

Suicide and Serious Mental Illness

An Overview of Considerations, Assessment, and Safety Planning



GRANT STATEMENT

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Introduction

People who live with serious mental illness (SMI)—such as major depression, bipolar disorder, and schizophrenia—are at increased risk of suicide. Understanding the problem of suicide for those with SMI is a critical component of a comprehensive suicide prevention plan. This resource provides an overview of the considerations and suicide prevention measures at the intersection of suicide and SMI.

- + Suicide prevention coordinators can use this resource for prevention planning, informing care transitions, and promoting best practices in clinical settings.
- + Clinicians can find helpful information and links to additional resources on suicide-safer care for those who live with SMI.

SMI Adviser and the Suicide Prevention Resource Center (SPRC) worked together to create this guide.

Considerations

Population Data

Suicide is a problem in the United States across all age groups from teens to older adults. It is important to look at data to understand the scope of the problem.

Between 2008 and 2018
**suicide rates increased
among all age groups.**

In recent years, suicide rates among adults between the ages of 25 and 44 have surpassed the suicide rates of older adults (65+).¹

In 2018
**suicide was the second
leading cause of death**

for youth and young adults
(ages 10-34).²

SMI Data

The rate of death by suicide for people with mood disorders—such as depression or bipolar disorder—is estimated to be **25 times higher** than the general population. Among adults diagnosed with schizophrenia, **1 in 20 dies by suicide**, a rate that is **20 times higher** than the general population.

<http://www.sprc.org/scope/suicide-serious-mental-illness>

1. Centers for Disease Control and Prevention, National Center for Health Statistics. (2020). 1999-2018 Wide Ranging Online Data for Epidemiological Research (WONDER), Multiple Cause of Death files [Data file]. Retrieved from <http://wonder.cdc.gov/ucd-icd10.html>

2. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (February 2020). Retrieved from www.cdc.gov/injury/wisqars

Risk & Protective Factors

Risk factors are associated with an increased risk for suicide. Protective factors are related to a decreased risk for suicide. People with SMI have additional risk factors that increase their risk for suicide.

It is best practice to ask about suicidal ideation with anyone who has these risk factors, and especially with those who have SMI. Strengthening protective factors will help reduce the risk for suicide.

General Risk Factors	Risk Factors associated with SMI	Protective Factors
<ul style="list-style-type: none"> + Prior suicide attempt(s) + Mental health diagnoses, particularly depression and other mood disorders + Misuse and abuse of alcohol or other drugs + Access to lethal means (e.g., firearms, medications) + Knowing someone who died by suicide, particularly a family member + Social isolation + Chronic disease and disability + Lack of access to behavioral health care 	<ul style="list-style-type: none"> + Under- or unemployed + Low income + Homelessness + Poor functioning across domains (e.g., social, work) + Cognitive deficits (e.g., executive functioning, learning, memory, attention) + Untreated psychiatric symptoms (e.g., depression, mania, command hallucinations, delusions) + Hopelessness + Isolation + Perceived discrimination 	<ul style="list-style-type: none"> + Effective behavioral health care + Connectedness to individuals, family, community, and social institutions, including peer support + Life skills (e.g., problem-solving and coping skills) + High self-esteem + A sense of purpose or meaning in life + Cultural, religious, or personal beliefs that discourage suicide

Ideation

The lifetime prevalence of suicidal ideation, by the best estimation available, is about 9%. This means that **9 out of 100** people have disclosed having a suicidal thought at some time in their life.

Clinicians: Some individuals who are at risk for suicide won't volunteer that information upfront even if they already see you for treatment. They may be reluctant to disclose even when asked directly.

Therefore, establish rapport and ask about suicidal ideation early in the clinical interview and throughout the assessment.

Create an environment where it is safe to talk about suicidal thoughts.

- + Model direct discussion of the topic for patients.
- + Express that other people in similar circumstances have had thoughts of suicide.

Suicidal ideation occurs on a broad continuum from no ideation to passive (a wish to sleep forever) to active (a desire to die). It is essential to understand the relationship between passive and active suicidal ideation. Passive ideation does not mean the patient has no risk for suicide. Passive ideation can change very quickly to active suicidal plans. For some people, disclosing passive ideation can be a way to see if it is okay to talk about suicide with you, and for others, it can represent an attempt to hide active plans for suicide. For people who report **ANY** suicidal ideation, it is vital to conduct a thorough clinical assessment and continue to assess suicidal ideation severity, intensity, plans, and desire for death at regular intervals throughout treatment and to develop collaborative safety plans.

Best practice in suicide risk assessment includes:

- + Ask early in the initial clinical interview
- + Ask directly (see Three Ways to Ask box)
- + Ask others when possible (such as spouses or caregivers with youth)
- + Monitor suicidal ideation and behavior until they remit
- + Reassess periodically

Three Ways to Ask

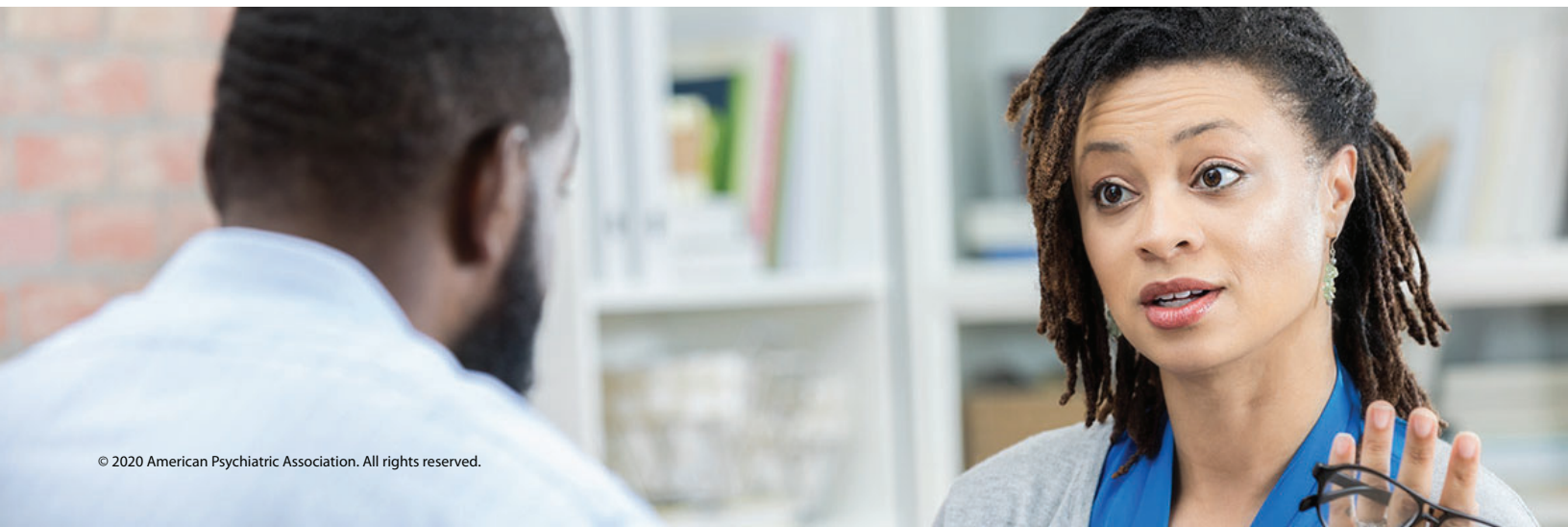
- 1 Have you ever wished you could go to sleep and not wake up?
- 2 Have you had any thoughts about ending your life?
- 3 Does it ever get so bad that you think about ending your life?

Suicide risk assessment should include questions related to:

- + Suicidal ideation (severity, intensity, and duration)
- + Desire for escape/death
- + History of suicidal ideation and suicide attempts (include precipitating events and methods used/considered)
- + Methods the individual has considered and level of planning
- + Level of intent to act
- + Access and lethality of methods

Reassess suicide risk:

- + When a precipitating event associated with a previous attempt recurs or is anticipated
- + If signs of change in mental status or behavior occur
- + At times of increased stress
- + Immediately after self-harm behavior
- + If signs of emotional reactivity or behavioral instability occur
- + At times of transition, including:
 - Change in caregiver (for example, rotation of residents at the hospital or during a therapist's vacation)
 - Change in treatment setting including discharge from hospital
 - Change in treatment approach or medication



Assessment Tools

These tools are useful for brief screening.

- [Patient Health Questionnaire-9 \(PHQ-9\)](#)
- [Columbia Suicide Severity Rating Scale \(C-SSRS\)](#)

These standardized clinical assessment approaches provide structure and guidelines for the clinical evaluation of suicide risk.

- [Assessing and Managing Suicide Risk \(AMSR\)](#)
- [Recognizing and Responding to Suicide Risk \(RRSR\)](#)
- [Collaborative Assessment and Management of Suicidality \(CAMS\)](#)

Safety Planning

Work together with the patient to write down a plan for safety.

Safety plans are developed collaboratively with the person at risk of suicide to identify specific behaviors, actions, and situations that help them stay safe. A safety plan directly addresses reducing access to lethal means. The following resources can support you with safety planning in your setting.

- [Safety Planning Guide: A Quick Guide for Clinicians](#)
- [Safety Plan Template](#)
- [Micro-learning: Collaborating on Safety Plans](#)
- [Online training: Counseling on Access to Lethal Means](#)

Work with family members/supporters.

Work with the family members/supporters who are identified on the safety plan (with patient consent) to gain their assent to be a resource for the individual. Provide them with necessary information on what helps (and what doesn't). **Together, write down a family/support crisis response plan** to remind family members and supporters what to do to help support the patient. This crisis response plan serves as a companion document to the patient safety plan.

Want to Learn More?

Use these online resources to learn more about suicide prevention.

Suicide Prevention Resource Center

- www.sprc.org

SMI Adviser

- <https://smiadviser.org/category/suicide-prevention-and-crisis-management>

Zero Suicide in Health and Behavioral Health

- <http://zerosuicide.edc.org/about>

Visit www.SMIadviser.org

