Suicidal Behaviors

OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations for the treatment of suicidal behavior. The CPG discusses suicide and behavioral health implications. In addition, the CPG outlines the organizations that WellCare aligns with regarding suicide and Measureable Health Outcomes.

OVERVIEW

Suicide ranks as the 10th leading cause of death in the United States; globally, an estimated 700,000 people take their own lives annually. Among adolescents and young adults, suicide constitutes 1 of the top 3 causes of death.[1] Men die by suicide 3.5 times more often than women; on average, there are 121 suicides per day. Firearms account for almost 50% of all suicides with the highest rate among adults between 45 and 64 years of age — especially White men who accounted for 7 of 10 suicides in 2015. The second highest rate (19%) occurred in those over age 85. Adolescents and young adults age 15 to 24 had a suicide rate of 12.5% in 2015.[2]

While there is not a total count of suicide attempts in the nation, the CDC collects data from hospitals on non-fatal injuries from self-harm. Over 494,000 people visited a hospital for injuries due to self-harm; this suggests that approximately 12 people harm themselves for every reported death by suicide. It is important to note that many suicide attempts go unreported or untreated. Estimates indicated that at least one million people nationwide engage in intentionally inflicted self-harm. Females attempt suicide three times more often than males. In 2015, the highest suicide rate was among American Indians and Alaska Natives followed by among Whites. Much lower and roughly similar rates were found among Hispanics, Asians and Pacific Islanders, and Blacks. Additional information on minorities and suicide can be found below under *Cultural Considerations.*[2]

Numerous activities are associated with suicidal potential, including the following: [1]

- Making a will
- Getting the house and affairs together
- Unexpectedly visiting friends and family members
- Purchasing a gun, hose, or rope
- Writing a suicide note
- Visiting a primary care physician - A significant number of people see their primary care physician within 3 weeks before they commit suicide.

Suicidal individuals have a number of characteristics, including the following: [1]

- A preoccupation with death
- A sense of isolation and withdrawal
- Few friends or family members
- An emotional distance from others
- Distraction and lack of humor (individuals often seem to be "in their own world" and lack a sense of humor)
- Focus on the past – for example, dwelling on past losses and defeats and anticipate no future; they voice the

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notion that others and the world would be better off without them
- Haunted and dominated by hopelessness and helplessness

Hierarchy of Support

GUIDELINE HIERARCHY

CPGs are updated annually or as necessary due to updates made to guidelines or recommendations by the American Psychiatric Association (APA). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to suicidal behavior, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with APA on the topic of suicidal behavior. Highlights from their respective publications are below.

AMERICAN PSYCHIATRIC ASSOCIATION (APA)

WellCare adheres to the 2003 *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors* published by the APA. The guideline can be viewed in its entirety here however highlights are below:[3]

- Components of assessing patients with suicidal behaviors including:
  - Conducting a thorough psychiatric evaluation;
  - Inquiring about suicidal thoughts, plans, and behaviors;
  - Establishing a multiaxial diagnosis;
  - Estimating suicide risk; and
  - Additional considerations when evaluating patients in specific treatment settings

- Components of psychiatric management of those with suicidal behaviors:
  - Establish and maintain a therapeutic alliance
  - Attend to the patient's safety
  - Determine a treatment setting
  - Develop a plan of treatment
  - Coordinate care and collaborate with other clinicians
  - Promote adherence to the treatment plan
  - Provide education to the patient and family
  - Reassess safety and suicide risk
  - Monitor psychiatric status and response to treatment
  - Obtain consultation, if indicated

- Treatment modalities including somatic therapies and psychotherapies.

- Documentation and Risk Management topics specific to suicide:
  - The usefulness and limitations of suicide contracts
  - Communication with significant others
  - Management of suicide in one's practice
  - Mental health interventions for surviving family and friends after a suicide

Evidence Based Practice

MEASUREMENT OF COMPLIANCE

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare's Clinical Policy Guiding Document titled *Quality Improvement.*

NOTE: To access Clinical Policy Guiding Documents visit www.wellcare.com – select the Provider tab, then "Tools" and "Clinical Guidelines".

Care Management

The goals for Care Management are to support the member's ability to self-manage his or her disease/disorder, minimize risks of suicide, assist member in developing a crisis plan, educating member on recognizing when to utilize crisis plan and remove barriers preventing member from implementing crisis plan, connecting member to appropriate treatment and resources and empowering and assisting member in achieving their goals.

Assessment. A clear and complete evaluation and clinical interview with regard to the following are used to determine the need for suicide intervention:[1]

- **Suicidal ideation.** Determine whether the person has any thoughts of hurting himself or herself.
- **Suicide plans**. If suicidal ideation is present, the next question must be about any plans for suicidal acts; the general formula is that more specific plans indicate greater danger.
- **Purpose of suicide.** Determine what the patient believes his or her suicide would achieve; this suggests how seriously the person has been considering suicide and the reason for death.
- **Potential for homicide**. Any question of suicide also must be coupled with an inquiry into the person's potential for homicide.

Circumstances in Which a Suicide Assessment May Be Indicated Clinically[2]

- Emergency department or crisis evaluation
- Intake evaluation (on either an inpatient or an outpatient basis)
- Before a change in observation status or treatment setting (e.g., discontinuation of one-to-one observation, discharge from inpatient setting)
- Abrupt change in clinical presentation (either precipitous worsening or sudden, dramatic improvement)
- Lack of improvement or gradual worsening despite treatment
- Anticipation or experience of a significant interpersonal loss or psychosocial stressor (e.g., divorce, financial loss, legal problems, personal shame or humiliation)
- Onset of a physical illness (particularly if life threatening, disfiguring, or associated with severe pain or loss of executive functioning)

The following is a list of 12 things that should alert a clinician to a real suicide potential:[1]

1. **Patients with definite plans to kill themselves**. People who think or talk about suicide are at risk; however, a patient who has a plan (e.g., to get a gun and buy bullets) has made a clear statement regarding risk of suicide
2. **Patients who have pursued a systematic pattern of behavior in which they engage in activities that indicate they are leaving life.** For example, saying goodbye to friends, making a will, writing a suicide note, and developing a funeral plan.
3. **Patients with a strong family history of suicide.** Risk increases when approaching the anniversary of a family member's suicide or the age at which a relative committed suicide.
4. **The presence of a gun, especially a handgun.**
5. **Being under the influence of alcohol or other mind-altering drugs.**
6. **Encountering a severe, immediate, unexpected loss.** For example, being fired suddenly or left by a spouse.
7. **If the patient is isolated and alone.**
8. **If the person has a depression of any type.**
9. **If the patient experiences command hallucination*.** Can be a powerful message of action leading to death.
10. **Discharge from psychiatric hospitals.** This is a very difficult time of transition and stress; the structure,

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support, and safety of the institution are no longer available to the patient and may increase their risk of suicide.
11. **Anxiety.** The constant sense of dread and tension proves unbearable for some
12. **Clinician's feelings**. Regardless of what the patient says or does, clinician observation is vital.

* A command hallucination is an auditory hallucination that instruct a patient to act in specific ways; these commands can range in seriousness from innocuous to life-threatening.

Looking at the following patient characteristics, the mental status review is designed to focus on evaluating an individual's potential for committing suicide:[1]

- **Appearance.** In addition to noting the dress and hygiene of patients who are depressed, clinicians should assess for physical evidence of suicidal behavior (e.g., wrist lacerations, neck rope burns).
- **Affect.** Pay attention to a flat affect by the patient when describing his or her thoughts and plans of suicide.
- **Thoughts.** Three types of thought changes represent areas for major focus and concern: (1) command hallucinations (usually auditory) telling the patient to kill himself or herself, (2) delusions about the benefits of suicide (e.g., family will be better off), (3) an obsession with taking his or her own life.
- **Homicidal potential.**
- **Judgment, insight, and intellect.**
- **Orientation and memory.** The focus of this is to determine if the person is delirious or has dementia.

Intervention. Intervention for a suicidal patient should consist of multiple steps, as follows:[1]

- The individual must not be left alone
- Anything that the patient may use to hurt or kill himself or herself must be removed
- The suicidal patient should be treated initially in a secure, safe, and highly supervised place; inpatient care at a hospital offers one of the best settings

After the initial intervention, which usually includes hospitalization, it is critical that there be in place an ongoing management treatment plan.

MEASURABLE HEALTH OUTCOMES

Targeted Case Management outcomes (**Extended Program Goals)** result from successful self-management (see Case Management Objectives).

- **Symptoms**: Member will score <20 on the PHQ9 and will reply “several days” or “none at all” on question 9 regarding thoughts of self-harm within 90 days
- **Adherence**: Member will attend >75% of behavioral health appointments within 90 days
- **Engagement:** Member will be able to list at least three supportive people and at least two reasons for living within 90 days
- **Utilization:** Member will have a reduction of ER visits and inpatient admissions related to suicide attempts or ideation by >30% as evidenced by medical claims and service authorizations within 90 days

CASE MANAGEMENT GOALS

Goals should target specific care gaps and/or adherence issues, and measure the member’s progress towards self-management and adherence which lead to the targeted health outcomes above.

- **Symptoms**: Member will obtain a mood journal and list at least 3 personal goals related to personal control, problem-solving and/or self-esteem within 30 days
- **Symptoms**: Member will list at least 3 positive coping skills for thoughts of self-harm and share with CM or provider within 90 days
- **Symptoms:** Member will list at least 3 symptoms of behavioral health diagnosis and at least 2 treatment options within 30 days
- **Adherence:** Member will be connected to and attend appointments with a therapist and/or psychiatrist within 30 days
- **Engagement:** Member will list at least 2 protective factors that can be obtained, such as improved support system, connection to religious or spiritual organization, securing employment or involvement in a volunteer, vocational rehabilitation program or hobby or social activity within 90 days

- **Engagement:** Member write a list of at least 3 people or agencies to call if symptoms start getting worse and hang list where it is easily accessible within 30 days
- **Engagement:** Member will list at least 3 negative effects that alcohol or illicit substance have on the brain or the body within 30 days
- **Utilization:** Member will be able to list at least 3 warning signs of suicide and utilize crisis prevention plan prior to visiting ER or admitting to BH inpatient unit within 90 days

CASE MANAGEMENT OBJECTIVES

- Identify risk of suicide; such as past attempts, substance abuse, history of impulsivity, history of trauma, stressful life events, family history of suicide attempts and protective factors; such as strong support system, being a caregiver, having stable housing and employment and strong religious beliefs
- Assess for plan and intent and for access to lethal means of completing suicide such as firearms, knives, medications and chemicals and work with member and family to reduce access to means
- Work with member as well as caregiver and behavioral health provider on creating a crisis intervention plan including securing or removing potential weapons or other threats from environment, having a list of people to call, and having a safe place to go in time of crisis
- Refer member to crisis hotline and suicide prevention support group or mental health support and education group through agencies such as NAMI and DBSA
- Educate member on their mental health diagnosis including symptoms, treatment and recognizing signs of decompensation and warning signs of suicide
- Educate member on dangers of overdosing on medications such as opiates, benzodiazepines, acetaminophen and aspirin and work with member, family and providers on limiting amounts of medications available to member
- Refer member to therapist, specifically those trained in CBT or DBT if possible
- Refer member to psychiatrist for medication management
- Refer member to Cobalt if possible
- Screen for alcohol or substance abuse and connect member to appropriate substance abuse treatment if needed.
- Educate on medications used for management of depression and suicide.
  - Lithium has been associated with reduced risk of suicide in patients. Education on recognizing signs of Lithium toxicity and the importance of regular blood level monitoring and BUN and Creatinine levels
  - Antidepressants are effective treatment for depression but may increase the risk of suicide in children and adolescents and the elderly

MEDICAL BEHAVIORAL INTEGRATION

Major physical or chronic illnesses, including chronic pain place members at an increased risk for suicide, as do mild dementia, epilepsy and any medically unexplained complaints.

MEMBER EDUCATIONAL RESOURCES

There are no Krames/StayWell publications at this time on the topic of suicide behavior. It is critical for patients to appreciate that suicidal behavior reflects mental illness. Moreover, the patient's family needs to see the patient's behavior as a sign of an underlying problem. Family members often struggle with a series of conflicting feelings about the patient's suicidal activities. Education and an opportunity to discuss their feelings can help. The following resources may also be helpful to members:

- **American Association of Suicidology** - http://www.suicidology.org/
- **CDC Suicide Prevention** - http://www.cdc.gov/ViolencePrevention/suicide/
- **National Institute of Mental Health Suicide Prevention** http://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml

SPECIAL CONSIDERATIONS

Ketamine. The injectable anesthetic ketamine may reduce suicidal ideation independently of its effects on depressive symptoms and anxiety, according to an analysis of data from four independent clinical studies examining the use of this agent in 133 patients with treatment-resistant depression, including 57 patients who had suicidal thoughts at baseline. At 230 minutes after a single subanesthetic infusion of ketamine (0.5 mg/kg), correlations between changes in suicidal

ideation and depression ranged from 0.23 to 0.44 (P < .05), accounting for up to 19% in the variance of ideation change, and correlations with anxiety ranged from 0.23 to 0.40 (P < .05), accounting for similar levels of variance.[3] After the effects of ketamine on depression (F1587 = 10.31; P = .001) and anxiety (F1567 = 8.54; P = .004) were controlled for, ketamine infusion significantly reduced suicidal ideation in comparison with placebo.[1]

Related WellCare Guidelines

In addition to the information contained in this document, please reference the following CPGs:

- *Anxiety Disorders: HS-1057*
- *Behavioral Health Conditions and Substance Use in High Risk Pregnancy: HS-1040*
- *Behavioral Health Screening in Primary Care Settings: HS-1036*
- *Bipolar Disorder: HS-1017*
- *Child and Adolescent Behavioral Health: HS-1049*
- *Depressive Disorders Adults, Children & Adolescents: HS-1022*
- *Gender Reassignment, Transgender Issues: HS-1059*
- *Opiate Use Disorder and Treatment: HS-1053*
- *Persons with Serious Mental Illness and Medical Comorbidities: HS-1044*
- *Post-Traumatic Stress Disorder: HS-1048*
- *Schizophrenia: HS-1026*
- *Substance Use Disorders: HS-1031*

Information related to suicide prevention can also be found in the following age-specific Preventive Health CPGs: *Adolescent (HS-1051), Adult (HS-1018)* and *Older Adult (HS-1063).*

NOTE: Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then "Tools" and "Clinical Guidelines".

References

1. Soreff, S. Suicide. MedScape Web site. http://emedicine.medscape.com/article/2013085-overview. Updated December 7, 2017. Accessed April 18, 2018.
2. Suicide Statistics. American Foundation for Suicide Prevention Web site. https://afsp.org/about-suicide/suicide-statistics/. Accessed April 18, 2018.
3. Practice guideline for the assessment and treatment of patients with suicidal behaviors. American Psychiatric Association Web site. https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf. Published 2003. Accessed April 18, 2018.
4. Racial and Ethnic Minority Populations. Substance Abuse and Mental Health Services Administration Web site. https://www.samhsa.gov/specific-populations/racial-ethnic-minority. Updated January 17, 2018. Accessed April 18, 2018.
5. Suicide Prevention Resource Center. (2013). *Suicide among racial/ethnic populations in the U.S.: Blacks.* Waltham, MA: Education Development Center, Inc. http://www.sprc.org/sites/default/files/migrate/library/Blacks%20Sheet%20August%2028%202013%20Final.pdf. Accessed April 18, 2018.
6. Suicide Prevention Resource Center. (2013). Suicide among racial/ethnic populations in the U.S.: Hispanics. Waltham, MA: Education Development Center, Inc. http://www.sprc.org/sites/default/files/migrate/library/Hispanics%20Sheet%20Aug%2028%202013%20Final.pdf. Accessed April 18, 2018.
7. Hersh K, Borum R. Command Hallucinations, Compliance, and Risk Assessment. http://jaapl.org/content/jaapl/26/3/353.full.pdf. Accessed April 18, 2018.

Disclaimer

Medical Policy Committee Approval History

Date	History and Revisions by the Medical Policy Committee
5/3/2018	• Approved by MPC. No changes.
6/28/2017	• Approved by MPC. Enhanced Care Management and Measures of Compliance sections. Revised with CM, DM, QI, UM, BH and the Chief Medical Directors.
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