



DEPARTMENT OF THE NAVY
NAVAL MEDICAL COMMAND
WASHINGTON, D.C. 20372

IN REPLY REFER TO

NAVMEDCOMINST 6520.1A
MEDCOM-34
31 Mar 86

NAVMEDCOM INSTRUCTION 6520.1A

From: Commander, Naval Medical Command

Subj: EVALUATION AND DISPOSITION OF PATIENTS PRESENTING WITH
SUICIDAL IDEATION OR BEHAVIOR

Encl: (1) Evaluating a Suicide
(2) Assessment of Suicidal Risk

(A)
(A)

1. Purpose. To provide guidance for the evaluation and disposition of patients presenting with suicidal ideation or behavior.

2. Cancellation. NAVMEDCOMINST 6520.1

3. Background. Psychiatrists and clinical psychologists, as well as physicians who are not specialists in mental health, are called upon to evaluate and treat patients presenting with suicidal ideation or behavior. Since lethality is difficult to predict, it is essential that the identification and management of patients presenting with suicidal ideation or behavior be carefully conducted. (R)

4. Action. Commanding officers and officers in charge of medical treatment facilities shall ensure that the following actions are accomplished in their facilities: (R)

a. There shall be a thorough evaluation of patients presenting with suicidal ideation or behavior. Enclosures (1) and (2) are provided for consideration in the conduct of this evaluation. All evaluations for suicidal ideation or behavior should be conducted by a psychiatrist or clinical psychologist whenever possible. However, if neither of these is available, then a physician with appropriate clinical privileges shall conduct the evaluation.

b. On occasions where a physician other than a psychiatrist must evaluate patients for suicidal ideation, the decision should always be to admit if the evaluation discloses evidence of suicidal ideation. The patient shall be admitted for an observation period subsequent to any suicidal behavior, whether viewed as a bona fide attempt or as a gesture.

c. Psychiatrists and clinical psychologists, as mental health specialists, have additional expertise in the evaluation and treatment of patients presenting with suicidal ideation or behavior. When one of these providers performs an evaluation, the patient may be either admitted to an inpatient psychiatric ward or provided with outpatient management and treatment.

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d. Written, facility-specific procedures for ensuring the safety and nonelopement of suicidal patients in an inpatient setting shall be developed, implemented, reviewed annually, and revised as needed according to the facility's quality assurance program. Further, there shall be a written, facility-specific protocol providing clear guidance for referral to appropriate civilian agencies for all nonactive duty patients presenting with suicidal ideation or behavior.

e. Adequate documentation in the patient's health record shall be made before release of any patient. When the initial evaluation reveals no suicidal ideation or behavior and no need for followup, an entry shall be made in the health record to document this. If followup evaluation or treatment on an outpatient basis subsequent to any action by medical authorities (evaluation or post-inpatient evaluation and treatment) is indicated, this also must be documented in the health record.

f. The medical component of the patient's operational unit will be informed as soon as possible of the results of the evaluation and proposed treatment plan. Recommendations for care at the operational unit should be made at this time. Further, the appropriate command element (commanding officer, executive officer, or duty officer) will be advised as soon as possible regarding a positive finding of suicidal ideation or behavior involving one of their personnel. Any recommendations for nonmedical management and administrative disposition by the command will be given at this time.

g. Comprehensive educational liaison between mental health professionals and other professional staff, as well as members of the fleet, shall be provided. The major emphasis should be upon the identification and evaluation of the potentially suicidal individual, and the subsequent appropriate action by professionals, commanders, supervisors, and shipmates.


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EVALUATING A SUICIDE

Here is a list of symptoms of potential suicide that may help you make a positive evaluation. They are in no special order and are not of equal weight, but the more of these symptoms the individual exhibits the more likely he or she is suicidal:

1. Means. Is a suitable suicidal tool available to the person? This factor carries double weight if the person frequently mentions that he or she has the means.
2. Previous Attempt. Recent studies corroborate that approximately 75 percent of accomplished suicides have made a previous attempt.
3. Family History. Statistically, persons who have had a suicide in the family (especially one or both parents) are more likely to commit or attempt suicide than those who have not.
4. Lack of Roots. Very few persons commit suicide in the town or region of their birth. The farther away from home, family connections, and close friends a person gets; the more likely suicide becomes.
5. Withdrawal. The potential suicide often systematically eliminates social contacts. He or she will drop out of clubs, church, job, and will avoid old friends. The person can then reasonably say, "I'm not needed."
6. Confusion. The potential suicide has a marked inability to separate and evaluate problems. He may say in the same breath, "My wife has left me and I'm two payments past due on the TV set." He or she cannot deal effectively with many problems because he or she cannot clear their mind of others.
7. A Vague Illness. The potential suicide will often complain about indefinite physical illness, an "ache all over feeling," or chronic psychosomatic signs are important because they reflect a high degree of disorganization.
8. Urge to Kill. The potential suicide may be seeking revenge, thinking, "You may be sorry when I'm gone." This is a dangerous attitude because it may give birth to homicide.
9. Fear of the Future. Although it sounds incongruous, many persons commit suicide because they fear death. "I know it's cowardly to think of suicide," they say, but actually they are thinking that if they can accomplish suicide they won't have to fear the things that really worry them.

Enclosure (1)

10. Financial Reverse. This situation may cause the loss of status as much as the loss of money.

11. Rationalization. Occasionally the potential suicide will attempt an aggressive defense of suicide. This is especially true where the person is following the footsteps of a relative.

12. Negative Protest. This is a tricky factor. If a person tells you in an overemphatic manner that he or she is not contemplating suicide, be careful.

13. A Feeling of Failure. Despite any past successes, the potential suicide will harp on his or her failures, even small ones. They will say they are inefficient, forgetful, and make mistakes that others notice.

ASSESSMENT OF SUICIDAL RISK

BEHAVIOR OR SYMPTOM	INTENSITY OF RISK		
	LOW	MODERATE	HIGH
Anxiety	Mild	Moderate	High, or panic state
Depression	Mild	Moderate	Severe
Isolation/ withdrawal	Vague feelings of depression, no withdrawal	Some feelings of helplessness, hopelessness, and withdrawal	Hopeless, helpless, withdrawn, and self-deprecating
Daily functioning	Fairly good in most activities	Moderately good in some activities	Not good in any activities
Resources	Several	Some	Few or none
Coping strategies	Generally constructive	Some that are constructive	Predominantly destructive
Significant others	Several who are available	Few or only one available	Only one, or none available
Psychiatric help in past	None, or positive attitude toward	Yes, and moderately satisfied with	Negative view of help received
Life style	Stable	Moderately stable or unstable	Unstable
Alcohol/drug use	Infrequently to excess	Frequently to excess	Continual abuse
Previous suicide attempts	None, or of low lethality	None to one or more of moderate lethality	None to multiple attempts of high lethality
Disorientation/ disorganization	None	Some	Marked
Hostility	Little or none	Some	Marked
Suicidal plan	Vague, fleeting thoughts but no plan	Frequent thoughts, occasional ideas about a plan	Frequent or constant thought with a specific plan