Suicidal Behaviors

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]

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:

- 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 - They often seem to be "in their own world" and lack a sense of humor (anhedonia)
- Focus on the past - They dwell on past losses and defeats and anticipate no future; they voice the notion that others and the world would be better off without them
- Haunted and dominated by hopelessness and helplessness

Assessment of Suicide Risk[1]

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

- **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.

The following is a list of 13 things that should alert a clinician to a real suicide potential:

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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. **Psychotic symptoms especially in adolescents.** Research suggests that adolescents with psychopathology who report psychotic symptoms are at clinical high risk for suicide attempts. Symptoms in adolescents may serve as a marked for that population being at high suicidal risk.
6. **Being under the influence of alcohol or other mind-altering drugs.**
7. **Encountering a severe, immediate, unexpected loss.** For example, being fired suddenly or left by a spouse.
8. **If the patient is isolated and alone.**
9. **If the person has a depression of any type.**
10. **If the patient experiences command hallucination.** This can be a powerful message of action leading to death.
11. **Discharge from psychiatric hospitals.** This is a very difficult time of transition and stress; the structure, support, and safety of the institution are no longer available to the patient and may increase their risk of suicide.
12. **Anxiety.** The constant sense of dread and tension proves unbearable for some
13. **Clinician's feelings**. Regardless of what the patient says or does, clinician observation is vital to an assessment.

Mental Status Review

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

- **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:

- 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.

PROFESSIONAL ORGANIZATIONS

WellCare adheres to the 2003 practice guideline set forth by the American Psychiatric Association[2] - the guideline can be accessed at http://psychiatryonline.org/guidelines.

SPECIAL CONSIDERATIONS

Ketamine.[1] 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.

MEMBER EDUCATION

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

NCQA HEDIS STANDARD

CMS has published the following metric related to behavioral health:

Improving or Maintaining Mental Health

Metric Description: Percent of all plan members whose mental health was the same or better than expected after two years. The percentage of sampled Medicare enrollees (denominator) whose mental health status was the same or better than expected (numerator).

NCQA has published the following measure for this topic:

Follow-Up After Hospitalization for Mental Illness. Members who are hospitalized due to a mental health diagnosis should follow up with a mental health practitioner:

- 7-Day Follow-Up should include an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge.
- 30 Day Follow-Up should include an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge.

REFERENCES

1. Soreff, S. Suicide. MedScape Web site. http://emedicine.medscape.com/article/2013085-overview. Published September 10, 2014. Accessed February 3, 2015.
2. Practice guideline for the assessment and treatment of patients with suicidal behaviors. American Psychiatric Association Web site. http://psychiatryonline.org/guidelines. Published 2003. Accessed February 3, 2015.

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MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	History and Revisions by the Medical Policy Committee
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12/1/2011	• New template design approved by MPC.
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