content for short-term ideation reduction (Recommendation 18).

Pharmacologic Interventions

Clozapine: Recommended for patients with schizophrenia/schizoaffective disorder and ideation/past attempts (Recommendation 11).

Ketamine Infusion: Suggested purely as an adjunctive treatment for short-term ideation reduction specifically in patients with Major Depressive Disorder (Recommendation 12).

System Integration | The Post-Acute Vulnerability Window

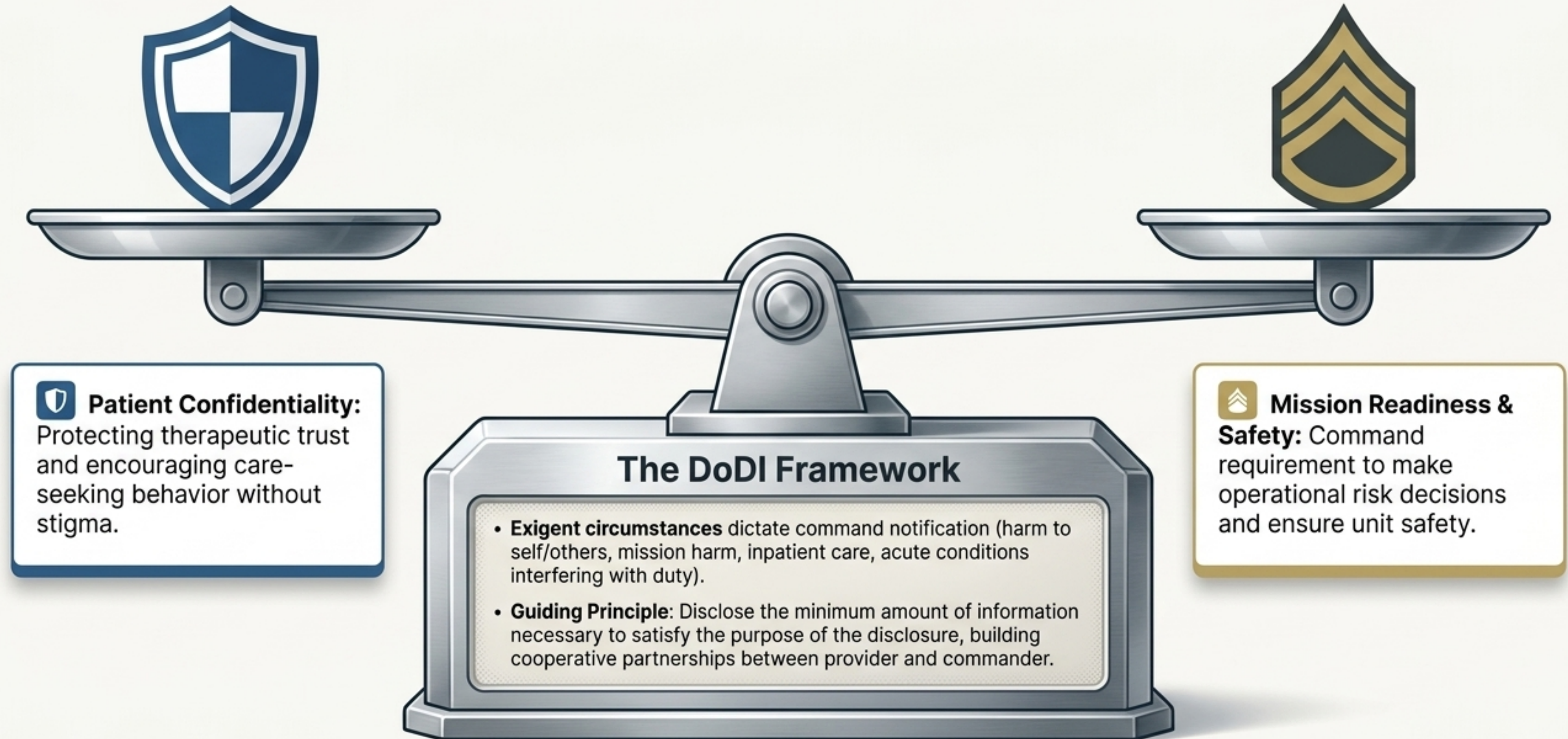


The period following acute care intervention is a **highly vulnerable transition**. Structured post-acute care provides a critical safety net.

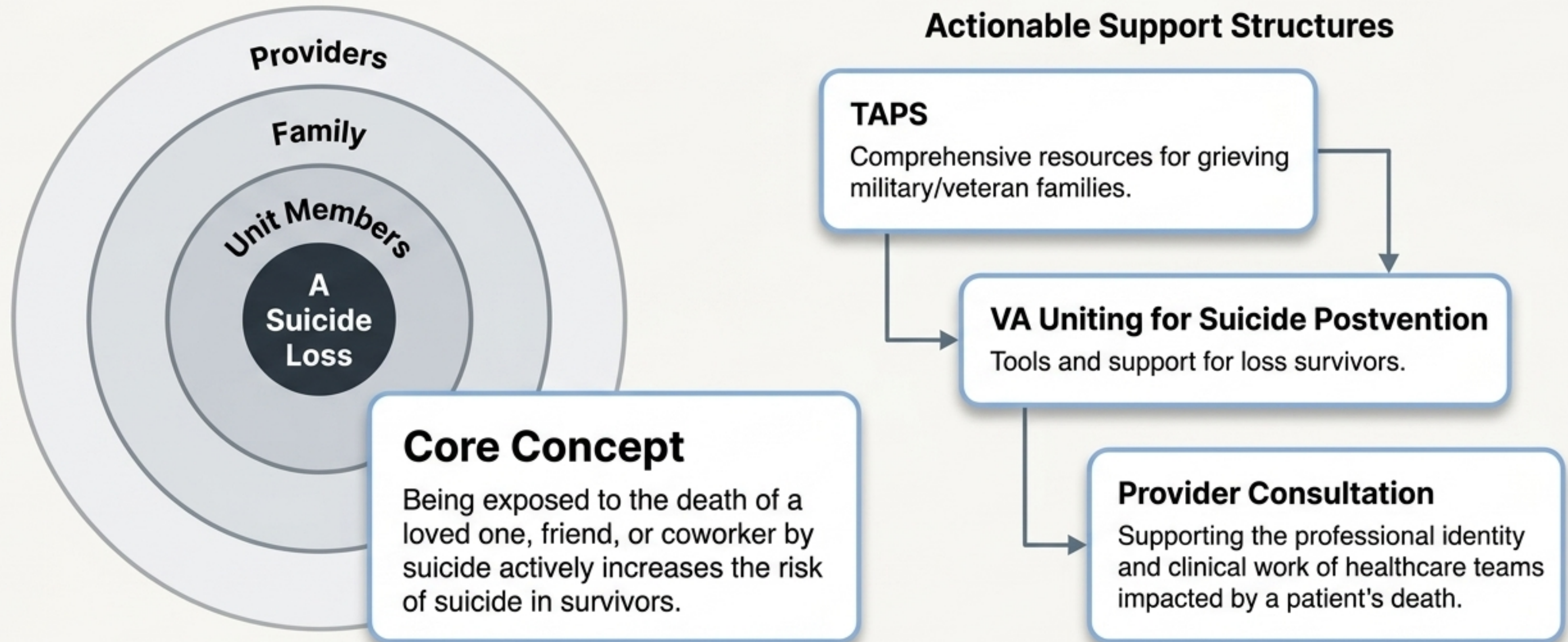
Recommendation Badge

We suggest sending periodic caring communications (e.g., postal mail, text messages) for 12 months following hospitalization related to suicide risk to reduce the risk of suicide attempts (Recommendation 16).

System Integration | Command Consultation (Active Duty)



System Integration | Postvention is Prevention



“Helping those who have been bereaved by suicide is a direct form of suicide prevention with a population known to be at risk.” — National Strategy for Suicide Prevention