This care process model (CPM) was developed by Intermountain’s Behavioral Health Clinical Program. Informed by guidelines from the American Association of Suicidology and the Center for Suicide Risk Assessment at Columbia University Medical Center, this CPM provides guidance for prevention, assessment, and treatment for patients with suicidal thoughts, feelings, or behaviors. This CPM focuses on prevention and treatment in primary care, emergency departments, and hospitals, though may also be applied to other clinical environments.

Why Focus on Suicide Risk?

- Suicide is a leading cause of preventable death in Utah.\(^{vipp}\) An average of 501 Utahns die from suicide, and 3,698 Utahns attempt suicide each year.\(^{vipp}\) According to the CDC, Utah adults have the highest incidence of suicidal thoughts in the U.S. — 6.8% of Utah adults reported having suicidal thoughts during 2008–2009; the national average during the same period was 3.7%.\(^{cro}\)

- Primary care providers (PCPs) and mental health (MH) providers are positioned to help. A significant portion of patients who died by suicide visited healthcare providers in the year before they died by suicide (see table at right).\(^{av}\) Screening for suicide could help identify patients at risk and reduce suicide in our community.

- Many Utahns who died by suicide had an addictive substance in their system. According to the 2012 Utah Toxicology Report, the most common substances found in victims who died by suicide fell into the “other” category (43.9%), which includes OTC drugs and benzodiazepines. Next most common substances were alcohol (33.3%), antidepressants (24%), and opiates (21.3%).\(^{udh}\) Monitoring patients’ drug use and access to substances could help prevent suicides.

- Suicide affects more than just the person who attempts or dies by suicide. A 2002 study found that 7% of the U.S. population knew someone who died of suicide during the past 12 months. The death of a loved one by suicide is, in itself, a risk factor for suicide and contagion is a real concern.

- Suicide strains the economy. Suicide costs the U.S. economy approximately $34.6 billion a year in combined medical and work loss costs; each suicide costs an average of more than $1 million.\(^{cdc}\)

<table>
<thead>
<tr>
<th>TABLE 1: Percent of patients who visited a PCP or MH provider before suicide</th>
<th>MH provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>1 month</td>
</tr>
<tr>
<td>All</td>
<td>45%</td>
</tr>
<tr>
<td>≤35 years</td>
<td>23%</td>
</tr>
<tr>
<td>≥55 years</td>
<td>58%</td>
</tr>
</tbody>
</table>

Screening with the Columbia-Suicide Severity Rating Scale (C-SSRS)

Appropriate screening may identify patients at increased risk of suicide who need treatment, and psychotherapy can prevent suicides.\(^{soc}\) Intermountain recommends screening adult and pediatric patients per the algorithms in this CPM — and measures providers’ screening practices. Intermountain uses the Columbia-Suicide Severity Rating Scale (C-SSRS) for several reasons:

- It provides consistent language to enable tracking and measurement of suicide prevention efforts and patient population risk over time.
- It is well-validated, and it reduces false positives,\(^{sot}\) enabling us to focus on the right patients.
- It has become a local standard in Utah. The State Office of Education, the Utah Department of Human Services, and others have begun using the C-SSRS.

What’s Inside?

- THE C-SSRS
- ALGORITHMS AND TREATMENT GUIDELINES
- RISK AND PROTECTIVE FACTORS
- SPECIAL POPULATIONS
- CONSIDERATIONS FOR CARE
- PREVENTION AT INTERMOUNTAIN
- UNIFORM TERMINOLOGY
- REFERENCES

Measurement & Goals

- Reduce the suicide rate in our communities and our system
- Establish reliable incidence and prevalence rates within the Intermountain system
- Integrate proven tools for identifying and screening patients in emergency departments (EDs), primary care, Behavioral Health (BH) clinics, and other appropriate settings
- Modify risk factors (e.g., mental and physical health problems) when possible and refer to specialized treatment when necessary
- Coordinate our resources (between primary care, MHI clinics, community resources, EDs, and so on) to reduce patient suffering and improve access to resources
- Drive appropriate use of Patient Safety Attendants (PSAs) in EDs
KEY POINTS

- Intermountain uses several versions of the C-SSRS to consistently identify and track patient suicide ideation and behaviors across the continuum of care.
- Different versions of the C-SSRS have the same questions. The algorithms on pages 4–9 guide which assessment to use.
- All versions of the C-SSRS are integrated into iCentra, with decisions and education links based on patient responses.
- Safety planning is a critical and proven component of managing these patients. Intermountain has a Safety Plan that provides patients with a tool they can use when suicidal thoughts arise after discharge. (See page 16 for more information.)

THE C-SSRS

The Columbia-Suicide Severity Rating Scale (C-SSRS) helps clinicians classify a person’s suicidal ideation and behavior, determine levels of risk, and make clinical decisions about care. It also standardizes the assessment method and terminology across Intermountain. (See page 11 for terminology and definitions.) Intermountain uses several versions of the C-SSRS, as defined briefly in the table below and described in detail on the next page.

Why screen?

The effect of screening is challenging to measure. However, a systematic review by the U.S. Preventative Services Task Force (USPSTF) found that screening could likely identify adult patients at increased risk of suicide who may need treatment. Evidence also shows that psychotherapy can reduce the risk of suicide attempts. Many people who die by suicide have sought medical care in the year prior to their deaths; this suggests that these moments of contact may present an opportunity to intervene and possibly prevent suicide.

Does screening increase suicide?

Many clinicians are concerned that talking or asking about suicide may prompt suicidal behaviors or ideation in children or adolescents, but this is not supported by evidence. A 2005 randomized controlled trial found that students exposed to suicide questions were no more likely to report suicidal ideation than students who weren’t exposed to suicide questions.

TABLE 2: C-SSRS versions

<table>
<thead>
<tr>
<th>C-SSRS Version</th>
<th>Description</th>
<th>Who administers this screen?</th>
<th>History period assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult/Adolescent (≥12 years) Quick Screen</strong></td>
<td>Used in primary care and EDs to quickly screen patients for suicidal thoughts and behaviors; 3–6 questions (depending on patient responses).</td>
<td>Any clinician can administer this screen. At Intermountain, the Quick Screen is used by: PCPs treating patients at low risk</td>
<td>Past month</td>
</tr>
<tr>
<td><strong>Pediatric (≤11 years), Quick Screen</strong></td>
<td>Used in primary care and EDs to quickly screen patients for suicidal thoughts and behaviors; same questions as adult version, but asked in an age-appropriate manner.</td>
<td>PCPs treating patients at low risk</td>
<td>Lifetime and past 1 month</td>
</tr>
<tr>
<td><strong>Adult/Adolescent (≥12 years) Lifetime/Recent Assessment</strong></td>
<td>Used for full assessment during initial visit; 2-page assessment (number of questions varies based on patient responses).</td>
<td>Any MD, Mental health specialists, ED crisis workers, Other trained clinicians</td>
<td>Since last visit/since last assessment</td>
</tr>
<tr>
<td><strong>Pediatric (≤11 years) Lifetime/Recent Assessment</strong></td>
<td>Used for full assessment during initial visit; same questions as adult version, but asked in an age-appropriate manner.</td>
<td>Trained MH team members (care managers, health advocates, etc.)</td>
<td>Current risk</td>
</tr>
<tr>
<td><strong>Adult/Adolescent (≥12 years) Since Last Visit Version</strong></td>
<td>Used to assess patient at follow-up visits; same questions as the Lifetime/Recent versions.</td>
<td>Treated patients at low risk</td>
<td>Since last visit/since last assessment</td>
</tr>
<tr>
<td><strong>Pediatric (≤11 years) Since Last Visit Version</strong></td>
<td>Used to assess the patient’s level of risk during initial visit and over time; 1-page list of suicide risk and protective factors.</td>
<td>Treated patients at low risk</td>
<td>Since last visit/since last assessment</td>
</tr>
<tr>
<td><strong>Suicide Prevention — Risk Assessment Tool</strong></td>
<td>Used to assess the patient’s level of risk during initial visit and over time; 1-page list of suicide risk and protective factors.</td>
<td>Treated patients at low risk</td>
<td>Since last visit/since last assessment</td>
</tr>
</tbody>
</table>
The **C-SSRS Quick Screen** safety measures

The C-SSRS Quick Screen is used in settings across Intermountain as the initial screen for suicidal thoughts and behaviors. The table below indicates:

- The risk level based on a positive response to each question
- Actions to take in each setting based on patient responses

The algorithms that follow (on pages 4 through 9) provide the steps for asking these questions. (You can skip questions based on patient responses.)

**TABLE 3: Patient safety measures and response protocols based on Quick Screen responses**

<table>
<thead>
<tr>
<th>C-SSRS Quick Screen questions (in the last month)</th>
<th>Action if patient response “Yes”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
<td>Level of risk</td>
</tr>
<tr>
<td></td>
<td>“Yes” indicates</td>
</tr>
<tr>
<td>1. Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>Wish to be dead</td>
</tr>
<tr>
<td>2. Have you actually had any thoughts of killing yourself?</td>
<td>Nonspecific thoughts</td>
</tr>
<tr>
<td>3. Have you been thinking about how you might kill yourself?</td>
<td>Thoughts with method (without specific plan or intent to act)</td>
</tr>
<tr>
<td>4. Have you had these thoughts and had some intention of acting on them?</td>
<td>Intent (without plan)</td>
</tr>
<tr>
<td>5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td>Intent with plan</td>
</tr>
<tr>
<td>6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?</td>
<td>Behavior</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ALGORITHM: SUICIDE ASSESSMENT AND PREVENTION – CLINIC CARE

PREVENTION at Intermountain and in Utah (see page 10)

Patient screens positive for suicide on PHQ-9 (1–3 to question 9) or clinical suspicion of suicidal ideation or behaviors present (a)

SCREEN for suicide risk using the C-SSRS Quick Screen (see page 2) (PCP or MA)

ASK Question 1 (b):
Have you wished you were dead or wished you could go to sleep and not wake up?

ASK Question 2:
Have you actually had any thoughts of killing yourself?

If yes to 1, no to 2

ASK Question 3:
Have you been thinking about how you might kill yourself?

If yes to 3

ASK Question 4:
Have you had these thoughts and had some intention of acting on them?

ASK Question 5:
Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

ASK Question 6 (b):
Have you ever done anything, started to do anything, or prepared to do anything to end your life?

For LOW risk:
• Consider referral to MHI or BH provider (c)
• Consider patient education (d)

For MODERATE risk:
• Assess risk factors (e) and either facilitate evaluation for inpatient admission or complete Safety Plan with follow-up within 24–48 hours
• Educate patient (d)

For HIGH risk:
• Facilitate immediate evaluation (f)
• Educate the patient (d)

If yes to 6

Indicates an Intermountain measure

Note: Patient response to question 6 may increase risk and result in additional steps.
CLINIC CARE ALGORITHM NOTES AND ADDITIONAL ROLES

(a) Clinical suspicion of suicidal ideation

The PCP determines clinical suspicion of suicidal ideation based on history, presentation, self-harm behaviors, etc. If the PCP has any clinical suspicion, the patient should receive the C-SSRS Quick Screen (Adult/Adolescent or Pediatric).

The C-SSRS informs, but does not replace, clinical judgment. If any clinician has a suspicion of suicide risk, initiate the referrals and safety measures at the level deemed appropriate.

(b) Questions 1 and 6: Ideation and Behaviors

At a minimum, you’ll ask questions 1 and 6, which ask the patient about ideation and behaviors. Question 6 can increase a patient’s risk level, even if Question 1 is negative. (A patient who answers “no” to question 1 but “yes” and “in the past 4 weeks” for question 6 is high risk.)

(c) Tips for facilitating a referral

See page 16 for tips for increasing the likelihood that the patient will follow through on the referral.

(d) Patient education

Use the following Krames HealthSheets to educate the patients about suicide. These sheets also provide links to suicide support lines (NIMH, NAMI, NMHA, and the National Suicide Hotline).

- Recognizing Suicide Warning Signs in Yourself
- Warning Signs of Suicide and What You Can Do
- Recognizing Suicide Warning Signs in Others
- Depression and Suicide in Older Adults

See page 19 for access and printing directions.

(e) Risk/protective factors and admission/discharge criteria

Base decisions to admit and discharge patients on the patient’s risk and protective factors, as well as admission and discharge criteria.

See pages 12 and 13.

(f) Further evaluation and referral for high-risk patients

For high-risk patients, evaluate the patient and use clinical judgment and C-SSRS tools (see page 2) to assess level of risk. MHI team members and MAs can support each step.

<table>
<thead>
<tr>
<th>DO</th>
<th>CONSIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Administer the C-SSRS Lifetime/Recent Version (Adult/Adolescent or Pediatric version) to further assess the patient. Although some questions are the same as the C-SSRS Quick Screen, re-asking the questions helps develop a risk profile using the Risk Assessment Tool.</td>
<td>• Have someone sit with the patient if you consider the patient to be a risk to him or herself.</td>
</tr>
<tr>
<td>• Complete the Intermountain Safety Plan with the patient. (See page 16.)</td>
<td>• Urgent referral to the ED if immediate risk exists.</td>
</tr>
<tr>
<td>• Follow up with the patient in 2–3 days.</td>
<td></td>
</tr>
</tbody>
</table>

(g) Team members

Different team members in the clinic support the patient depending on availability and patient risk. If an immediate risk exists, have someone sit with the patient until you’ve facilitated the next appropriate intervention. The following team members may be involved in the process, as well as others:

- Primary care provider
- MHI coordinators
- Care managers
- Health advocates
- Mental health specialists
- The patient’s family members
ALGORITHM: SUICIDE ASSESSMENT AND PREVENTION – EMERGENCY CARE

Patient presents with mental health concern or clinical suspicion of suicidal ideation present (a)

SCREEN for suicide risk using the C-SSRS Quick Screen (see page 2) (triage nurse)

ASK Question 1 (b):
Have you wished you were dead or wished you could go to sleep and not wake up?

ASK Question 2:
Have you actually had any thoughts of killing yourself?

no to 1, yes to 2 OR yes to both

ASK Question 3:
Have you been thinking about how you might kill yourself?

ASK Question 4:
Have you had these thoughts and had some intention of acting on them?

ASK Question 5:
Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

ASK Question 6 (b):
Have you ever done anything, started to do anything, or prepared to do anything to end your life?

CRISIS WORKER (g) and ED DOCTOR (i) determine inpatient admit, discharge (d), etc.

LOW risk
- Consider referral to MHI or BH provider (c) at discharge from ED (d)
- Consider patient education (e)

MODERATE risk
- Initiate nursing interventions (f)
- Order crisis worker evaluation (g)
- Psychiatric consult recommended (h)

HIGH risk
- Initiate nursing interventions (f)
- Order patient safety attendant (PSA) (c) until crisis worker evaluation complete
- Notify ED physician (j)
- Order crisis worker evaluation (g)
- Psychiatric consult highly recommended (h)

MOD risk
- Order crisis worker evaluation (g)
- Psychiatric consult recommended (h)

LOW risk
- Consider referral (c) at discharge from ED (d)
- Consider patient education (e)

Note: Patient response to question 6 may increase risk and result in additional steps.
## Suicide Prevention

### Have patient change into hospital gown (may leave on underwear).

### Recognizing Suicide Warning Signs in Yourself

#### Make admit/discharge decision (based on risk assessment, or)

#### Secure room (remove plastic bags, secure needles, secure cords, etc.)

#### Complete the Intermountain Safety Plan with the patient. (See page 16.)

#### Work with the ED doctor and on-call psychiatrist as applicable to make decisions:
- Take a recommendation to the ED doctor/determine next steps.
- Make admit/discharge decision (based on risk assessment, admission/discharge criteria, etc., see page 12).

### Secure room (remove plastic bags, secure needles, secure cords, etc.).

### Recognizing Suicide Warning Signs in Yourself

#### Warning Signs of Suicide and What You Can Do

- **Do I feel restless and unable to sit still?**
- **Do I eat more or less than usual?**
- **Have I been feeling sad, down, or blue on most days?**
- **Do I feel life isn’t worth living?**
- **Do I cry more than usual?**
- **Do I feel hopeless?**
- **Suddenly being happy or calm after being depressed, a serious but treatable illness. Once it is treated, suicidal thinking often goes away.**
- **Help by getting the person to a trained professional.**
- **Don’t try to handle this alone.**
- **Get Help.**

### Recognizing Suicide Warning Signs in Others

#### Warning Signs of Suicide and What You Can Do

- **Feeling that death is the only solution to your problems**
- **Giving away things you own**
- **Buying a gun or other weapon**
- **Suddenly being happy or calm after being depressed, a serious but treatable illness. Once it is treated, suicidal thinking often goes away.**
- **Help by getting the person to a trained professional.**
- **Don’t try to handle this alone.**

### Emotional Well-Being

#### Give them your phone number or contact information.

### Additional Resources

#### Mental Health America

- **800-784-2433 (800-SUICIDE)**
- [www.nmha.org](http://www.nmha.org)

#### National Alliance on Mental Illness

- **866-615-6464 www.nami.org**

#### National Institute of Mental Health

- **800-969-6642 www.nimh.nih.gov**

### Crisis Worker Evaluation

- **Administer the C-SSRS Lifetime/Recent Version** *(Adult/Adolescent or Pediatric).* Although some questions are the same as the C-SSRS Quick Screen, the crisis worker asks all questions to develop a risk profile using the **Risk Assessment Tool.**

- **Complete the Intermountain Safety Plan with the patient. (See page 16.)**

- **Work with the ED doctor and on-call psychiatrist as applicable to make decisions:**
  - Take a recommendation to the ED doctor/determine next steps.
  - Make admit/discharge decision (based on risk assessment, admission/discharge criteria, etc., see page 12).

### Psychiatric Consult

The on-call psychiatrist should be consulted before the patient is discharged for all high-risk patients. A psychiatric consult is recommended before discharge for moderate-risk patients.

### Patient Safety Attendant (PSA)

PSAs often attend to multiple patients at the same time. Assign a PSA only when there is a high risk based on clinical judgment or when the patient answers “yes” to any of questions 4 to 5 and/or 6 (past 4 weeks). The crisis worker or ED doctor can call off the PSA.

### ED Doctor

The ED doctor determines next steps (admit, discharge, etc.) by weighing other health concerns and level of suicide risk.

**Note:** If the Crisis Worker is delayed, the ED doctor can administer the C-SSRS Lifetime/Recent Version *(Adult/Adolescent or Pediatric)* and the **Risk Assessment Tool.**

### Additional Notes

- **Boarding.** The Joint Commission states that a patient who stays in the ED for 4 hours past the time of admit is classified as a boarded patient. Additional interventions are required from the physician and nurse, including medication reconciliation, diet accommodations, ongoing safety needs, and immediate psychiatric needs.

- **Involuntary commitment.** See page 17 for information about involuntary commitment.
ALGORITHM: SUICIDE ASSESSMENT AND PREVENTION – INPATIENT CARE

PREVENTION at Intermountain and in Utah (see page 10)

Patient presents with mental health concern or clinical suspicion of suicidal ideation present (a)

SCREEN for suicide risk using the C-SSRS Quick Screen (see page 2)

ASK Question 1 (b): Have you wished you were dead or wished you could go to sleep and not wake up?

ASK Question 2: Have you actually had any thoughts of killing yourself?

no to 1, yes to 2
OR yes to both

ASK Question 3: Have you been thinking about how you might kill yourself?

ASK Question 4: Have you had these thoughts and had some intention of acting on them?

ASK Question 5: Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

ASK Question 6 (b): Have you ever done anything, started to do anything, or prepared to do anything to end your life?

If yes to 1 and no to 2

LOW risk
• Continue with plan of care

Note: Patient response to question 6 may increase risk and result in additional steps.

MODERATE risk
• Continue with plan of care
• Initiate nursing interventions (e)

HIGH risk
• Notify charge nurse/shift coordinator
• Notify attending physician
• Assess need for 1:1
• Initiate nursing interventions (e)
• Administer C-SSRS Lifetime/Recent Assessment (Adult/Adeoscent or Pediatric)

HIGH risk
If in the past 4 weeks:
• Notify charge nurse/shift coordinator
• Notify attending physician
• Assess need for 1:1
• Initiate nursing interventions (e)

MOD risk
If 1–12 months ago:
• Assess risk factors and consider referral to MHI or BH provider (c)
• Initiate nursing interventions (e)

LOW risk
If ≥1 year ago:
• Consider referral to MHI or BH provider (c)
• Consider patient education (d)

Create Safety Plan, provide referrals (c) and education (d), and follow up with patient before discharge (f)
## INPATIENT CARE ALGORITHM NOTES AND ADDITIONAL ROLES

### (a) Mental health concerns or clinical suspicion of suicidal ideation

The nurse determines if the patient has mental health concerns based on the history, presentation, self-harm behaviors, etc. Any patient with a mental health concern should receive the C-SSRS Quick Screen (Adult/Adolescent or Pediatric).

The C-SSRS informs, but does not replace, clinical judgment. If any clinician has a suspicion of suicide risk, initiate the referrals and safety measures at the level deemed appropriate.

### (b) Questions 1 and 6: Ideation and Behaviors

At a minimum, you’ll ask questions 1 and 6, which ask the patient about ideation and behaviors. Question 6 can increase a patient’s risk level, even if Question 1 is negative. (A patient who answers “no” to question 1 but “yes” and “in the past 4 weeks” for question 6 is high risk.)

### (c) Tips for facilitating a referral

See page 16 for tips for increasing the likelihood that the patient will follow through on the referral.

### (d) Patient education

Use the following Krames HealthSheets to educate the patients about suicide. These sheets also provide links to suicide support lines (NIHM, NAMI, NMHA, and the National Suicide Hotline).

- Recognizing Suicide Warning Signs in Yourself
- Warning Signs of Suicide and What You Can Do
- Recognizing Suicide Warning Signs in Others
- Depression and Suicide in Older Adults

See page 19 for access and printing directions.

### (e) Nursing interventions

- Secure patient belongings: ask the patient to empty his or her pockets; collect all belongings and put them in a bag; ask a family member (with the patient’s permission) to remove the bag from the care treatment area and secure the bag at the nurse’s station or other designated area.
- Secure room (remove plastic bags, secure needles, secure cords, etc.).
- Have patient change into hospital gown (may leave on underwear).
- See Intermountain’s CPG: Suicide Precautions Pediatric/Adult Protocol

**Note:** Do not search the patient’s belongings (purses, backpacks, etc.). If you see a weapon (gun, knife, etc.), report it to security. You can also ask the patient about any suspicions during the assessment. If you see medications of concern, ensure that they are secured.

### (f) Discharge

For patients on non-behavioral health units, consult appropriate hospital resources (crisis workers, on-call psychiatrists, etc.) for evaluation prior to discharge to determine the next level of care.

Complete the Intermountain Safety Plan with the patient. (See page 16.)
KEY POINTS
- Treating mental illness is critical to preventing suicide.
- Prevention efforts at the Intermountain and the state level are critical to preventing suicides in our communities.

PREVENTION AT INTERMOUNTAIN AND IN UTAH

With the right tools and resources in place, we believe we can help prevent suicide among our patients and in our population. This section explains Intermountain’s recommendations to help clinics focus on prevention — and summarizes broader public efforts to improve services and raise awareness.

At Intermountain clinics

Establish and communicate a clinic focus on mental health and suicide prevention:
- Discuss suicide screening and treatment at regular staff trainings
- Review patient suicide cases with the team to determine what could be improved
- Establish open communication with patients about suicide risk
- Seek to reduce the factors that increase the risk for suicidal thoughts and behaviors and to increase the factors that help strengthen, support, and protect individuals from suicide (see risk factors on page 12)

Within the Utah community

Intermountain is working with the Utah Suicide Prevention Coalition to do the following:
- Promote public awareness that suicide is a preventable public health problem
- Develop broad-based support through public/private partnerships dedicated to implementing and sustaining suicide prevention efforts
- Improve the ability of health providers (including mental health) and first responders to better support individuals who are at risk of suicide
- Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all helping professionals, including graduate and continuing education programs
- Increase access to health and mental health services, prevention programs, and other community resources to better support individuals and families of individuals at risk of suicide
- Develop policy through State Agencies, legislature, and other avenues as possible to promote mental health and prevent mental illness and eliminate suicide
- Promote efforts to decrease the risk of suicides by reducing access to lethal means
- Improve surveillance, data, research and evaluation relevant to suicide prevention
- Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicide attempts and deaths from suicides

See utahsuicideprevention.org for more information.
UNIFORM TERMINOLOGY

When we use a variety of terms for the same behavior in documentation, discussion with other providers, with patients, and so on, care is inconsistent and comparison across epidemiological or drug safety data sets is compromised, decreasing confidence in data.\textsuperscript{POS}

The following definitions come from the CDC’s National Strategy for Suicide Prevention\textsuperscript{CDC} and the C-SSRS.\textsuperscript{POS} These terms define how we talk about and document suicide risk and behaviors:

- **Aborted or self-interrupted attempt**: When a person begins to take steps toward making a suicide attempt, but stops him or herself before engaging in any self-destructive behavior.
- **Affected by suicide**: All those who may feel the impact of suicidal behaviors, including those bereaved by suicide, as well as community members and others.
- **Bereaved by suicide**: Family members, friends, and others affected by the suicide of a loved one (also referred to as survivors of suicide loss).
- **Interrupted attempt**: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act. (If not for the interruption, an actual attempt would have occurred.)
- **Means**: The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs, guns, knives, etc.).
- **Methods**: Actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose).
- **Protective factors**: Factors that make it less likely that individuals will develop or engage in a suicidal behavior. Protective factors may encompass biological, psychological, or social factors in the individual, family, and environment.
- **Risk factors**: Factors that make it more likely that individuals will develop or engage in a suicidal behavior. Risk factors may encompass biological, psychological, or social factors in the individual, family, or environment.
- **Safety plan**: Written list of warning signs, coping responses, and support sources that an individual may use to avert or manage thoughts, feelings, impulses, or behaviors related to suicide.
- **Self-directed violence (or self-harm)**: Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-directed violence can be categorized as non-suicidal or suicidal.
- **Suicidal behaviors**: Acts and/or preparation toward making a suicide attempt or toward a death by suicide.
- **Suicidal ideation**: Thoughts of engaging in suicidal behaviors.
- **Suicidal intent**: Evidence (explicit and/or implicit) that at the time of injury the individual intended to kill him or herself or wished to die and that the individual understood the probable consequences of his or her actions.
- **Suicidal plan**: A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt, often including an organized manner of engaging in suicidal behavior such as a description of a time frame and method.
- **Suicidal thoughts**: General, non-specific thoughts of wanting to end one’s life/commit suicide.
- **Suicide**: Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
- **Suicide attempt**: A non-fatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

KEY RECOMMENDATIONS

- Use consistent language in documentation, coding, discussions with other providers, conversations with patients, and so on when discussing suicide to facilitate consistent coding, better tracking, and, ultimately, improved patient care.
- Avoid language that trivializes, interprets, disparages, or validates suicide or suicidal thoughts or behaviors.

UNACCEPTABLE AND ACCEPTABLE TERMS

According to the CDC, the following terms are currently unacceptable to use in clinical practice:

- Completed suicide
- Failed attempt
- Parasuicide
- Successful suicide
- Suicidality
- Nonfatal suicide
- Suicide gesture
- Manipulative act
- Suicide threat

Acceptable terms are attempted suicide and died by suicide.\textsuperscript{CDC}
RISK AND PROTECTIVE FACTORS

Understanding a patient’s risk and protective factors may affect the treatment plan, including determination of treatment setting. An initial goal should be to estimate the patient’s risk through knowledgeable assessment of risk and protective factors, with a primary and ongoing goal of reducing suicide risk.

Modifiable risk factors

- **Psychiatric disorders.** Of patients who attempt suicide, more than 90% have a major psychiatric disorder. Of patients who die by suicide, 95% have a psychiatric diagnosis (although many may not have a formal diagnosis; diagnosis may be based on autopsy). Correlation between inpatient psychiatric admissions and suicide indicate that increased severity of psychiatric disorder increases risk of suicide:
  - 8.6% of patients with an inpatient admission that involved a psychiatric disorder and suicidal ideation later died by suicide (compared to the general population’s lifetime risk of 0.5%).
  - 41% of people who died by suicide had a psychiatric inpatient admission within the previous year.

According to a meta-analysis and a longitudinal study of adults, the most common psychiatric disorders associated with suicide are depression, bipolar disorder, alcohol or other substance use disorder, schizophrenia, personality disorder, anxiety disorders, posttraumatic stress disorders, and delirium.

- **Health.** Physical illness such as chronic pain, recent surgery, and chronic or terminal disease increase suicide risk. BMI and risk of suicide are inversely related in men.

- **Hopelessness and impulsivity.** Hopelessness increases the risk of suicide even more than depression. According to a multiple regression analysis, hopelessness is 1.3 times more important than depression in predicting suicidal ideation.

- **Impulsivity** is associated with acting on suicidal thoughts, particularly among adolescents and young adults.

- **Lack of connections.** Those who lack connections (living alone, loss of a loved one, recent failed relationship, etc.) are at a higher risk for suicide.

- **Other important modifiable risk factors.** The following can also contribute to suicide risk and should be taken into account during patient assessment:
  - Accessibility to lethal means or other means, especially firearms and medications
  - Stress (job, marriage, school, relationship, etc., or loss related to any of these)
  - Contagion (see sidebar, page 15)

Nonmodifiable risk factors

- **Adverse childhood experiences.** A retrospective cohort study found the risk of attempted suicide increased 2- to 5-fold for those with adverse childhood experiences in any category (emotional, physical, and sexual abuse; household substance abuse, mental illness, and incarceration; parental domestic violence, separation, or divorce).

- **Family history and genetics.** The risk of suicide increases 6-fold for those with a first-degree relative who died by suicide. This may be a result of inherited mental illness or interactions with social and cultural influences.

- **History of suicide attempts.** Prior history of attempted suicide is strongest single factor predictive of suicide — it increases the likelihood of attempted suicide 5- to 6-fold. Up to 50% of those who die by suicide have attempted suicide before.

- **Age and gender.** Women attempt suicide 3 times more frequently than men, but men die by suicide 4 times more often than women. This is likely because women often choose less lethal methods than men. Suicide risk increases with age, but young adults attempt suicide more often than older adults.

- **Men age 85 and older have the highest suicide rate in the U.S.** Men age 50 to 54 have the highest suicide rate among all age groups and genders in Utah.
• Relationship status. Those never married have the highest risk of suicide, followed by people who are widowed, separated, or divorced.\textsuperscript{VPP} Relationship problems in general increase suicide risk.\textsuperscript{VPP}

• Occupation. Risk of suicide may be increased for patients in unskilled occupations (e.g., laborers, cleaners, and others who perform simple, manual tasks). People who are unemployed and economically strained are also at higher risk. Physicians are at a higher risk of suicide than other skilled workers.\textsuperscript{UTD1}

• Other important risk factors. The following can also contribute to suicide risk and should be taken into account during patient assessment:\textsuperscript{UTD1}
  – History of violent behavior in the previous year
  – Exposure to violence or negative sociopolitical, cultural, and economic forces
  – Living in rural areas
  – Lower scoring on intelligence tests

Protective factors
Conditions that promote strength and resilience and ensure that vulnerable individuals are supported and connected with others during difficult times make suicidal behaviors less likely. Consider the following protective factors as you assess the patient: HHS

• Social support and family connectedness is protective against suicide, while family discord increases the risk of suicide.

• Pregnancy decreases the risk of suicide, as does parenthood, particularly for mothers.

• Religiosity and spirituality and participating in religious/spiritual activities is associated with a lower risk of suicide.\textsuperscript{UTD1}

• Good coping skills and compliance with treatment are associated with reduced risk of suicide.

Risk assessment for inpatient care decisions
The admission and discharge criteria in the table below, combined with results of the C-SSRS assessments and the Risk Assessment Tool (see sidebar previous page), can help guide admission decisions.

<table>
<thead>
<tr>
<th>TABLE 4: Admission and discharge criteria</th>
<th>MODERATE risk — admit may be necessary</th>
<th>HIGH risk — admit</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW risk — discharge</td>
<td>Admission may be necessary:</td>
<td>Admission generally indicated:</td>
</tr>
<tr>
<td></td>
<td>• After a suicide attempt or aborted suicide attempt, in the presence of suicidal ideation with:</td>
<td>• After a suicide attempt or aborted suicide attempt if:\textsuperscript{FRI2}</td>
</tr>
<tr>
<td></td>
<td>– Psychosis</td>
<td>– Patient is psychotic</td>
</tr>
<tr>
<td></td>
<td>– Major psychiatric disorder (may not have formal diagnosis)</td>
<td>– Attempt was violent, near-lethal, or premeditated</td>
</tr>
<tr>
<td></td>
<td>– Past attempts, particularly if medically serious</td>
<td>– Precautions were taken to avoid rescue or discovery</td>
</tr>
<tr>
<td></td>
<td>– Possibly contributing medical conditions (e.g., acute neurological disorder, cancer, infection)</td>
<td>– Persistent plan and/or intent</td>
</tr>
<tr>
<td></td>
<td>– Lack of response to or inability to cooperate with partial hospital or outpatient treatment</td>
<td>– Distress is increased or patient regrets</td>
</tr>
<tr>
<td></td>
<td>– Need for supervised setting for medication trial or electroconvulsive therapy (ECT)</td>
<td>– Patient is male and &gt;45 years old, especially with new onset of psychiatric illness or suicidal thinking</td>
</tr>
<tr>
<td></td>
<td>– Need for skilled observation, clinical tests, or diagnostic assessments that require a structured setting</td>
<td>– Patient has limited family and/or social support, including lack of stable living situation</td>
</tr>
<tr>
<td></td>
<td>– Limited family and/or social support, including lack of access to timely outpatient follow up</td>
<td>– Current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident</td>
</tr>
<tr>
<td></td>
<td>– Lack of an ongoing clinician-patient relationship or lack of access to timely outpatient follow up</td>
<td>– Patient has change in mental status with metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting</td>
</tr>
<tr>
<td></td>
<td>– In the absence of suicide attempts or reported suicidal ideation/plan/intent but evaluation and/or history suggests a high level of suicide risk and a recent acute increase in risk</td>
<td>• In the presence of suicidal ideation with:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Specific plan with lethality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– High suicidal intent</td>
</tr>
</tbody>
</table>

ANTIDEPRESSANTS AND SUICIDE RISK
Starting in 2007, the Food and Drug Administration (FDA) required that all antidepressant medications carry an expanded black-box warning that identifies an increased risk of suicidal symptoms in young adults (12 to 24 years) during initial treatment. The label also states that “depression and other serious psychiatric disorders are themselves associated with increases in the risk of suicide.”\textsuperscript{FRI2} (The black-box warning indicating increased risk of suicidal thinking, feeling, and behavior in children and adolescents has been required since October 2004.)

The FDA analyses that led to the warning showed an elevated risk of suicide and suicide ideation in patients age 12 to 24; however, the risk was not significantly elevated and was only elevated during the first few weeks of antidepressant therapy.\textsuperscript{FRI2} Balancing the small increased risk of suicide in young adults against the clear risk of suicidality associated with depressive syndromes is critical to treatment.

It is recommended that clinicians warn patients aged 12 to 24 who are starting antidepressants that an increased risk of suicide exists. In addition, clinicians should:

• Encourage all patients to contact their clinician if they suffer any suicidal thoughts

• Evaluate patients with suicide ideation every 1 or 2 weeks

• Follow-up with these patients after 2 to 4 weeks\textsuperscript{UTD2}
KEY POINTS

- Awareness of special populations and increased incidence of suicide in certain populations can be helpful in assessment of suicide in patients.
- This CPM focuses on populations predominant in Utah communities. For a full discussion of special populations at increased risk for suicide, see the U.S. Surgeon General and the National Action Alliance for Suicide Prevention’s National Strategy for Suicide Prevention.

SPECIAL POPULATIONS

The 2012 U.S. Surgeon General and the National Action Alliance for Suicide Prevention’s National Strategy for Suicide Prevention identified special populations with increased suicide risk. This CPM focuses on groups most prevalent in our communities. It also focuses on the pediatric population because of differences in assessment and treatment approaches.

People in justice and child welfare settings

In jails, suicides occur 3 times more often than among the general population, and suicide is the third leading cause of death in prisons. The risk factors for suicide (mental health disorders, substance abuse, physical, sexual, and emotional abuse, self-injurious behavior, and so on) are highly predominant among adolescents involved in the juvenile justice and child welfare systems, putting them at high risk for suicide. Suicide among adolescents in contact with the juvenile justice system specifically occurs about 4 times more frequently than in adolescents in the general population.

Lesbian, gay, bisexual, and transgender (LGBT)

Numerous studies have shown increased suicide ideation and attempts among people who identify as LGBT. Because death certificates do not identify sexual orientation or gender identity, rates at which LGBT individuals die by suicide is not known. Some key findings summarized in the National Strategy include:

- Lifetime suicide attempts by gay and bisexual males were 4 times as high as heterosexual males.
- Lifetime suicide attempts by lesbian and bisexual females were almost 2 times as high as heterosexual females.
- Lesbian, gay, and bisexual adolescents and adults were almost twice as likely as heterosexuals to report a suicide attempt in the past year.
- Lesbian, gay, and bisexual adolescents were 3 times more likely to report a lifetime suicide attempt than heterosexual adolescents; they were 4 times as likely to make a medically serious attempt.

Military service members and veterans

Rates of suicide among members of the military have historically been lower than the rest of the population, but numbers have been rising since about 2006. Currently, CDC estimates that veterans account for approximately 20% of deaths from suicide in America. Rates appear to be increasing among two key populations: veterans who have returned from service in Afghanistan and Iraq, and those who receive health care services from the Veterans Health Administration (VHA). See the sidebar for information about an ongoing study of suicide risk among members of the military.

American Indians

Youth suicide rates among American Indians are much higher than the general U.S. population. In 2009, the suicide rate among U.S. American Indians 10 to 18 years was 10.37 per 100,000 (compared to 3.95 per 100,000 in general population). Risk factors specific to this population include substance use, discrimination, limited access to mental health services, and historical trauma.
Children and adolescents

• **Medical lethality.** For children and adolescents, medical lethality is not necessarily related to severity of the attempt. Patients may accidentally ingest lethal amounts of a substance or overestimate the toxicity of a small amount while making an attempt with serious intent. In the latter situation, children and adolescents may follow an attempt with a subsequent attempt with more lethal means.

• **Methods.** Young patients typically have limited access to methods that have a high mortality rate, with the exception of drugs — both prescription and over the counter — and choose overdose as the preferred approach. Clinicians should be aware of local preferences among children and adolescents and inquire about the patient’s familiarity and previous experiences with these methods during both psychiatric and pediatric assessments.

Note that the Food and Drug Administration (FDA) requires that all antidepressant medications carry an expanded black-box warning that identifies an increased risk of suicidal symptoms in young adults (18 to 24 years) during initial treatment. See sidebar page 13 for more information.

Assessment of suicidality in pediatric and adolescent patients

The primary purpose of assessment is to uncover and address the precipitants to, and other predisposing factors of, the suicide attempts. Relationship problems with friends and family and school failures that produce frustration and narcissistic injury can lead to suicidal behavior. Children and adolescents may express a real desire to die as a means of obtaining relief or of escaping from a difficult situation.

The assessment of intent focuses on several important questions:

- Why was this method chosen? What were the expectations from the attempt? (Did the patient think that the attempt was going to kill him or her?) How reversible was the attempt? (If possible, could the patient change his or her mind and quickly recover from the attempt?) Does the patient demonstrate any ambivalence about living? How strong was the patient’s intent to die? Was there evidence of premeditation, including preparations and precautions against discovery?

Treatment notes

- Clinicians should be particularly concerned when the idea of suicide seems perfectly acceptable to the patient.

- Lack of available social support may indicate a need for inpatient psychiatric admission to guarantee appropriate psychiatric follow-up and reduce the patient’s risk. This is a much stronger indicator for admission in children than adults.

Patients bereaved by suicide

Research has shown that individuals bereaved by suicide are at increased risk of dying by suicide themselves. Exposure to suicide also increases rates of guilt, depression, and other psychiatric symptoms. See sidebar for helpful resources.

CANCER PATIENTS

For patients diagnosed with cancer, the incidence of suicide is approximately double what it is for the general population. Research indicates that the risk of suicide is highest: During the first 3 months after diagnosis — over 2 1/2 times as high as in the 52 weeks after diagnosis (compared to the general population) Between 12 and 24 months for those with a good or moderate prognosis These results indicate that in addition to the impact of diagnosis, there is additional risk that occurs perhaps when there is recurrence or treatment failure.

Of note, the experience of pain and feelings of hopelessness appear to be major predictors of suicide risk. Studies have demonstrated that:

- Most cancer patient suicides followed an experience of inadequately managed or poorly tolerated pain, which increased the co-occurrence of depression, delirium, loss of control, and feelings of hopelessness.

- There is a stronger association between feelings of hopelessness and suicidal intent than between depression and suicidal intent, especially among those with terminal cancer.

- Patients with comorbid psychological disorders may experience heightened perceptions of pain and other physical symptoms that also contribute to suicidal thoughts.
KEY POINTS

- You can increase a patient’s likelihood of following up on an appointment by taking a few extra minutes during the referral process.
- Safety planning is a critical element of the treatment plan for these patients. This gives the patient a tool to support him or her after leaving treatment.
- Nonsuicidal self injury is highly predictive of future suicide attempts.
- Involuntary commitment may be necessary for patients with active suicidal ideation who are at an immediate risk of self harm or harm to others.

CONSIDERATIONS FOR CARE

This section discusses tips for working with suicidal patients, and common tools you’ll use when caring for them. It also discusses nonsuicidal self-injury and involuntary commitments.

Tips for facilitating a referral

At any point in care, you may be the only one who is able to reach a patient. As many as 70% of patients who attempt suicide never attend their first outpatient appointment after release from the ED. Follow these tips to increase referrals:

- Develop a personalized Safety Plan with the patient (see below).
- Request the patient’s permission to include the family and/or friends in conversations (similar to medical emergency conversations). Engage the patient’s family or other support system in the referral and the follow up if possible. Encourage the patient’s family to make sure the patient follows up on the referral.
- Emphasize that people can and do recover, and that treatment can help.
- Include the date of appointment and location of provider. When possible, schedule the first follow-up appointment before the patient is discharged, preferably within 24 to 72 hours and at least within 7 days after discharge.
- When possible, facilitate a phone call between the patient and the clinician (a warm hand-off). This is especially important if the patient will have a new clinician.
- Provide crisis line cards (available free on the Lifeline website).
- Review the discharge plan with the patient verbally.
- Educate the patient on suicide and treatment. This may be the only education and treatment the patient receives, but it can make a difference. See page 19 for education resources.

Safety plans

Collaborative safety planning is effective element of the treatment of suicide risk. The Safety Plan provides the patient with a tool they can use when suicidal thoughts arise after discharge. A Safety Plan is an important part of the treatment plan when working with suicidal patients.

Include the patient and family in the development and ongoing follow up of the Safety Plan. It is critical to help the patient and family think through each step. Once completed, scan the plan into iCentra so the provider can follow up.

See page 19 for printing and ordering directions.

A free cell phone app called “Safety Plan” is also available and can be recommended to patients. (App developed with permission from Stanley & Brown [2012]. Developers: Barbara Stanley, Gregory K. Brown, and Padraic Doyle. New York State Office of Mental Health.)
Non-suicidal self injury

Nonsuicidal self injury includes a variety of behaviors, such as:

- Superficial cutting
- Burning
- Self-strangulation

NSSI is more common than suicide attempts and is generally performed because patients are seeking ways to punish themselves for perceived mistakes, to relieve distress, or to gain attention when feeling alone, misunderstood, or isolated. NSSI is a strong predictor of future suicide attempts. The Adolescent Depression Antidepressants and Psychotherapy Trial (ADAPT) found in multivariate analysis that NSSI, not suicide attempts at baseline, were associated with the presence of at least 1 suicide attempt over a 28-week follow up.\textsuperscript{Wil}

NSSI has a similar diatheses with suicidal behavior; patients have poor social problem solving, high levels of arousal in response to frustration, difficulty with emotional regulation when in distress, and frequent self-critical cognitions. These patients have high rates of internalizing and externalizing disorders, particularly depression, and are more likely to experience early environmental adversity and suboptimal parental care. They develop a greater tolerance and decreased fear of death, increasing the propensity to “cross the boundary” from self injury to suicidal ideas and acts. Clinicians should orient care to decreasing the frequency of these behaviors as well as those related to suicide attempts.

Involuntary commitments

Involuntary commitment is a legal process for detaining a patient who needs mental health evaluation and care. The patient can be held in the hospital for up to 24 hours against his or her will until evaluated by a mental health provider. This process cannot be used to detain or hold patients for any other reason (e.g., medical reasons, intoxication, etc.).

For patients with active suicide ideation, involuntary commitment may be necessary. Any physician or designated examiner can order an involuntary commitment using a Commitment Blue Sheet. (Other commitment sheets include Pink Sheets, initiated by law enforcement and mental health officers, and White Sheets, initiated by the court.)

Patients are involuntarily committed to the local mental health authority and have not lost their civil rights. They have every right to refuse medical treatment. However, they cannot leave the facility. The physician can cancel the involuntary commitment at any time.

Pediatric patients can be detained with their parents’ consent, unless the child is emancipated (see the sidebar at right). If the parent does not consent to detaining a minor deemed at risk by a physician, the minor can be taken into protective custody or, if appropriate, the involuntary commitment process can be used (Pediatric Commitment Blue Sheet). In either case, DCFS should be contacted immediately and the physician should carefully document the grounds for detention as well as the need for and nature of any medical care or treatment provided to the minor. Protective custody may not exceed 72 hours; involuntary commitment allows for 24 hours of detention, not including weekends or holidays.

See Intermountain’s Clinical Education Update Involuntary Commitments — Pink Sheets, Blue Sheets, White Sheets for more information.

CONTAGION OF SUICIDE

Research indicates that the way media reports suicide can contribute to increased suicides and suicide attempts. Conversely, the media can inform about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. The following recommendations help media safely report on suicide.\textsuperscript{SPRC2} Intermountain team members should follow the same guidelines when talking to the media.

What to avoid:

- Detailed descriptions of the suicide, including specifics of the method and location.
- Romanticizing someone who has died by suicide, featuring tributes by friends or relatives, featuring first-person accounts from adolescents about their suicide attempts.
- Glamorizing the suicide of a celebrity.
- Oversimplifying the causes of suicides, murder-suicides, or suicide pacts, and presenting them as inexplicable or unavoidable.
- Overstating the frequency of suicide.
- Using the words “committed suicide” or “failed” or “successful” suicide attempt.
- Giving prominent placement to stories about suicide, using the word “suicide” in the headline.
- Describing the site or showing pictures of the suicide.

What to do:

- Always include a referral phone number and information about local crisis intervention services.
- Emphasize recent treatment advances for depression and other mental illness. Include stories of people whose treatment was life-saving or who overcame despair without attempting suicide.
- Interview a mental health professional who is knowledgeable about suicide and the role of treatment or screening for mental disorders as a preventive strategy.
- Emphasize decreasing trends in national suicide rates over the past decade.
- Emphasize actions that communities can take to prevent suicides.
- Report on activities coordinated by your local or state suicide prevention coalition.
- Include a listing of the warning signs, risk and protective factors for suicide.\textsuperscript{SPRC2}
KEY RECOMMENDATIONS

- Prescribe medications to modify risk associated with acute and chronic illness commonly associated with suicide.
- Refer to Intermountain guidelines and CPMs for treatment recommendations for comorbid mental health disorders.

PHARMACOTHERAPY

The most important concept in using medications to treat suicide risk is to reduce both acute and chronic risk factors.

Early and aggressive treatment is critical to address underlying psychiatric illnesses associated with suicidal thoughts. To guide treatment of specific disorders, Intermountain has several Care Process Models, including:

- Bipolar Disorder
- Substance Use Disorder
- Depression
- Eating Disorders
- Attention Deficit Hyperactivity Disorder (ADHD)
- Chronic Pain

In addition, the Mental Health Integration Care Process Model and supporting materials provide an approach and process for integrating mental healthcare into everyday primary care practice. For appropriate patients, this team-based approach promotes consultation and collaboration between PCPs, care managers, mental health specialists, and patients. The MHI approach reduces the burden on PCPs, improves clinical decisions, and allows patients and their families to receive an array of needed services within the primary care setting.

Mental illness and insomnia

This section addresses specific medications that treat the acute and chronic risk illnesses commonly associated with increased suicidality.

Anxiety, insomnia, and psychosis. Prominent acute risk factors that are modifiable include anxiety, insomnia, and psychosis. For these symptoms, consider the judicious use of benzodiazepines, sedatives, and/or antipsychotics.

Bipolar disorder. For patients with bipolar disorders, consider treatment with lithium. Long-term maintenance with lithium in patients with bipolar disorder has been associated with significant reduction in the risk of suicide-related behaviors.

Schizophrenia spectrum and psychotic disorders. For patients with schizophrenia, schizoaffective disorders, or current psychotic symptoms and suicidal-related behaviors, consider treatment with clozapine.

Depression. Consider electroconvulsive therapy (ECT) for patients who:

- Have episodes of major depression accompanied by suicidal thoughts or behaviors and/or
- Suffer from depression and associated psychotic or catatonic features and a delay in treatment response is considered life threatening

If treatment with antidepressants is indicated (see Depression CPM), select an antidepressant with low-risk lethality. SSRIs and other newer antidepressants pose lower risk of lethality. Antidepressant effects may not be observed for days or weeks after starting treatment. Educate patients about probable delay in symptom relief and monitor patients closely early in treatment.

INTERMOUNTAIN PATIENT RESOURCES

Safety Plan: Intermountain’s Patient Safety Plan is available on the Suicide A–Z Topic Page of intermountain.net or intermountainphysician.org. You can also order copies from i-printstore.org.

OTHER PATIENT RESOURCES

- hope4utah.com
- namiut.org/families-caregivers/suicide-prevention
- National Suicide Prevention Lifeline: 1-800-273-TALK
- Utah Suicide Prevention Coalition: utahsuicideprevention.org
- SAMHSA brochures: You can order the following brochures from the SAMHSA website for a minimal cost at: store.samhsa.gov/home
  - After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors
  - After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department
  - After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department
REFERENCES


PROVIDER RESOURCES

To find this CPM and other resources, clinicians can go to the Suicide Screening topic page of intermountain.net or intermountainphysician.org from the Behavioral Health Clinical Program page.

You will also find a Suicide Prevention Clinical Topic on the Clinical Topics A–Z list from the Clinical Programs page of intermountain.net or intermountainphysician.org/clinicalprograms.

You can also order copies from www.iprintstore.org.

The Suicide Prevention Resource Center provides free online training through this website: training.sprc.org.

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This CPM presents a model of best care based on the best available scientific evidence at the time of publication. It is not a prescription for every physician or every patient, nor does it replace clinical judgment.

All statements, protocols, and recommendations herein are viewed as transitory and iterative. Although physicians are encouraged to follow the CPM to help focus on and measure quality, deviations are a means for discovering improvements in patient care and expanding the knowledge base.

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REFERENCES, CONTINUED


