Suicidal Ideation
Clinical Practice Guideline

Overview of the Condition/Disease

Definitions:

- Suicide is death caused by self-directed injurious behavior with an intent to die as a result of the behavior
- Suicide Attempt is a non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury
- Suicide Gesture is a non-fatal, self-directed, potentially injurious behavior, but without the intent to die as a result; it may not result in significant physical harm; usually represents a signal of personal distress in individuals who have difficulty communicating that distress in more direct, effective ways; in individuals who underestimate the riskiness of the means they choose to harm themselves, their suicidal gestures may turn out to be inadvertent suicide attempts
- Suicidal Ideation is thinking about, considering, or planning suicide

Risk Factors:

- **History of previous suicide attempts, gestures, or threats:** This is the strongest single predictive factor. One of every 100 suicide attempt survivors will die by suicide within one year of their index attempt, a risk 100 times that of the general population. The risk is greatest in individuals with schizophrenia, unipolar major depression, and bipolar disorder.
- **Psychiatric Disorders:** 90% of individuals with a suicide attempt have a psychiatric disorder, which sometimes may not have been diagnosed. Psychiatric disorders most commonly associated with suicide include depression, bipolar disorder, alcoholism or other substance abuse, schizophrenia, personality disorders, anxiety disorders including panic disorder, posttraumatic stress disorders, and delirium. **Of note: Combinations of one or more of these disorders (e.g. depression and anxiety, depression, and alcohol abuse) can greatly increase the risk.**
- **Additional Psychiatric Factors:** Feelings of hopelessness, helplessness, low self-esteem or worthlessness, loss of control, or a dim view of the future.
- **Antidepressants:** While effective for treating depression and anxiety, these may sometime increase suicide risk in young adults (late teens and early 20's) during initial treatment, generally in the first few months.
- **Chronic Pain:** Multiple pain conditions, severe pain, more frequent episodes of intermittent pain (e.g. migraines), longer duration of pain (greater than 3 months), and insomnia.
- **General Medical Illness:** Cancer, chronic obstructive pulmonary disease, coronary artery disease, spine disorders, stroke, recent surgery, and chronic or terminal disease. Also, any sudden or chronically worsening medical problems that significantly compromised the ability to engage in personally meaningful activities (e.g., increasing blindness in a visual artist).

- **Social Isolation:** Lack of family and community supports or lack of connectedness to members of the individual's social network.
- **Sexual Orientation and Gender Identity:** Non-heterosexual individuals are 2-3 times more likely than heterosexuals to commit suicide.
- **Childhood or Recent Adversity:** Abuse (Sexual, physical, emotional, financial), physical neglect, loss of job, home, financial support, or persons to which they were close (e.g. due to death, divorce, relocation, etc.)
- **Family History:** Includes environmental and genetic components. The heritability of suicide is in the range of 30 to 50 percent. **Of note: It is not clear whether the genetic component is primarily responsible.**
- **Legal Problems:** first arrest, pre-sentencing hearing, upcoming trial, or other significant legal problems
- **Firearms:** Easy access to guns; Used in half of all suicides in the US
- **Military Service:** especially if individual is suffering from PTSD or post-traumatic guilt

Screening Tools

- **Columbia-Suicide Severity Rating Scale (C-SSRS):** The C-SSRS supports suicide risk screening through a series of simple, plain-language questions that anyone can ask. The answers help the facilitator identify whether someone is at risk for suicide, assess the severity and immediacy of risk, and gauge the level of support that person needs.

Best Practice Standards for Prevention and Management

Interventions can be offered after comprehensive evaluation to review risk and protective factors and identify targets for intervention.

- **Protective Factors:** Genuine connectedness to family, friends, or other sources of social support; parenthood, religiosity and active participation in religious activities; ready access to needed supports (e.g., medical and/or psychological services, financial assistance; etc.).
- **Risk Factors:** See page one of this clinical practice guideline
- **Current life stressors:** Losses or conflicts at home together with diminished coping capacity
- **Observation:** Observe whether the member seems disconnected, disengaged, or manifests a lack of rapport during interaction
- **Suicidal Ideation and Behavior:** Determine the presence of suicidal ideation, including content, intensity, frequency, and duration of the suicidal ideation through use of the C-SSRS screening tool.

Suicidal Ideation
Clinical Practice Guideline

Anticipating, Recognizing, and Responding to Symptoms

Seek timely medical attention when current interventions and/or medications are not managing symptoms.

Manifestation of symptoms:

- **Active Suicidal Ideation:** Thoughts of taking action to kill oneself. "I want to kill myself," "I want to end my life," or "I can't go on like this anymore and I don't want to be around anymore."
- **Passive Suicidal Ideation:** The wish or hope that death will overtake oneself. "I would be better off dead", "My family would be better off if I was dead" or "I hope I go to sleep and never wake up"

Interventions to Manage Symptoms

- **Medical Stabilization:** Member to receive appropriate medical interventions for an attempted suicide; surgical, stomach pumping, and antidotes as indicated. **Contact 911 for an attempted suicide or concern for threat of harm to self or others. A call to the police to perform a safety check can be a useful option in emergency situations.**
- **Appropriate Level of Care:** Involuntary hospitalization, inpatient hospitalization, partial hospitalization (day program), intensive outpatient program (i.e. 3 days/week for 3 hours), outpatient.
- **Involve People Close to Member:** Instruct supports that if member decompensates, member should return to emergency department and to **contact 911** if member refuses. Provide member and caregivers with local crisis numbers that are available 24 hours. **In acute, critical situations, identify a person (or persons) who can and will reliably act as a "lifeline," providing ongoing 1:1 support during the period of crisis, and assure their participation in this arrangement.**
- **Restrict Access to All Lethal Means of Suicide:** Firearms, medications/insulin, sharp objects, belts/rope, bedsheets, chemicals/cleansers, alcohol, etc.
- **Safety Plan:** Develop and implement a safety plan which is acceptable to both member and member supports, including means for coping. Ensure member has emergency services contact information, as well as the means and ability to communicate (i.e. adaptive equipment to make call for blind or deaf individual). Ensure all involved supports have a copy.
- **Crisis Plan:** This plan is developed and implemented with the member and the county crisis team where member resides. All providers working with the member should have a copy of this crisis plan.
- **Pharmacotherapy:** Psychiatrist and/or primary care provider (PCP) involvement with member's plan of care, particularly regarding ongoing medication management.
- **Psychotherapy:** Approach and treatment goals determined by clinician.

- **Confidentiality:** In life-threatening situations, communications necessary for the provision of care take priority over HIPPA regulations regarding patient confidentiality.
- **Follow Up:** Ensure follow up clinical care is scheduled with formal supports (i.e. PCP, Psychiatry, Therapy) and informal supports such that member feels connected and supported. Follow-ups may be as soon as later the same day or the next day, according to the level of risk. Identify and try to avoid triggers, identify specific coping strategies and healthy activities to manage or that distract member from suicidal ideation. **Of note: 1/3 of all suicides in the first year following discharge occur in the first month.**

Guidelines and Process for Interdisciplinary Team

- Care teams will complete suicide risk screening using the C-SSRS upon member's enrollment and at least every six months with care plan reviews.
- C-SSRS suicide risk screening may be warranted more often based on risk factors presented during contact with the member.
- Care teams will complete the C-SSRS screening within the member's MIDAS CM assessment.

Cultural Considerations

- In general: ethnic and cultural minority groups have continued to experience a disproportionate burden of disease, injury, premature death, and disability when compared to the white population
- Health disparities can mean lower life expectancy, decreased quality of life, loss of economic opportunities, as well as perceptions of injustice
- Health disparities are reflected in decreased productivity, increased health care costs, and social inequities
- Contributing factors to ethnic, cultural, and gender disparities:
    - Mistrust in the health care system (stemming from historical mistreatment or neglect)
    - Personal and group experiences of discrimination
    - Varying degrees of health literacy
    - Provider prejudice or unconscious bias
    - Low cultural competency and clinical humility among health care providers
    - Discordance in patient-provider gender, race, and/or ethnic background
    - Under representation of minority health care providers (only 19% of RNs in the workforce are from racial or ethnic minorities)
- While suicide can be a sensitive topic to discuss, it's important that it is addressed. Please be considerate of members at higher risk and make sure to provide education when necessary.

Suicidal Ideation
Clinical Practice Guideline

Quality Assurance Monitoring

Internal file reviews are completed by internal staff utilizing an assessment tool developed by the Quality Management Department. Peer to Peer reviews occur quarterly. Findings are shared with Program Management and staff.

Additional Resources

- Law Enforcement: 911
- National Suicide Prevention Lifeline: 988
- Dial 211 Wisconsin for support
- Crisis Text Line: Text HOME or HELP or HELLO to 741741
- Options for Deaf & Hard of Hearing: 1-800-799-4889
- Veterans Crisis Line: Call 1-800-273-8255 or Text 838255

- SAGE National LGBT Elder Hotline: 1-877-360-LGBT (5428)
    - English, Spanish, and translation in 180 languages available
- Trans Lifeline: 1-877-565-8860
- TrevorLifeline (LBGT for people ages 18-25): 1-866-488-7386 or Text START to 678-678
- Distress Helpline: Call 1-800-985-5990 or Text TalkWithUs to 66746
- Suicide Prevention Resource Center: https://www.sprc.org/
- National Institute of Mental Health: https://www.nimh.nih.gov/index.shtml
    - Suicide Prevention: https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml
- Substance Abuse & Mental Health Services Administration: 1-800-662-HELP (4357) https://www.samhsa.gov/
- National Drug Helpline: 1-844-289-0879

References

Centers for Disease Control and Prevention. (2021). Fast Facts. Retrieved from https://www.cdc.gov/suicide/facts/index.html

Rush, A. (2020). Effect of antidepressants on suicide risk in adults. In. P.P Roy-Byrne & D. Solomon (Ed), *UpToDate*. Retrieved February 19, 2021 from https://www.uptodate.com/contents/effect-of-antidepressants-on-suicide-risk-in-adults?topicRef=1708&source=see_link

Schreiber, J. & Culpepper, L. (2020). Suicidal ideation and behavior in adults. In. P.P. Roy- Byrne & D. Solomon (Ed.), *UpToDate*. Retrieved February 19, 2021 from https://www.uptodate.com/contents/suicidal-ideation-and-behavior-in-adults?search=suicidal-ideation-and-behavior

Substance Abuse and Mental Health Services Administration. Columbia Suicide Severity Rating Scale (C-SSRS). Retrieved from https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf