A Train EDUCATION Continuing Education for Healthcare Professionals

Suicide in America

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Contact hours: 6

Course price: $49

Course Summary

The purpose of this course is to educate healthcare professionals and others about the scope and seriousness of suicide. It identifies groups who are disproportionally affected by suicide, provides information about suicide screening, discusses psychosocial and pharmacologic treatments, describes the role of supportive third parties, spells out practical guidelines to reduce access to lethal means, and relates aspects of military culture that may affect the incidence of suicide in active-duty military and veterans.

Criteria for Successful Completion

A score of 80% or higher on the post test, a completed evaluation form, and payment where required. No partial credit will be awarded.

Accreditation

To find specific accreditations or approvals, click here.

Course Objectives

When you finish this course you will be able to:

1. Describe the recent scope of suicide nationally and worldwide.
2. Relate 3 warning signs and 3 risk factors related to suicidal ideation and behaviors.
3. Describe 5 demographic groups disproportionately impacted by suicide.
4. List 3 gender differences related to suicidal ideation and behaviors.
5. Explain the 4 main components of suicide risk screening and assessment.
6. Describe the 2 main components of management of suicidal patients.
7. Define lethal means.
8. Relate 3 reasons why safety planning is a critical part of care for suicidal patients.
9. Describe 4 main components of social and community support.
10. Explain 3 aspects of military culture that may affect the incidence of suicide in active-duty military and veterans.

Instructions

Once you've finished studying the course material:

1. Record your test answers on the answer sheet.
2. Complete the course evaluation.
3. Complete your registration and payment*.

Mail the completed forms with your payment to:

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1. Surge in Suicide Rates

Mental health has traditionally been the purview of psychiatrists and mental health practitioners. Over the last two to three decades however, family practice physicians, nurse practitioners, allied health professionals, social workers, and other healthcare providers are increasingly responsible for screening, assessing, and managing chronic mental health problems. Because of this, all healthcare providers must be knowledgeable about suicide risk factors and warning signs; understand suicide assessment and screening tools; and know when, where, and how to treat or refer a client who is at risk for self-harm.

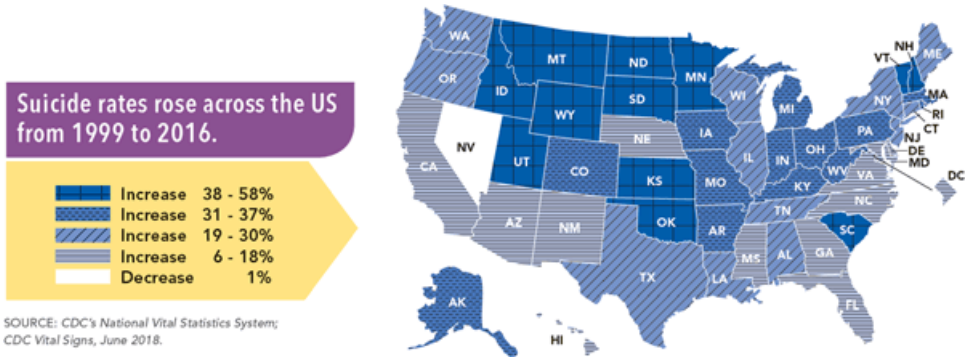
Defining Terms

- **Suicide** is defined as death caused by self-directed injurious behavior with intent to die as a result of the behavior.
- A **suicide attempt** is a non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in injury.
- **Suicidal ideation** refers to thinking about, considering, or planning suicide.

Source: NIMH, 2019.

Throughout the world, suicide is an increasingly serious public health concern. Every year over 800,000 people die by suicide, and between 10 and 20 million attempt suicide. Often suicidal thoughts precede a suicide attempt or completed suicide. Among those thinking about suicide, about one-third attempt suicide, and more than half of these attempts occur within the first year after the onset of suicidal thoughts (Brüdern et al., 2018).

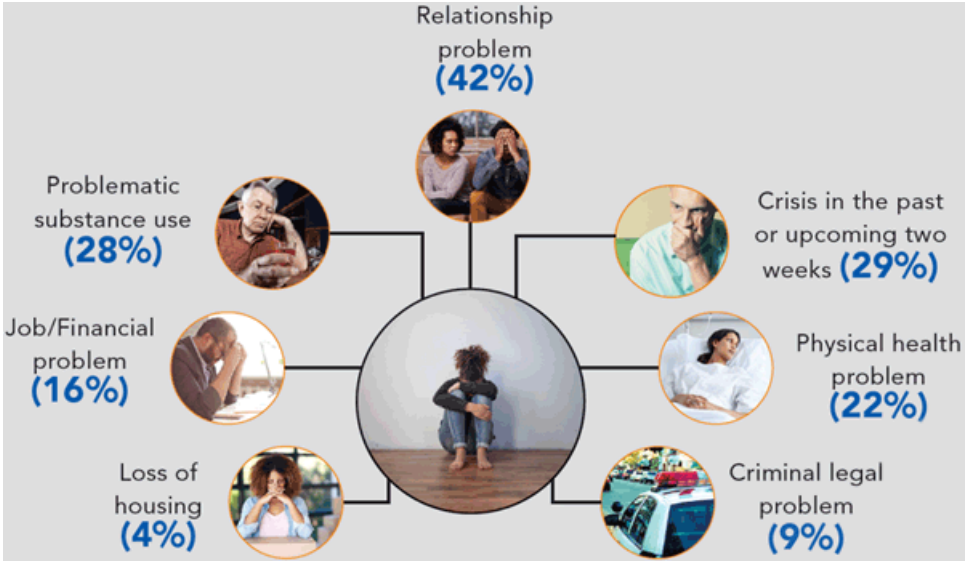
U.S. Suicide Rates, 1999–2016



Suicide rates vary from state to state. Source: CDC, 2018a.

In the United States, approximately 47,000 people die from suicide each year, making it the country's tenth leading cause of death (NIMH, 2019). Suicide is not limited to any one age, socioeconomic or ethnic group, or gender. Remarkably, in 2017 there were more than twice as many suicides in the United States as homicides (NIMH, 2019).

For youth and young adults (ages 10–24) suicide is the second leading cause of death (19.2% of deaths). It is also the second leading cause of death for adults aged 25 to 44 (10.9%). For middle-aged adults (age 45–64) suicide rates subside somewhat but still represent the eighth leading cause of death (3.1% of deaths). For the populations aged 65 and over, suicide is not among the 10 leading causes of death (Heron, 2019).



Many factors contribute to suicide among those with and without known mental health conditions.
Source: CDC's National Violent Death Reporting System, data from 27 states participating in 2015.

Key Points About Suicide

- Suicide is not a personal weakness or family failure.
- Suicide prevention is everyone's responsibility.
- Silence and stigma harm individuals, families, and communities.
- Suicide does not affect all communities equally or in the same way.
- People experiencing suicidal thoughts retain the right to make decisions about their care.

Biological, psychological, social, environmental, and situational factors influence suicidal behaviors. Childhood trauma, substance abuse, poverty, untreated mental health problems, loss of housing, financial difficulties, health problems, legal issues, and relationship problems are some of the factors that may contribute to suicidal ideation and behaviors. Unfortunately, many people do not or cannot get the help they need because of provider shortages, stigma, and the cost of care.

2. Warning Signs and Risk Factors

For healthcare providers, identifying warning signs and risk factors, accessing services, and providing evidence-based care are key challenges. In the United States, about 33% of people who took their life were in contact with mental health services the year before their death. Nearly half of those were seen in primary care the *month* before death (McCabe et al., 2017). Because of these sobering statistics it is critically important that healthcare providers be educated about and aware of risk factors and warning signs associated with suicidal behaviors.

Warning Signs

Warning signs are *actions or behaviors* that are observed by or reported to another, and indicate risk for suicide within minutes, hours, or days. Warning signs can be acute and urgent or simply red flags for concern.

About 80% of people who attempt suicide show some sort of warning sign. Knowing and recognizing these signs can help family and friends take action before suicidal thinking turns into action. Recognition of warning signs provides an opportunity for early assessment and intervention.

Widely accepted **general suicide warning signs** include:

- Anxiety, agitation, sleeplessness
- Feeling that there is no reason to live
- Rage, anger, or aggression
- Recklessness
- Increased alcohol or drug abuse
- Withdrawal from family and friends
- Abrupt mood swings
- Hopelessness, feeling trapped (USDVA, 2019)

Three **specific suicide warning signs** require immediate attention:

1. Communicating suicidal thought verbally or in writing, especially if this is unusual or related to a personal crisis or loss
2. Seeking access to lethal means such as firearms or medications
3. Demonstrating preparatory behaviors such as putting affairs in order (USDVA, 2019)

Risk Factors

A **risk factor** is anything that makes it *more likely* for a person to develop a disorder. Although suicide is rare in comparison to its associated risk factors, increased risk has been associated with prior attempts, emotional and financial loss, illness, hopelessness and isolation, childhood experiences, and access to lethal means. Increased risk is also associated with relationship, community, and societal issues such as local epidemics of suicide, stigma, lack of medical services, family history of suicide, and certain cultural and religious beliefs.

Mental Illness

Although suicidal behavior is strongly associated with mental disorders, no linear relationship exists; the vast majority of people with mental disorders do not experience suicidal behavior. Because of this, psychiatric disorders as risk factors for suicidal behavior have only limited predictive power (Brüdern et al., 2018).

Suicide is nevertheless overrepresented in people with mental illness, and a large percentage of suicide victims have a diagnosable mental health disorder. The odds for suicide in people with severe depression, schizophrenia, and bipolar disorder are approximately 3 to 10 times that of the general population, with a higher risk in males than females. Despite this, suicide occurs in only 3% to 5% of these cases (Fosse et al., 2017).

A poor social network and social withdrawal, command hallucinations,* delusions, and mental disorders other than depression are associated with an increased risk of suicidal behaviors in people with mental illness. This can include

bipolar disorder, schizophrenia, coexisting physical illness, family history of mental illness, multiple admissions to inpatient treatment, unplanned discharge, and prescription of antidepressants (Fosse et al., 2017).

*__Command hallucinations__ are hallucinations in the form of commands; they can be auditory or inside of the person's mind or consciousness. The contents of the hallucinations can range from the innocuous to commands to cause harm to the self or others.

For patients admitted to a specialized mental health facility, there is a 50- to 200-times increased risk of suicide compared to the population at large. In two meta-analyses that included 42 studies and close to 3,500 suicide completers, central suicide risk factors were:

- Prior suicide attempts
- History of deliberate self-harm
- Family history of suicide
- History of suicidal ideation
- Depression, hopelessness
- Agitation
- Social or relationship problems (Fosse et al., 2017)

Although both evidence and common sense suggests that suicides can be avoided with effective treatment of mental disorders, most people in need do not receive adequate treatment. This is because mental conditions are under-recognized, which limits the potential to identify and appropriately treat individuals at risk for suicide.

Medical Issues, Stress, and Illness

Certain medical conditions, chronic illness, and stressful life events are associated with an increased risk for suicidal behaviors. Chronic pain, ongoing stress, cognitive changes, loss of mobility, sensory changes, and difficulty making decisions and solving problems are some of the many challenges related to long-term illness and disability. Physical and psychological trauma can also be risk factors for suicide.

Co-morbid conditions may increase the likelihood that a suicide attempt becomes a completed suicide; for example, if a person with a chronic condition such as hepatitis C swallows a bottle of acetaminophen, they are likely to suffer severe liver damage. By the same token, a person with severe anemia may not survive a suicide attempt involving a significant loss of blood.

Substance Use Disorders

Every year about 650,000 people receive treatment in emergency departments (EDs) following a suicide attempt. More than 40% of these admissions involve drug-related suicide attempts, and many involve a prescription drug or over-the-counter (OTC) medication. Substance use disorders are a strong risk factor for suicide attempts and suicide. Indeed, suicide is a leading cause of death among people who misuse alcohol and drugs (SAMHSA, 2016).

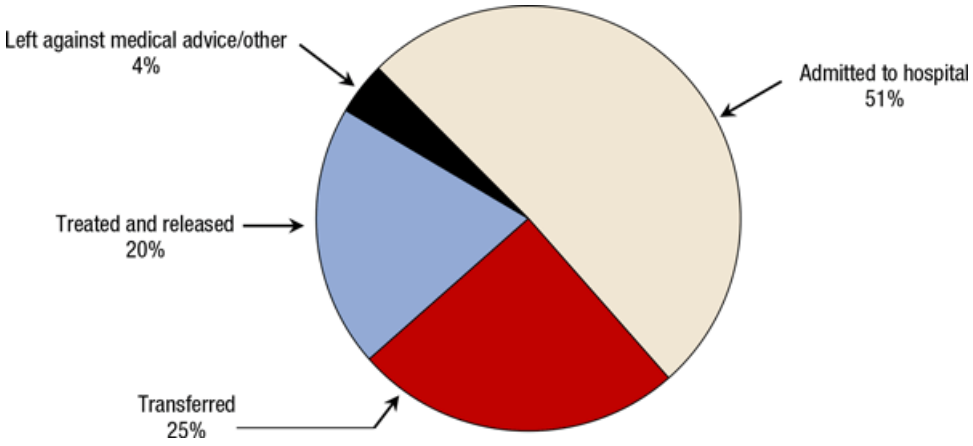
Alcohol misuse or dependence is associated with a suicide risk that is *10 times greater* than the suicide risk in the general population, and individuals who inject drugs are at about *14 times greater* risk for suicide. Acute alcohol intoxication is present in about 22% of suicide attempts (SAMHSA, 2016). Depression—a common co-occurring diagnosis among people who abuse substances—also confers risk for suicidal behavior (CSAT, 2015).

Did You Know. . .

The number of ED visits for drug-related suicide attempts increased 41% overall from 2004 to 2011 and more than doubled among people age 45 to 64 (Crane, 2016).

A person admitted to the ED at acute risk for suicide and who is also intoxicated by drugs or alcohol should be kept under observation and assessed for suicide risk when no longer intoxicated or in acute withdrawal. Following assessment in the ED, about half of these patients are admitted to the hospital, about a quarter are transferred to another healthcare facility, and slightly less than a quarter are discharged after being treated. About 4% leave against medical advice or die in the ED (Crane, 2016).

Outcomes of ED Visits Involving Drug-Related Suicide Attempt (2004 to 2011)



Source: Crane, 2016.

Substance Use Disorders

The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), no longer uses the terms *substance abuse* and *substance dependence*, rather it refers to **substance use disorders,** which are defined as mild, moderate, or severe, determined by the number of diagnostic criteria met by an individual.

Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacologic criteria.

Most Common Substance Use Disorders in the U.S.

- Alcohol use disorder
- Tobacco use disorder
- Cannabis use disorder
- Stimulant use disorder
- Hallucinogen use disorder
- Opioid use disorder

Source: SAMHSA, 2015.

Even when a person is in treatment for a substance use disorder, the prevalence of suicidal ideation and suicide attempts remains high. This is also true for those who have at one time been in treatment (CSAT, 2015).

Abstinence is a primary goal of any client with a substance use disorder and suicidal thoughts or behaviors. For most clients abstinence reduces risk, although some individuals remain at risk even after achieving this goal. This can include patients with:

- Independent depression
- Difficulties that promote suicidal thoughts
- Personality disturbances such as borderline personality disorder
- History of trauma (such as sexual abuse)
- Major psychiatric illness (CSAT, 2015)

Did You Know. . .

The *number* of substances used seems to be more predictive of suicide than the *types* of substances used.

One of the reasons alcohol and drug misuse significantly affects suicide rates is the disinhibition and impulsivity that occurs when a person is intoxicated. Impulsivity and disinhibition are overarching issues related to suicidal behaviors. In fact, angry impulsivity has been repeatedly identified as a common risk factor. Although impulsivity is found in a wide range of diagnoses, it is highly associated with bipolar disorder, substance abuse, and certain personality disorders, as well as a history of early child abuse (Fawcett, 2012).

Immigrants and Refugees

For people migrating to the United States, stress associated with migration can be a risk factor for suicidal ideation. Ending ties with their country of origin, loss of status and social networks, language barriers, unemployment, financial problems, a sense of not belonging, and feelings of exclusion can lead to depression, anxiety, PTSD, alcohol and drug abuse, loneliness, and hopelessness (Ratkowska & De Leo, 2013).

Refugees, one of the most vulnerable groups of immigrants, may be fleeing war, torture, and persecution, and suffering

with PTSD, depression, and anxiety. Lack of adequate preparation, the way in which refugees are received in the destination country, poor living conditions, lack of social support, and isolation add to these vulnerabilities. Refugees may also feel guilty for leaving loved ones at home. The sense of guilt, together with isolation and trauma, may be risk factors for suicide (Ratkowska & De Leo, 2013).

Migration poses a risk not for the families who remain in the country of origin. For example, it has been observed that the next of kin of Mexican emigrants to the United States were at greater risk of suicidal ideation and suicide attempts than Mexicans without a family history of immigration. Immigration can weaken family ties, lead to feelings of loneliness and insecurity, and increase the risk of suicide among family members who remain at home (Ratkowska & De Leo, 2013).

Immigrants from predominantly collectivist societies may face serious problems of adaptation due to a real or perceived lack of social support, a disparity between expectations and reality, and low self-esteem. Many immigrants undergo radical changes in their social status and may also be subject to discrimination. This could be an additional risk factor for suicide, as evidenced by one of the U.S. studies where immigrants' suicide rates were positively correlated with the negative words used by the majority to describe their ethnic group (Ratkowska & De Leo, 2013).

In most studies conducted in Europe, America, and Australia, the highest risk of suicide was found in immigrants from northern Europe (including the United Kingdom, Ireland, and Finland), and Eastern Europe (especially from Russia and Hungary). The lowest risk was found in immigrants from southern Europe and the Middle East (Ratkowska & De Leo, 2013).

For immigrants from Asian countries, the risk of suicide seems generally low for men but appreciably higher for women. The rates vary not only in relation to the country of origin but also for the gender of the immigrant. For example, in a study conducted in the United States, Asian, black, and Hispanic men had the lowest risk of suicide, while non-Hispanic white and Asian women had higher risk than the host population (Ratkowska & De Leo, 2013).

The high suicide rates among immigrants from Northern and Eastern Europe might be partly explained by the high alcohol consumption typical of these countries. For example, there is a significant correlation between alcohol consumption and suicide in Finland; Finnish immigrants who died by undetermined causes of death in Sweden also tend to have high alcohol levels in their blood. A similar trend was found in Russia, where suicide rates related to alcohol abuse are very high, and among Russian immigrants who died by suicide in Estonia (Ratkowska & De Leo, 2013).

The low rates of suicide among immigrants from southern Europe, the Middle East, and Asia may be due to some protective social factors, such as the strong influence of traditional values, family, and religious beliefs. These countries are more collectivist, have strong family ties, and a strong group identity outside their country of origin. Both in Catholic and Muslim countries, religion may be a strong deterrent to suicide, which is considered a sin in the Catholic religion and is forbidden by Islamic law. The protective role of religion could also depend on the ties with the religious community, which might represent a strong source of social support (Ratkowska & De Leo, 2013).

Among asylum seekers, those at higher risk for suicide are young, male, low income, with past traumatic experiences and lack of social support. Refugees and asylum seekers often have several of these risk factors (Ratkowska & De Leo, 2013).

Diagnostic Dilemma: Psychosis or PTSD

A 32-year-old black African, Muslim woman with a history of both PTSD and psychosis presented to mental health services for the first time with a history of auditory and visual hallucinations, persecutory delusions, suicidal ideation, recurring nightmares, hyper-arousal, and insomnia. She reported seeing blood on the walls, men in white following her, and hearing voices saying that some men were coming to get her. These symptoms were worse at night. She became very distressed and troubled to the point of wanting to end her life.

Her background history suggested co-morbid PTSD. Twelve years before, she saw her family (parents, sisters and brother) being killed during the civil war in her birth country in Africa. Her clinical PTSD symptoms, such as the recurring nightmares, hyper-arousal, and insomnia, began shortly afterwards. Eight years later, she entered the United Kingdom as an asylum seeker.

During her first few years in the U.K., she had no social support, was unable to speak English, experienced homelessness, and was unsuccessful in gaining asylum. Her auditory and visual hallucinations and persecutory delusions started at this time. A few months before her first contact with mental health services, her psychotic symptoms and PTSD features became more frequent and intense. With no stable relationship, she became pregnant and visited her general practitioner, who referred her to our first-episode psychosis unit.

Upon admission to the psychosis unit, she presented as kempt yet she appeared distressed. She was withdrawn and quiet and there was some delay in her responses to questions. She was tearful and her mood was low but reactive. She described vivid and clear auditory and visual hallucinations and persecutory delusions. Her medical psychiatric, personal, and family histories were unremarkable. A physical examination, neurologic examination and brain magnetic resonance imaging (MRI) scan were normal. The results of routine blood investigations were in the normal range, and a pregnancy test was positive. At the clinical interview, she clearly fulfilled the criteria for PTSD and psychotic disorder not otherwise specified.

Because of the intensity of her symptoms, her distress and suicidal ideation, the mental health team recommended ongoing hospitalization. She was started on trifluoperazine* (5 mg/day) and cognitive-behavioral therapy for psychosis.

She also started a prenatal follow-up. She self-reported a partial improvement in her clinical picture—and her psychotic symptoms gradually resolved over a three-week period, although they occasionally resurfaced when she was under stress or whenever her medication compliance lapsed.

* **Trifluoperazine** (Stelazine) is a typical antipsychotic primarily used to treat schizophrenia. It is in a class of drugs called phenothiazines.

She was discharged from hospital and is now living in temporary accommodations funded by local services and waiting for her asylum re-application to be processed. She continues to have ongoing PTSD symptoms, associated with the initial tragic event, as persistent remembering of the stressor event with recurring and vivid memories, nightmares, hyper-arousal, and initial insomnia. She also avoids circumstances resembling the initial stressor event, such as wars and violence.

Source: Coentre & Power, 2011.

Documenting Risk

Documentation should describe the gathering of information, whether or not a consultation is needed, a description of the action taken by the healthcare provider to address the patient's risk, and what steps were taken to follow up. Documentation provides a written summary of any steps taken, along with statements that show the rationale for the plan. The plan should make good sense in light of the seriousness of risk (CSAT, 2015).

Gathering information involves collecting relevant facts. Screening questions should be asked of all new patients when you note warning signs and any time you have a concern about suicide, whether or not you can pinpoint the reason. Inquiries start with open-ended questions that invite the client to provide more information. Followup questions are then asked to gather additional, critical information.

Consultation is a formal process whereby information and advice are obtained from (a) a professional with clear supervisory responsibilities, (b) a multidisciplinary team that includes such people, and/or (c) a consultant experienced in managing suicidal clients who has been vetted by your agency for this purpose. Immediate supervision or consultation should be obtained when clients exhibit **direct suicide warning signs** or when, at intake, they report having made a **recent suicide attempt**. Substance abuse relapse during treatment is also an indication for supervisory involvement for clients who have a history of suicidal behavior or attempts.

Caveat

Do not make a judgment about the seriousness of suicide risk or try to manage suicide risk on your own unless you have an advanced mental health degree and specialized training in suicide risk management, and it is understood by your agency that you are qualified to manage such risk independently.

Taking responsible action means your actions should make good sense in light of the seriousness of suicide risk. Seriousness is defined as the likelihood that a suicide attempt will occur and considers the potential consequences of an attempt. Judgments about the degree of seriousness should be made in consultation with a supervisor or a treatment team, not by a healthcare provider acting alone.

Suicide prevention efforts are ongoing rather than one-time actions requiring consistent**followup**. A team approach is essential, which requires a healthcare provider to follow up on referrals and coordinate with other providers in an ongoing manner.

The following case **example** highlights the importance of documentation using the four-step process: (1) gather information, (2) access supervision or consultation, (3) take responsible action, and (4) follow up.

Fernando, Iraqi War Veteran

This case is based on a progress note for Fernando, a 22-year-old Hispanic male and Iraq war veteran, who was doing well in treatment for dependence on alcohol and opiates, but had missed his group therapy sessions and had not returned phone calls for the past 10 days. This situation occurred in a substance abuse clinic within a hospital and required immediate supervision and interventions of high intensity.

Step One: Gather Information

Fernando came in, unannounced at 10:30 a.m. today and reported that he relapsed on alcohol and opiates 10 days ago and has been using daily and heavily since. Breathalyzer was 0.08, and he reported using two bags of heroin earlier this morning. He reported that he held his loaded rifle in his lap last night while high and drunk, contemplating suicide.

Step Two: Access Supervision or Consultation

Upon consultation with a supervisor, it was determined that Fernando was at acute risk of self-harm, and acute emergency intervention was needed because of intense substance use, suicidal thoughts with a lethal plan, and access to a weapon.

Step Three: Take Responsible Action

At 11:00 a.m., a hospital security guard and the nurse who had evaluated Fernando escorted him to the ED, where he was checked in. He was cooperative throughout the process.

Step Four: Follow-up

Dr. McIntyre, the ED physician, determined that Fernando required hospitalization. He is currently awaiting admission. This evaluating nurse will follow up with the hospital unit after he is admitted and will raise the issue of his access to a gun.

Source: CSAT, 2015.

3. Suicide, Race, and Ethnicity

In the United States, suicide rates are highest among American Indian, Alaska Native, and white populations. But these broad demographic groups are diverse with regard to national origin and ethnicity, which can mask the impact of suicide in different subgroups. For example, the broad Asian population's overall low suicide rate may hide the high impact of suicide in some Asian ethnic groups.

American Indians and Alaska Natives

American Indians and Alaska Natives face severe historical trauma, high rates of poverty and isolation, cultural taboos around death and suicide, and lack of access to mental healthcare. Among American Indian and Alaska Native youth, the suicide rate is 3 to 4 times higher than for other American youth and is the second leading cause of death in this age group (WSDOH, 2016).

The risk for co-occurrence of substance abuse, depression, and diabetes is over 12 times higher for AI/ANs than for whites (Cwik et al., 2016). The suicide rate for American Indian juveniles is more than double the white non-Hispanic rate and more than triple the rates for the other racial/ethnic groups (CSAT, 2015).

Hispanic/Latinos

Hispanics/Latinos have fairly similar rates of suicidal thoughts and behaviors compared with white, non-Hispanic individuals. Among youth and young adults, the prevalence of suicidal thoughts and behavior increases among Hispanics/Latinos who are more acculturated to mainstream American culture, particularly among females (CSAT, 2015).

African Americans

The suicide rate for African Americans is 70% lower than that of the non-Hispanic white population. However, the suicide death rate for African Americans men is significantly higher than for African American women (OMH, 2017).

Among African American youth, suicide *risk* peaks in early twenties for males and late twenties for females. A study looking at suicide rates from 1983 to 2012 for African Americans showed the following: the risk in males increased with age, peaking at ages 20 to 24 years, and then declined except for slight increases at older ages (60–74 years). For females, the risk increased with age until peaking at ages 25 to 29 years and then declined except for slight increases at middle ages (35–44 years) (Wang et al., 2016).

Asian Americans

The six largest Asian American subgroups in the United States are Asian Indians, Chinese, Filipinos, Japanese, Koreans, and Vietnamese; these subgroups account for 84% of all Asian Americans in the United States.*

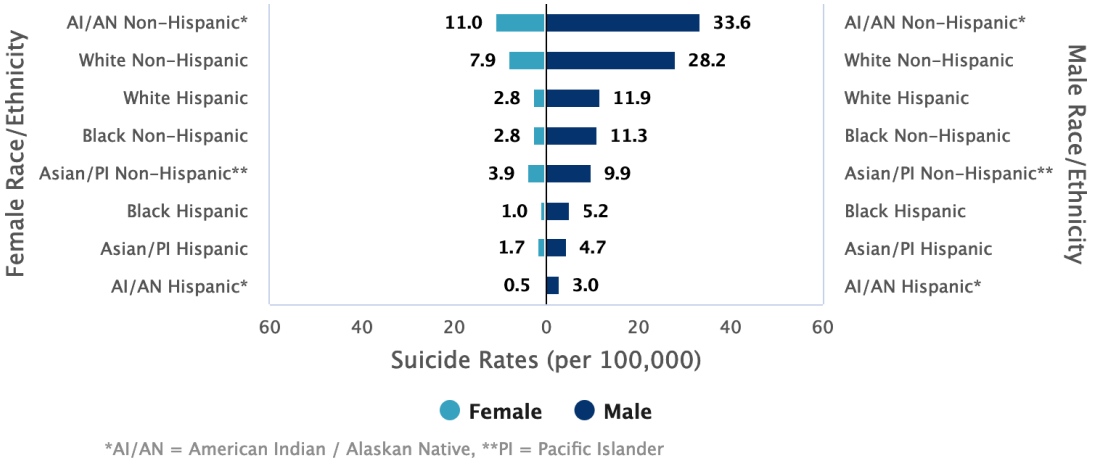
Among these Asian subgroups, Korean males have more than twice the frequency of death due to suicide (5%) compared to non-Hispanic Whites (2%), and suicide was ranked as the fifth leading cause of death, higher than every other Asian subgroup and non-Hispanic whites. Mortality rates for suicide among Korean males were twice that of any other Asian subgroup (Hastings et al., 2015).

*Additional Asian subgroups residing in the United States include Afghanis, Bangladeshis, Bhutanese, Burmese, Cambodians, Hmong, Nepalese, Pakistanis, Singaporeans, Sri Lankans, Taiwanese, and Thai.

White Americans

Very little research has focused on why suicide rates are high among white populations. CDC data from 16 states show the most common circumstances around suicide for white *men* include mental and physical health problems, trouble in intimate relationships, alcohol dependence, and problems at work. Cultural taboos about seeking help and appearing vulnerable often isolate white men from both support systems and resources that could help (WSDOH, 2016).

Suicide Rates by Race (per 100,000)



Source: NIMH, 2019 Figure 3. Data courtesy of CDC.

4. Age and Gender Differences

Suicide is not limited to any one age or gender but nevertheless rates do vary among these groups. For teens, young adults, and middle-aged adults ,suicide has nearly tripled since the 1940s. Although suicide *attempts* are more frequent among young adults, older men and women have the highest rates of suicide in almost all countries.

Teens and Young Adults

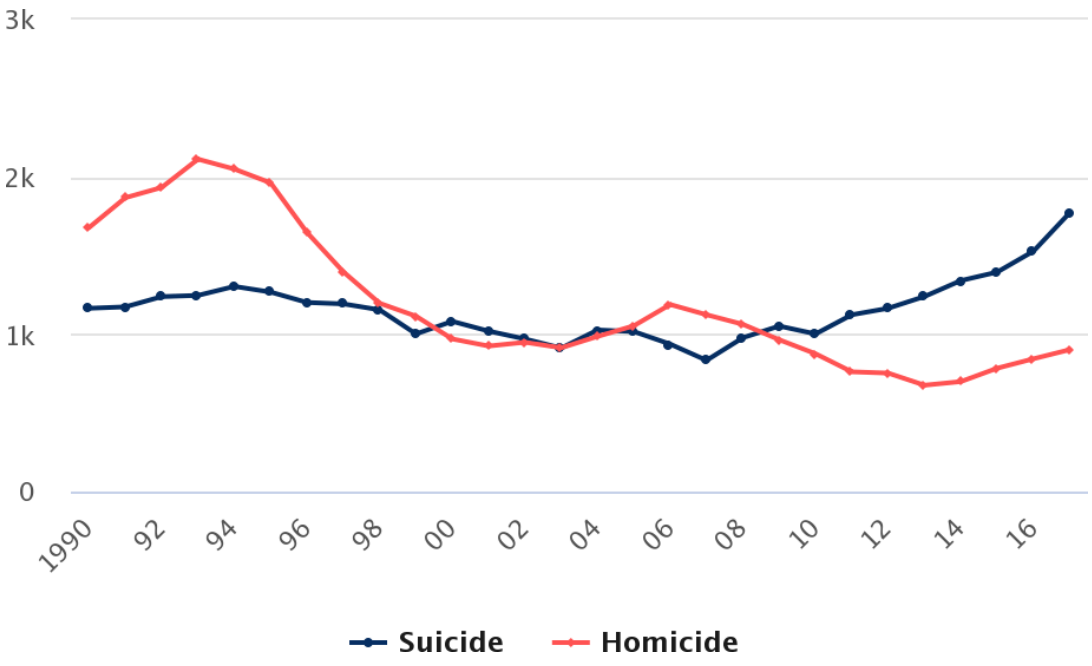
Throughout the United States, suicide is the **second leading cause of death** for youth between the ages of 10 and 24. Teens ager 10 to 17 have the highest rate of suicidal *attempts* of any age group. Suffocation accounts for nearly half of suicide deaths, closely followed by firearms (CDC, 2019).

Family history of suicide, depression, mental health problems, incarceration, access to lethal means, alcohol and drug abuse, and suicidal behavior by others can put a young person at increased risk for suicidal behaviors. An increased risk of suicide has also been linked to moving frequently, due to fewer opportunities for developing healthy social connections and supports.

Certain youth are at higher risk than others. Boys are more likely than girls to die from suicide; however, girls are more likely than boys to *attempt* suicide. Native American/Alaskan Native youth have the highest rates of suicide-related fatalities. Hispanic youth are more likely to report attempting suicide than their black, white, and non-Hispanic peers.

Among youth aged 10 to 17, there are many more suicides than homicides. Although in the 1990s homicides significantly outnumbered suicides, in the last five years nearly twice as many youths died as a result of suicide than homicide (OJJDP, 2019).

Number of Suicide and Homicide Victims Ages 10–17, 1990–2017

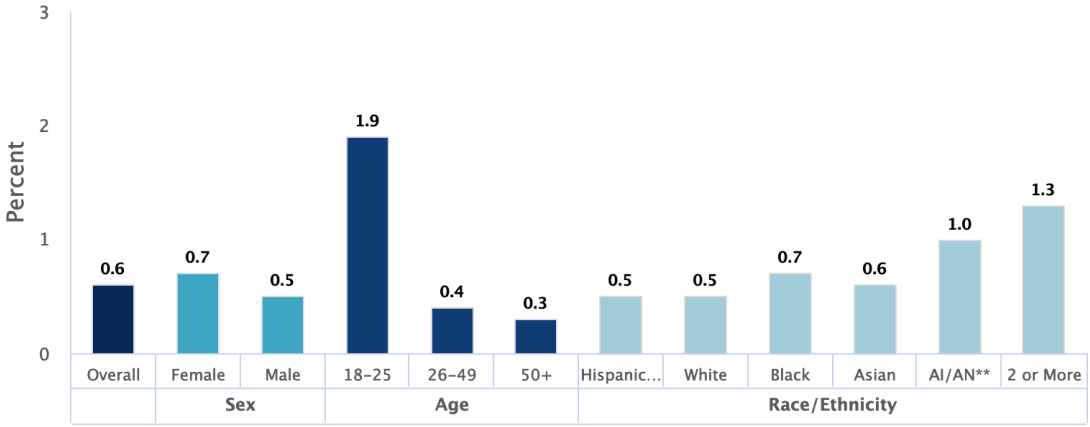


Homicide victims ages 10 to 17 outnumbered youth suicide victims through 1999. More recently, however, the trend reversed as suicides outnumbered homicides annually since 2009. By 2017, nearly twice as many youth died as a result of suicide than homicide.
Source: OJJDP, 2019.

Middle-Aged Adults (45–64 years)

For middle-aged adults, suicide is the **eighth leading cause** of death. Although middle-aged adults have a lower percentage of suicidal attempts than younger adults they have higher rates of death from suicide. The death rate from suicide has significantly increased in recent years, and is higher than for any other age group. This increase is seen for both middle-aged males and females (CDC, 2019).

Past Year Prevalence of Suicide Attempts Among U.S. Adults (2017)



Source: Data courtesy of SAMHSA. Chart, NIMH, 2019 figure 8.

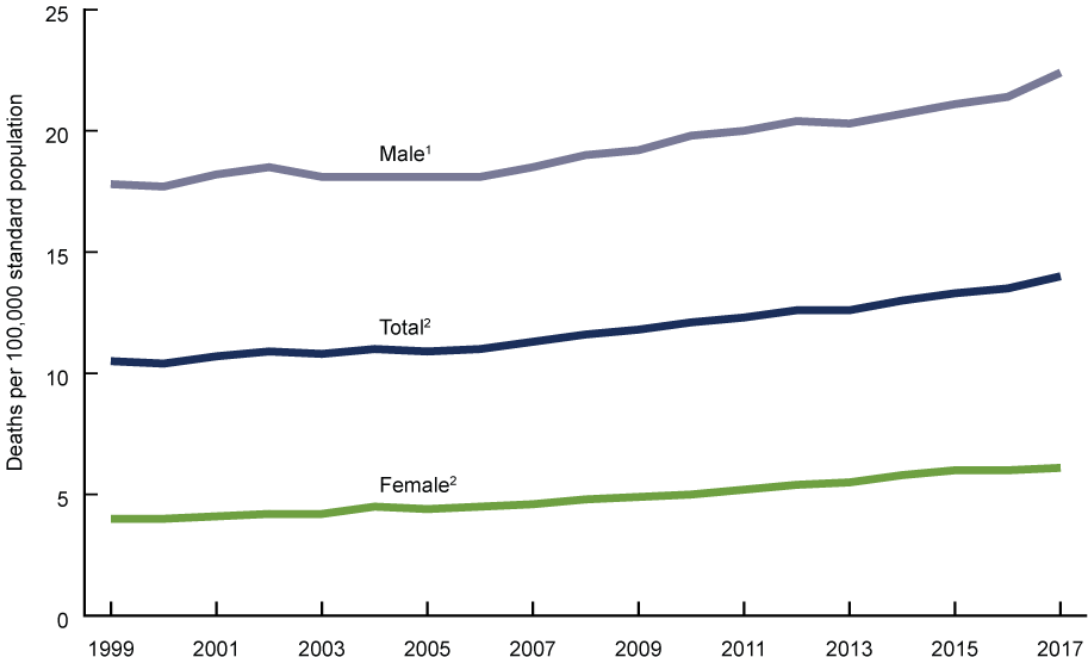
Older Men and Women

Physical illnesses and physical disability are strongly associated with suicide attempts in older adults. Limited social connectedness, changes in cognition, loss of control, social exclusion, and loneliness are associated with suicidal ideation, non-fatal suicidal behavior, and suicide. Strong risk factors for death by suicide include death of a spouse or partner, bereavement, having a mental disorder, and experiencing physical illness. Research has identified three clusters among patients aged 80 and older who died by suicide: (1) married or widowed patients, (2) individuals who were living alone or socially isolated, and (3) people suffering from dementia or depression (Conejero et al., 2018).

Gender Differences

From 1999 through 2017, suicide rates increased for both males and females. During this period, the age-adjusted suicide rate increased 33%. Compared with rates in 1999, suicide rates in 2017 were higher for males and females in all age groups from 10 to 74 years (CDC, 2018b).

Age-Adjusted Suicide Rates, by Sex (United States, 1999–2017)



[1]Stable trend from 1999 through 2006; significant increasing trend from 2006 through 2017, $p < 0.001$.
[2]Significant increasing trend from 1999 through 2017 with different rates of change over time, $p < 0.001$.
Source: CDC, 2018b Figure 1.

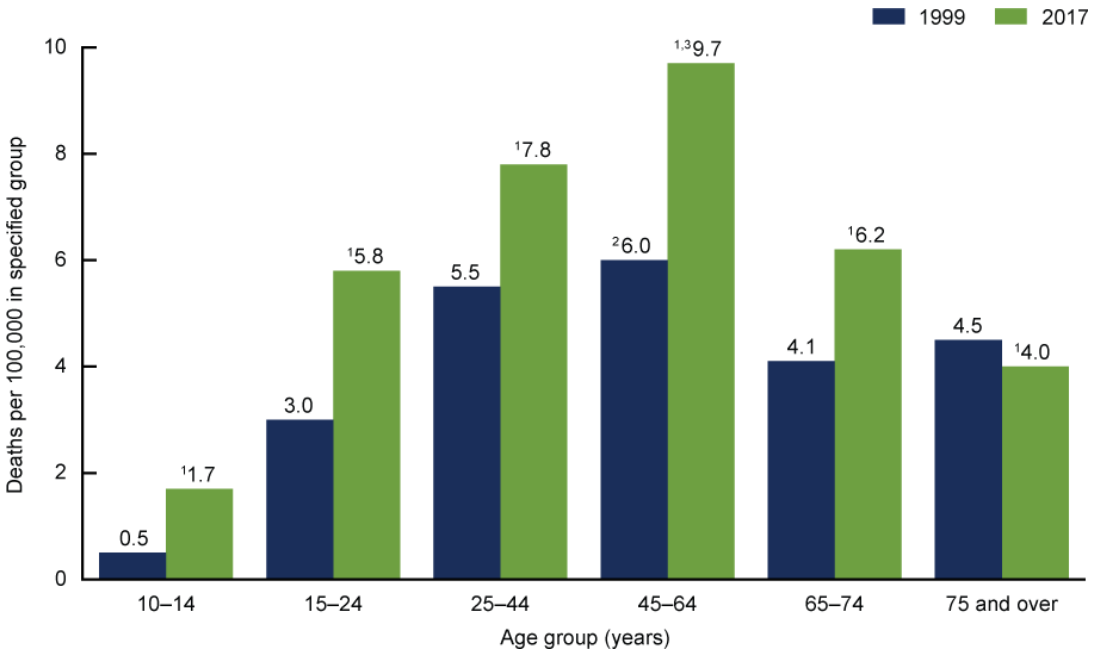
Although women are more likely than men to attempt suicide, men are likely to use deadlier methods. Suicide is most

common in women aged 35 to 64 years, peaking in women aged 45 to 54 years. Starting at about 50 years of age, suicide rates among women tend to diminish progressively, until old age, when rates start increasing again (Mendez-Bustos et al., 2013).

Data from the Nurses' Health Study indicated that suicide rates among middle-aged women in the United States have increased by more than 30% in recent years, exceeding even the relative increases observed among middle-aged men. However, women who were socially well integrated* had a more than 3-fold lower risk for suicide over 18 years of followup (Tsai et al., 2015).

***Social integration** was measured with a 7-item index that included marital status, social network size, frequency of contact with social ties, and participation in religious or other social groups (Tsai et al., 2015).

Suicide Rates for Females, by Age Group (United States, 1999 and 2017)



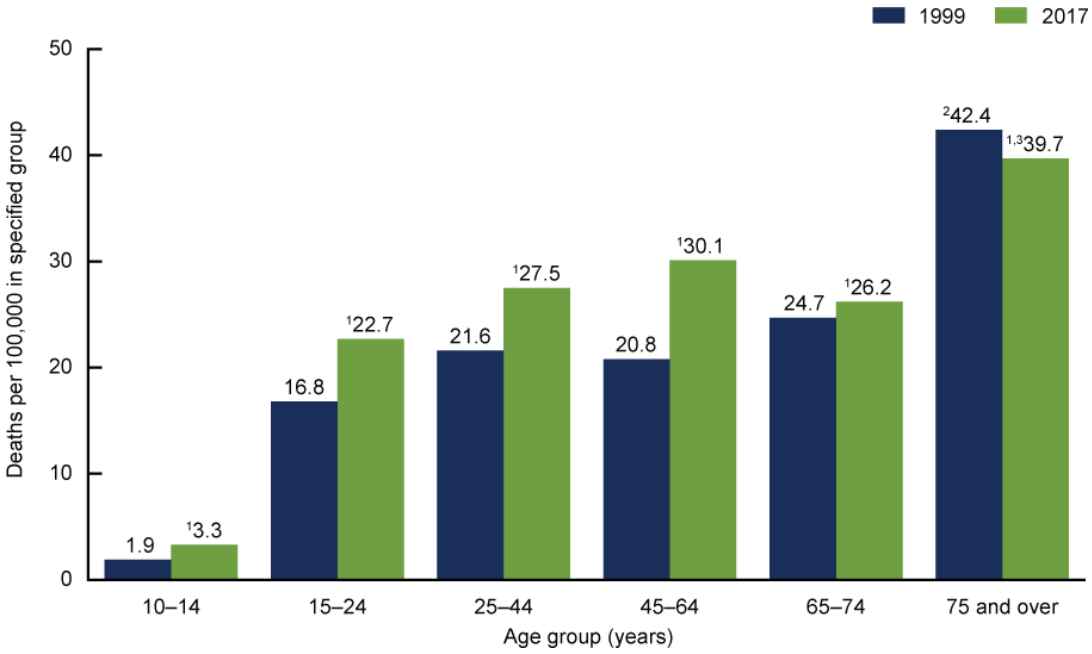
[1]Significantly different from 1999 rate.
[2]Significantly higher than rates for all other age groups in 1999.
[3]Significantly higher than rates for all other age groups in 2017.
Source: CDC, 2018b Figure 2.

In men, social withdrawal, anger, and reduced problem solving capacity may be signs of suicidal ideation. Statements of suicidal intent, calmness, anger, apathy, hopelessness, risk-taking, and appearing "at peace" may indicate someone who is planning a suicide attempt. Signs preceding *death by suicide* include desperation and frustration in the face of unsolvable problems, helplessness, worthlessness, statements of suicidal intent, and emergence of a positive mood state (Hunt et al., 2017).

Male participants in a 2015 Australian study reported experiencing some or all of the following four factors in the development of suicidality:

- Periods of depressed or disrupted mood
- Conceptions of masculinity that strongly influenced decision-making (such as stoicism)
- Social isolation and use of avoidant coping strategies
- At least one, but often many, personally meaningful stressors (Player et al., 2015)

Trends in Suicide Rates Among Males (United States, 1999 and 2017)



[1]Significantly different from 1999 rate.
[2]Significantly higher than rates for all other age groups in 1999.
[3]Significantly higher than rates for all other age groups in 2017.
Source: CDC, 2018b Figure 3.

Retired Builder

A 69-year-old Caucasian man—a retired builder with a medical history of chronic depression—was brought to hospital after a failed suicide attempt. The attempt consisted of self-asphyxiation with car exhaust fumes and shooting himself three times with a three-inch nail gun. The initial shot was directed upward through the submental triangle behind the chin. It pierced his tongue, upper denture plate, and hard palate, effectively pinning his mouth shut. The subsequent two shots were fired into the fourth intercostal space immediately left of the sternum.

On admission to the ED the patient was distressed but hemodynamically stable. An examination revealed nail gun entry wounds on his left anterior chest wall over the precordial area, and at the submandibular area under his chin, pinning his mouth closed. The nails within the thorax could not be confidently located on chest X-ray; however, transthoracic echocardiography suggested a nail had possibly penetrated into the right ventricle. There was no associated pericardial effusion. The patient was immediately transferred to the operating room where preparations for an exploratory midline sternotomy and thoracotomy were made.

The potential for rapid hemodynamic deterioration due to the intrathoracic penetrating injury required urgent surgical exploration. The uncertainty in the location of the intrathoracic nails meant the exact nature of the surgical repair was not defined and provision was made for lung separation. In this case, the chest x-ray failed to allow an adequate view of the nail within the thorax. Although transthoracic echocardiography suggested the nail had penetrated the right ventricle, the exact location of the nail was not clear.

Cardiopulmonary bypass was initiated to facilitate surgical exposure. During cardiopulmonary bypass, the endobronchial balloon was deflated, as lung isolation was not required, and cardiac repair was completed uneventfully. Removal of the nail from his mouth required a small incision into the hard palate and extraction using surgical pliers, removing the nail from his hard palate, upper denture, and tongue. The patient made an excellent recovery and was discharged five days later to a psychiatric community hospital for ongoing psychological rehabilitation.

Source: Lim et al., 2013.

Suicide Among Nurses

The loss of a nurse colleague to suicide is more common than generally acknowledged and is often shrouded in silence, at least in part due to stigma related to mental health and its treatment. Compared with what is available for physicians, a standard procedure for how to handle the suicide of a nurse colleague does not exist. Because of this, unit managers are left to develop a recovery plan independently to support staff in their grief and recovery (Davidson et al., 2018).

Several international studies, although outdated, nevertheless describe factors that are relevant today to nurses in the United States: ethical conflicts, organizational deficits, role ambiguity, shift work, social disruption of families due to work hours, team conflict, and workload. In two U.S. studies performed using data from the Nurses' Health Study, a combination of work and home stress, smoking, and Valium use were identified as suicide risk factors (Davidson et al., 2018).

A critical review of nine additional studies found that collective risk factors leading to nurse suicide included access to lethal means, depression, knowledge of how to use lethal doses of medications and toxic substances, personal and work-related stress, smoking, substance abuse, and under-treatment of depression (Davidson et al., 2018).

Nursing is demanding and stressful work, with frequent exposure to human suffering and death, and burnout is common. Many nurses point to daily ethical issues and ethics-related stress, perceive limited respect in their work, and are increasingly dissatisfied with their work situations (Davidson et al., 2018).

Despite knowledge that nurse suicide exists, the occurrence of nurse suicide is shrouded in silence, avoidance, and denial. No public data identifying a national nurse suicide rate is available, yet data on suicide rates are readily available for physicians, teachers, police officers, firefighters, and military personnel. Transparency is complicated by a lack of standardized reporting of death by suicide. Reporting characteristics vary from county to county; some do not include occupation. In states that do report occupation, the occupation code is usually entered in free text, resulting in difficulty constructing a methodology for accurate data analysis (Davidson et al., 2018).

Soana Starts a New Job

I was hired on the ICU night shift after having moved to a new town. The culture was quite different from my previous hospital. The night nurses were noticeably less collaborative, with more of a “get your own work done so you can sit and read” attitude. I was used to a culture where “no one sits down until everyone can sit down.”

The day shift seemed different, but maybe that was because the day shift supervisor Penny was a bright ray of light. I remember Penny very well. She looked like a perfect West Coast girl, tan, with beautiful white teeth sparkling in her warm smile; [she was] energetic, always warm and friendly, with a hint of mischief. A consummate professional, Penny was a fierce patient advocate and was loved by the staff, physicians, and families. I wanted to be like Penny. Her leadership on the day shift was missing in my night shift colleagues.

I’d been at my new job for about 6 months when I received a call asking if I could come in early to start my shift. There had been a tragedy among the staff and there were nurses who were unable emotionally to finish their shifts. When I asked what had happened, the charge nurse told me Penny had died. They were looking for relief to allow the grieving nurses to go home.

When I arrived, everyone in the ICU was red-eyed from crying and looking shell-shocked. When I asked what happened to Penny, I was told she was found dead at her home by her husband, from whom she had recently separated. I was shocked and saddened by the news but, since I only knew Penny from our brief encounters at staff meetings and change of shift, I was able to contain my own emotions enough to relieve one of her closest colleagues.

Weeks later, after the funeral and many mournful days in our unit, we were told Penny’s death was due to an intentional injection of a neuromuscular blocking agent. She had removed the drugs from the unit’s secured drug storage locker the day before. Only those very close to her knew of her marital problems. No one at work would ever suspect Penny was suffering so much in her personal life. She never let her pain show. Interactions with Penny were always upbeat and positive.

We all missed Penny terribly in those months after her suicide. We asked ourselves how we could have missed or misjudged her degree of despair over her failing marriage. Unfortunately, the culture on nights in ICU did not improve and I requested a transfer to the surgical trauma unit on the opposite side of the hospital. The ICU just wasn’t the same without Penny and the staff was still struggling with emotions.

I’ll never forget Penny—her wonderful personality and her gifts as a nurse and leader. I still struggle with how someone with so many caring colleagues, and access to support and help, could have seen no hope in her situation.

I’ve since learned that suicide is a complex and dynamic emotional condition. There are stigmas that need to be overcome so nurses (and all people) suffering from depression, hopelessness, and despair know they can seek help and will not be judged. Maybe Penny thought because she was a nurse she should be able to handle her life situation and depression on her own.

Source: Davidson et al., 2018 (edited for length).

5. The Screening and Assessment Process

Dallas's Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital found that 1.8 percent of patients were at high suicide risk and up to 4.5 percent were at moderate risk.

Joint Commission, 2016

A good clinical assessment can in itself be the start of a suicide prevention effort. However, determining who is at risk, using either screening tests or clinical judgment, is extremely difficult, primarily because suicide is a relatively rare event (CSAT, 2015). Screening and assessment tools typically have two goals: (1) to identify current suicidal ideation, and (2) to assess the potential for future suicidal behaviors (Harris et al., 2015).

No matter which tool is used, screening for and assessing risk depends heavily on the skills and philosophical approach of the individual clinician; it requires a caring, non-judgmental approach. The way questions are asked and the words and phrasing used influence the patient's response (McCabe et al., 2017).

If the screen indicates increased risk or if harm appears imminent, complete a more thorough assessment or make an immediate referral, **making sure your client transitions safely from your office or clinic to the point of actual service**.

The Joint Commission recommends that all patients be screened for suicidal ideation using a brief, standardized, evidence-based screening tool (JC, 2016). The overall goal is to identify people who have thoughts of self-harm but have not yet formulated a plan or acted on those thoughts.

A screen can be as simple as waiting room questionnaire or a quick, two-question screening tool, which can help identify high-risk individuals. Research has shown that a brief screening tool can identify individuals at risk for suicide more reliably than leaving the identification up to a clinician's personal judgment or by asking about suicidal thoughts using vague or softened language (JC, 2016).

Screening is most effective when:

- A simple screening tool is used.
- Questions are practiced ahead of time.
- Suicide warning signs, risk factors, and protective factors are understood.
- Clinicians are aware of their own attitudes about suicide.
- Services are coordinated with other practitioners and family members.
- Referral appointments are kept. (CSAT, 2015)

Importance of Secondary Suicide Risk Screening

In a multicenter study of 1,376 emergency department patients with recent suicide attempts or ideation, an intervention consisting of secondary suicide risk screening by the ED physician, discharge resources, and post-ED telephone calls resulted in a small but meaningful reduction (5%) in the proportion of patients subsequently attempting suicide over the 12-month observation period and a 30% decrease in the overall number of suicide attempts.

Source: Miller et al., 2017.

If a client screens positive for suicide risk, the standard of care established by The Joint Commission requires a thorough suicide risk assessment. To determine the proper course of treatment for a client determined to be at risk for suicide, either conduct a more comprehensive assessment or refer your client for secondary screening and assessment (JC, 2016).

Screening Tools

A number of screening and assessment tools have been validated for use in healthcare settings. The*Patient Health*

Questionnaire 2 and *9* (screens for depression) are increasingly being used for suicide screening. Although not intended to be a comprehensive list, other examples of screening and assessments tools include the Columbia Suicide Screen, the EDSAFE Patient Safety Screener, the Suicide Behaviors Questionnaire, and the Beck Suicide Intention Scale.

Patient Health Questionnaire 2 (PHQ2)

The *Patient Health Questionnaire 2* (PHQ2) is a validated screening tool used by many large hospital organizations to screen patients for suicide risk. This tool was originally designed to screen for depression. The PHQ2 asks a client to answer two questions and indicate—over the last 2 weeks—how often he or she has been bothered by either of the following problems:

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless

Answers are given as 0 to 3, using this scale: 0 = Not at all; 1 = several days; 2 = more than half the days; 3 = nearly every day.

If a client responds "not at all" to both questions on the PHQ2, then no additional screening or intervention is required, unless otherwise clinically indicated. If a client responds yes to one or both questions on the PHQ2, then an additional assessment should be initiated. Your organization will need to identify the score that necessitates intervention in your particular setting.

Patient Health Questionnaire (PHQ9)

A more comprehensive version of the *Patient Health Questionnaire*—called the PHQ9—is used to screen or diagnose depression, measure the severity of symptoms, and measure a client's response to treatment (NYSDOH, 2016). The PHQ9 is administered if a client answers yes to any of the PHQ2 questions. A study using the PHQ9 found that those who expressed thoughts of death or self-harm were 10 times more likely to attempt suicide than those who did not report those thoughts (Joint Commission, 2016).

Columbia-Suicide Severity Rating Scale

Another commonly used, brief screening tool is the *Columbia Suicide Screen*. It is an 11-item measure, created by researchers at Columbia University and validated by the National Institute of Mental Health. It is used to evaluate mood, substance abuse, and suicidal ideation and attempts. This tool reportedly has lower rates of false positives (results that falsely suggest suicide risk) than other screening tools.

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

- Whether and when they have thought about suicide (ideation)
- What actions they have taken—and when—to prepare for suicide
- Whether and when they attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition (Columbia Lighthouse Project, 2016)

Emergency Medicine Network's EDSAFE Patient Safety Screener

A brief screening tool—primarily used as part of an initial inpatient nursing assessment—is the *Emergency Medicine Network's EDSAFE Patient Safety Screener* for emergency departments (JC, 2016). This tool can also be used in outpatient and other settings. It contains three questions:

1. Over the last 2 weeks, have you felt down, depressed, or hopeless?
2. Over the last 2 weeks, have you had thoughts of killing yourself?
3. In your lifetime, have you ever attempted to kill yourself? If so, when?

If a client screens positive on the *EDSAFE Patient Safety Screener*, a secondary screen is recommended to help guide the decision to refer to a mental health specialist. The secondary screen asks:

1. Did the patient screen positive on the PSS items—active ideation with a past attempt?
2. Has the individual begun a suicide plan?
3. Has the individual recently had intent to act on his/her ideation?
4. Has the patient ever had a psychiatric hospitalization?
5. Does the patient have a pattern of excessive substance use?
6. Is the patient irritable, agitated, or aggressive?

All individuals who screen positive on the *Patient Safety Screener* should: (1) have appropriate precautions in place to ensure safety during the visit, and (2) receive a written Safety Plan at discharge from the emergency department (EMN,

2017).

Suicide Behaviors Questionnaire—Revised (SBQ-R)

The *Suicide Behaviors Questionnaire—Revised* (SBQ-R), a screening tool used mostly in emergency departments, asks clients four questions:

1. Have you ever thought about or attempted to kill yourself?
2. How often have you thought about killing yourself in the past?
3. Have you ever told someone you were going to commit suicide, or that you might do it?
4. How likely is it that you will attempt suicide someday?

Beck Suicide Intention Scale

The Beck Suicide Intention Scale (SIS) examines subjective and objective aspects of the suicide attempt, the circumstances at the time of the attempt, and the patient's thoughts and feelings during the attempt. It is based on a clinical interview using an instrument with 15 items referring to the patient's precautions and beliefs of the act. Each item is scored on a scale from 0 to 2, with a possible total score of 30 indicating the highest intention of suicide and a wish to die (Grimholt et al., 2017).

The SIS questionnaire covers precautions, planning, communication, and expectations regarding medication load, the degree of planning, and wish to die or live. It is divided into two sections: the first eight items constitute the "circumstances" section (part 1) and are concerned with the objective circumstances of the act of self-harm; the remaining seven items, the "self-report" section (part 2), are based on the patients' own reconstruction of their feelings and thoughts at the time of the act (Grimholt et al., 2017).

When Harm Is Imminent

The potential for imminent self-harm exists when a person feels he is a burden, when there is no longer a sense of belonging, and when there is a history of self-injury. **Imminent harm** means a person is at **immediate risk** of self-harm or suicide.

The risk of imminent harm is elevated during the days and weeks following hospitalization for a suicide attempt, especially for people diagnosed with major depression, bipolar disorder, and schizophrenia. If a screen indicates that a patient is at immediate risk of self-harm be ready to talk, keep the person safe, and have referral information readily available. The overreaching goal is not to diagnose but to keep the patient safe until help arrives.

It is important to ask if a patient has recently engaged in self-injurious behaviors—deliberate acts done with the knowledge that they can or will result in some degree of physical or psychological injury. This includes direct and intentional self-injury that causes tissue damage, injury to oneself, or injury to health. It also includes suicide attempts (Xin et al., 2016).

The concern is that these behaviors can become chronic and evolve into other forms of self-harm, such as suicide attempts. Because non-suicidal, self-injurious behavior and suicidal behavior often occur together, it is important to consider the nature of the link between these two types of behavior (Grandclerc et al., 2016).

Assessing a Patient's Safety

Safety is an important aspect of your initial screen. Safety means there is an absence of suicide risk, that patients are protected and have a sense of control over their lives (Berg et al., 2017).

To assess safety, begin with an open-ended question: "Has something happened recently that has affected your well-being?" The response might be: "My mother just died—I'm very depressed. All my family is gone now." If there is no response or the response is delayed, ask a more direct question: "Now that your mother has died, what else in your life brings you joy?" Follow with a question of concern: "I wonder—have you ever thought of hurting yourself?" Asking about suicidal behavior does not plant a seed.

Develop a series of questions that help you determine the level of care needed for patient safety. Ask if patients has ever harmed theselves, as well as how many times and in what ways. Practice on a regular basis—otherwise, you'll be tongue-tied when confronted with a potentially suicidal patient. To develop fluency, practice questions with co-workers, friends, or family members.

If attempts have accelerated and become more sophisticated, this should increase your concerns about safety. The more times a person attempts suicide, the more likely he or she is to complete the event.

Taking Lethality into Account

Lethality is related to the severity of physical consequences as well as the amount of medical intervention needed following an attempt (Kar et al., 2014). It focuses on the method being considered and the circumstances surrounding the attempt. Clients who have a clear intention of taking their life, who feel unsafe, or who have chosen a lethal method

require higher levels of protection than those with less inclination toward dying.

There is often a mismatch between a patient's intent and the lethality of the method chosen. Clients who genuinely want to die (and expect to die) may survive because the chosen method was not foolproof or because they were interrupted or rescued (CSAT, 2015).

Levels of Risk

The decision to refer a patient to a mental health professional or the ED depends on the patient's presentation and level of risk. Patients with serious thoughts of suicide, a plan or intent to engage in self-directed violence, a recent suicide attempt, or those with prominent agitation, impulsivity, or psychosis, are at **high acute risk**.

A patient in acute suicidal crisis must be kept in a safe healthcare environment under one-to-one observation. Immediate access to care should be provided through an emergency department, inpatient psychiatric unit, respite center, or crisis unit. These clients (and their visitors) should be checked for items that might be used to make a suicide attempt or to harm others. They should be kept away from anchor points for hanging and material that can be used for self-injury. Some specific lethal means that are easily available in general hospitals and that have been used in suicides include: bell cords, bandages, sheets, restraint belts, plastic bags, elastic tubing, and oxygen tubing (JC, 2016).

Patients with suicidal ideation and a plan but with no intent or preparatory behavior are considered to be at **intermediate acute risk** and an evaluation by a behavioral health specialist is recommended. If closer evaluation warrants a higher level of care, the patient may be hospitalized. If a patient feels capable of maintaining safety using non-injurious coping methods and a safety plan, the patient may be managed in outpatient care.

For patients who screen positive for suicidal ideation and deny or minimize suicide risk or decline treatment, try to obtain corroborating information by requesting the patient's permission to contact friends, family, or outpatient treatment providers. If the client declines consent, HIPAA permits a clinician to make these contacts without the patient's permission when the clinician believes the client may be a danger to self or others (JC, 2016).

Low acute risk patients, those with recent suicidal ideation who have no specific plans or intent to engage in self-directed violence and have no history of active suicidal behavior, can be referred to a behavioral health specialist to determine the need for treatment and to address symptoms and safety issues.

Patients that at some point in the past had reported thoughts about death or suicide, but currently don't have any of these symptoms are generally **not at an elevated risk** for suicide. These individuals can be followed in routine care, continue to receive treatment for their disorder, and be re-evaluated periodically for thoughts and ideation.

If a client is thought to be at lower risk of suicide, make personal and direct referrals and linkages to outpatient behavioral health and other providers for followup care within one week of initial assessment, rather than leaving it up to the patient to make the appointment (JC, 2016).

Level of Risk and Appropriate Action in Primary Care

High Acute Risk

Indicators of suicide risk

- Persistent suicidal ideation or thoughts
- Strong **intention** to act or plan
- Not able to control impulse **or**
- **Recent suicide attempt** or **preparatory behavior††**

Contributing Factors†

- Acute state of mental disorder or acute psychiatric symptoms
- Acute **precipitating** event(s)
- Inadequate **protective factors**

Initial action based on level of risk

- Maintain direct observational control of the patient
- Limit access to lethal means
- Immediate transfer with escort to Urgent/ED care setting for hospitalization

Intermediate Acute Risk

Indicators of suicide risk

- Current suicidal **ideation** or thoughts

    - No **intention** to act
    - Able to control the **impulse**
- **No recent suicide attempt** or **preparatory behavior** or rehearsal of act

Contributing Factors†

- Existence of warning signs or risk factors†† and
- Limited protective factors

Initial action based on level of risk

- Refer to Behavioral Health provider for complete evaluation and interventions
- Contact Behavioral Health provider to determine acuity of referral
- Limit access to lethal means

Low Acute Risk

Indicators of suicide risk

- Recent suicidal **ideation** or thoughts
- No **intention** to act or plan
- Able to control the **impulse**
- No planning or rehearsing a suicide act
- No previous attempt

Contributing Factors†

- Existence of **protective factors and**
- Limited **risk factors**

Initial action based on level of risk

- Consider consultation with Behavioral Health to determine:
    - Need for referral
    - Treatment
- Treat presenting problems
- Address safety issues
- Document care and rationale for action

†Modifiers that increase the level of risk for suicide of any defined level:
Acute state of substance use: Alcohol or substance abuse history is associated with impaired judgment and may increase the severity of the suicidality and risk for suicide act
Access to means: (firearms, medications) may increase the risk for suicide act
Existence of multiple risk factors or warning signs or lack of protective factors

††Evidence of suicidal behavior warning signs in the context of denial of ideation should call for concern (eg, contemplation of plan with denial of thoughts or ideation).

In some instances, an immediate response is required. Examples of immediate actions include: arranging transportation to a hospital ED for evaluation, asking a mental health specialist to evaluate a client further, or contacting a spouse to have a gun removed from the home. Examples of non-immediate, but important, actions include making a referral for a client to an outpatient mental health facility for evaluation, scheduling the client to see a psychiatrist for possible medication management, and ordering past mental health records from another provider.

Valeria Cuts Her Wrists (Again)

Joanna is a physical therapist working in a small rural outpatient rehab clinic in northern California. She recently had a client referred for evaluation and treatment of low back pain. When her client, Valeria, walked in from the waiting room, Joanna noticed she was hunched over a little, had her head down, walked slowly, and had bandages on both wrists.

Before beginning the physical examination, Joanna asked if Valeria ever thought about harming herself. Valeria's direct and frank response startled Joanna. With her eyes downcast and in a timid voice, Valeria said that, yes, she had hurt herself in the past and had thought about suicide. She nervously related, "The first time I tried to hurt myself, I took a bottle of aspirin. The second time I was 17 and I slit my wrists but I screamed when I saw the blood."

Joanna asked her if anything had happened recently that had affected her well-being or mood. Valeria tearfully said, "Last week my boyfriend broke up with me and it really upset me. Two days ago I drank 2 bottles of whiskey and slit my wrists in the bathtub. When I saw the blood in the water I got scared and jumped out of the tub and drained the water. I taped my

wrists but I didn't tell anyone what had happened." She asked Joanna why she was asking her about suicide when she was at the clinic for back pain.

Test Your Knowledge

What do you think stands out in Valeria's description of her suicide attempts?

1. She is very calm and articulate.
2. She seems upset but not depressed.
3. Her suicide attempts have become more sophisticated.
4. She doesn't seem to really want to harm herself.

Answer: C

Joanna noted that Valeria's attempts have accelerated and become more sophisticated. This increased her concern about Valeria's safety because the more times a person attempts suicide, the more likely they are to complete the event. It is the clinic's policy to screen all clients for suicidal ideation and behaviors using the Patient Health Questionnaire 2 so Joanna asked Valeria: "Over the last 2 weeks, how often have you been bothered by any of the following problems?"

- Little interest or pleasure in doing things
- Feeling down, depressed, or hopeless

Valeria indicated she has these feelings every day (3) on both of the screening questions.

What should Joanna do?

Joanna's outpatient physical therapy clinic has no mental health services but her clinic has a policy that anyone who marks a 2 or 3 on either PHQ2 screening question should receive a more thorough assessment and be referred to a mental health specialist. Joanna's supervisor tells her to either use the PHQ9 for a more thorough assessment or refer her client to the local emergency department for assessment by a mental health professional. Because Joanna is not a mental health professional and has not been trained on the PHQ9, she decides to refer Valeria to the local emergency department.

Valeria has no family living nearby and Joanna feels she is a danger to herself, so she decides to call the police to transport Valerie to the emergency department. She also provides Valeria with the phone number for a suicide hotline. Joanna follows up with a call the ED and learns that Valeria arrived safely at the hospital.

Understanding Intent

Screening for suicide can be very awkward and success depends upon your ability to ask difficult questions that help you understand a person's intentions. Often people who intend to harm themselves are relieved to be able to share their feelings and get help.

Intentions guide a behavior or lead to an outcome. Intent is a measure of how hard a person is willing to try or the likelihood a person will perform or try to perform a particular behavior. Intention is an important underlying driver of behavior (Williams, 2016).

If a patient clearly intends to harm himself, refer him to someone who is**licensed** to decide about an involuntary hold. A person who agrees to be hospitalized must be placed in the least restrictive environment. However, depending on the level of risk, a patient can be held against his wishes. Determining whether a patient is safe (and whether they can be held against their will) is left to providers who are legally licensed to make that determination.

Understanding Stigma

There is a misconception—even among some healthcare providers—that people who harm themselves choose to suffer. This creates stigma regarding self-harm. General psychiatric admission for self-harming is of uncertain therapeutic value and suicidal individuals and may even be harmful for patients with borderline personality disorder, especially if admissions are lengthy and unstructured. Although often lacking, specialized services are essential—particularly in situations of unique vulnerability, such as suicidal crisis. When the risks of suicide and severe self-harm are acute, it is essential that services are offered in a compassionate manner that honors the human dignity of the person who is suffering (Liljedahl et al., 2017).

About Self-Harm—A Nurse Practitioner's Perspective

Nonsuicidal self-injury often involves people with borderline personality disorders; self-harm is an antidote to psychological numbing. This doesn't let providers off the hook in terms of assessing safety and lethality but this sort of situation requires a different kind of assessment.

A clinician must decide what direction the self-harm is heading—from superficial and visible self-harm to deeper and less visible self-injury. People with certain types of mental illness are more likely to be associated with escalating self-harm, with an ever-greater likelihood of a completed suicide.

Unintentional vs. Intentional Overdose

[Material from this section is from DVA/DOD, 2013.]

Intentional overdose is a common method of attempted suicide and the possibility that an overdose was intentional should always be considered. When a patient is forthcoming, differentiating between unintentional and intentional overdose is generally straightforward. However, even if it was, some patients insist an overdose was **not** intentional; also, determining a person's intention is especially challenging in patients with a history of substance abuse.

There is limited data on the differentiation between unintentional overdose and suicidal behavior in substance abusers. Available data indicate that risk factors for suicide attempt (compared to unintentional overdose) include female gender, comorbid depression, interpersonal distress or disruption, and use of substances other than one's drug of choice. Prior suicide attempts also increase the likelihood that a recent overdose event was intentional.

A recent loss of tolerance can be a risk factor for*unintentional* overdose, for example due to incarceration or detoxification. Individuals using recreational drugs with high potential for miscalculation (eg, intoxicants sold in head shops as "bath salts") are more likely to experience unintentional overdose.

There are instances when intentionality is unclear or ambiguous even among substance abusers who are forthcoming. This can occur when an individual was experiencing suicidal ideation when she overdosed but appeared not to have intended to attempt suicide, or when a distressed person knowingly pushed the limits of dosage and stated "I don't care if I live or die" but seemed to have no clear agenda for suicide.

Obtaining information from family members, treatment providers, and medical records can be invaluable in making the determination between intentional and unintentional overdose. Intoxicated or psychotic patients who are unknown to the clinician and who are suspected to be at acute risk for suicide should be transported securely to the nearest crisis center or ED for evaluation and management. These patients can be dangerous and impulsive; assistance in transfer from law enforcement may be needed.

6. Management of the Suicidal Patient

Suicidal thoughts, if unchecked, evolve into a wish to die, an intention to act, and a plan to end one's life. The evolution of these steps can occur over minutes or years and each step presents an opportunity to intervene. Often, a patient's intentions are identified only after a suicide attempt is made, which makes the management particularly difficult.

Easy access to mental health services—especially during high-risk periods—is a key component of management, as is the management of major depression. Unfortunately, geography, transportation, insurance, and income challenges often limit access to healthcare services.

Improving a provider's ability to identify and manage risk factors, understanding the role of therapeutic interventions and psychiatric medications, restricting access to lethal means, and ensuring continuity of care have been shown to reduce rates of suicide and suicidal ideations in patients.

Psychotherapeutic Interventions

To the degree possible, care decisions should be made in a team environment with shared decision making and shared responsibility for care. The team must include the patient and his or her family, whenever possible and appropriate.

National Action Alliance for Suicide Prevention

Psychosocial interventions are intended to help people learn new ways of dealing with stressful experiences, identify patterns of thinking, and practice alternative actions when thoughts of suicide arise (NIH, 2017). **Psychotherapy** is a type of therapeutic intervention that takes place in a one-on-one or group format and can vary in duration from several weeks to several months or longer. Treatment that employs collaborative and integrated care engages and motivates patients, increases retention in therapy, and decreases suicide risk (Stone et al., 2017).

Terry

On the morning of December 25, 2000, Terry Wise tried to kill herself. She awoke two days later in the intensive care unit. The death of Terry's husband from Lou Gehrig's disease was a trigger for her suicide attempt; but in reality her attempt was the culmination of years of depression and other problems that started in her childhood. Terry was overwhelmed by an intense emotional pain that had been building for years, and when her husband died the pain became unbearable.

Right after Terry tried to kill herself, she felt lost. She didn't know what to do. She found no joy in living. Terry went to therapy, and ultimately it changed her life. By working with a counselor, Terry realized that the trauma she experienced when she was younger still affected her emotions as an adult. Her counselor helped her find ways to cope with her feelings. Therapy also allowed her to see how others would have reacted to her death by suicide. Most important, Terry's therapist trusted her and respected her and, for Terry, her therapist's compassion made a huge difference.

Terry's recovery was a process. It took time and hard work. She recalls: "And that is really the first step, to go from feeling that life is an endurance test to being able to tolerate being alive. And then you hope that the unendurable becomes bearable. Then you hope the bearable becomes manageable. Then you hope the manageable becomes pleasurable. And so it's a process. It evolved over time."

Source: SAMHSA, 2015.

Cognitive Behavior Therapy for Suicide Prevention (CBT-SP) uses a risk-reduction, relapse-prevention approach that includes an analysis of risk factors and stressors leading up to and following the suicide attempt. This is followed by the development of a safety plan, skill building, and psycho-education. CBT-SP includes family skill modules focused on family support and communication patterns as well as on improving the family's problem-solving skills. In a randomized controlled trial utilizing outpatient cognitive therapy, there was a 50% reduction in the likelihood of a suicide re-attempt relative to treatment as usual among adults who had been admitted to an ED for a suicide attempt (Stone et al., 2017).

Dialectical Behavioral Therapy (DBT) is a multi-component therapy for individuals at high risk for suicide and who may struggle with impulsivity and emotional regulation issues. DBT includes individual therapy, group skills training, telephone coaching, and a therapist consultation team. In a randomized controlled trial of women with recent suicidal or self-injurious

behavior, those receiving DBT were half as likely to make a suicide attempt at the two-year followup than women receiving community treatment. The women also required less hospitalization for suicide ideation, and had lower medical risk across all suicide attempts and self-injurious acts combined (Stone et al., 2017). DBT has also been shown to reduce the rate of suicide among people with borderline personality disorder (NIH, 2017).

The Improving Mood—Promoting Access to Collaborative Treatment (IMPACT)program aims to prevent suicide among older primary care patients by reducing suicide ideation and depression. IMPACT facilitates the development of a therapeutic alliance, a personalized treatment plan that includes patient preferences, as well as proactive followup by a depression care manager. The program has been shown to significantly improve quality of life, and to reduce functional impairment, depression and suicidal ideation over 24 months of followup relative to patients who received care as usual (Stone et al., 2017).

Collaborative Assessment and Management of Suicidality (CAMS), is a therapeutic suicide-specific assessment and treatment approach. The program's flexible approach includes the clinician and patient, who work together to develop patient-specific treatment plans. Sessions involve constant patient input about what is (and is not) working with the goal of enhancing the therapeutic alliance and increasing treatment motivation in the suicidal patient (Stone et al., 2017).

CAMS has been tested in several studies, in a variety of inpatient and outpatient settings. A community-based sample of suicidal outpatients randomly assigned to CAMS or enhanced care as usual (psychiatric care, medication, and case management) found better treatment retention among the CAMS group and significant improvements in suicidal ideation, overall symptom distress, and feelings of hopelessness at the 12-month followup (Stone et al., 2017).

Attachment-Based Family Therapy (ABFT) is a program for adolescents aged 12 to 18 designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety. A trial using ABFT found that suicidal adolescents receiving ABFT experienced significantly greater improvement in suicidal ideation over 24 weeks of followup than did adolescents assigned to enhanced usual care. Significantly, a higher percentage of ABFT participants reported no suicidal ideation in the week prior to assessment, at 12 weeks, and again at 24 weeks than did adolescents receiving enhanced usual care (Stone et al., 2017).

Psychiatric Medications

Pharmacologic intervention can be helpful in managing underlying mental disorders and decreasing self-directed violence.

Although there is limited evidence that psychiatric medications reduce suicidal thoughts and behaviors, a decrease in the long-term suicide rate for patients with mood disorders treated with lithium, neuroleptics, and antidepressants has been reported (Pompili & Goldblatt, 2012).

All medications used by patients at risk for suicide should be reviewed to prevent adverse drug interactions. When prescribing drugs to people who self-harm, consider the toxicity and limit the quantity dispensed or available. If possible, ask another person to be responsible for securing access to medications. Followup and monitoring for adverse events is crucial.

The only two evidence-based medications that have been shown to lower suicidal behaviors are lithium and clozapine. However, these medications do not reach therapeutic levels immediately. Anxiolytics, sedative/hypnotics, and short-acting antipsychotic medications may be used to directly address agitation, irritability, psychic anxiety, insomnia, and acute psychosis, until such time as a behavioral health assessment can be made. The amount and type of medication must be carefully chosen and titrated when an individual is under the influence of alcohol, illicit substances, or other medications.

Lithium

Lithium, a mood stabilizer, is used primarily to treat bipolar disorder, mood swings associated with other mental disorders, and, in some cases, to augment the effect of other medications used to treat depression. A number of studies have described the anti-suicide benefits of lithium for individuals on long-term maintenance (NIMH, 2016), possibly because it reduces the relapse of mood disorders. Other possible mechanisms include an effect on aggression or impulsivity, both of which are associated with an increased risk of suicide (Cipriani et al., 2013).

People treated for an affective disorder have a 30 times greater risk of suicide than the general population, and the evidence that lithium reduces the risk of suicide and possibly deliberate self-harm in people with bipolar disorder and recurrent unipolar depression indicates that lithium should continue to have an important clinical role (Cipriani et al., 2013).

Clozapine

Clozapine (marketed as Clozaril, Fazaclo ODT, Versacloz and generics) is an antipsychotic medicine used to treat schizophrenia in patients whose symptoms are not controlled with standard antipsychotic drugs. Clozapine is also used in patients with recurrent suicidal behavior associated with schizophrenia or schizoaffective disorder (FDA, 2019).

While clozapine is beneficial for some patients, there are risks associated with this drug. Specifically, clozapine can decrease the number of neutrophils, a type of white blood cell, that function in the body to fight off infections. When

neutrophils are significantly decreased, severe neutropenia may result and the body may become prone to infections. For this reason, patients taking clozapine need to have their absolute neutrophil count (ANC) monitored on a regular basis (FDA, 2019).

Key Point about Clozapine

Clozapine should be considered for patients diagnosed with schizophrenia at high risk for suicide, who do not have contraindications to clozapine, and *will be compliant with all required monitoring.*

Source: DVA/DOD, 2013.

Antidepressant, Antipsychotic, Antiepileptic, and Antianxiety Agents

[Unless otherwise cited material in this section is from Gusmão et al., 2013.]

Suicide is strongly associated with poor mental health, especially mood disorders.**Antidepressants** are the most common treatment for mood disorders, but effective use of these medications requires administration to patients who have been properly diagnosed and then adequately followed up (Gusmão et al., 2013).

There is a consensus as to the importance of primary care doctors' education programs for improving the management of depression with antidepressants in order to reduce the risk of suicide. Furthermore, a number of multi-component suicide prevention programs emphasize the crucial importance of primary care education programs to facilitate optimal antidepressant prescribing (Gusmão et al., 2013).

However, there are concerns about the efficacy and safety of antidepressants. Some researchers have suggested that antidepressants are no better than placebo and that antidepressants may actually increase the risk of suicidal behavior, particularly in young people. Others contend that there is a bias in these findings and that the benefits are in fact greater than the risk. For instance, an analysis of nearly 30 randomized controlled trials examined antidepressant prescribing in children and adolescents to age 18 with a diagnosis of major depressive disorder and showed that benefits appeared to far outweigh a small increased risk of suicidal behavior (Gusmão et al., 2013).

Although depressive symptoms are often associated with suicide risk, no antidepressant medication has been shown to lower suicide risk in depressed patients. However, because of the relationship between low cerebrospinal fluid serotonin levels and the emergence of aggression and impulsivity, the selective serotonin reuptake inhibitors (SSRIs) have been recommended for the treatment of depressive disorders when suicidal risk is present. Treatment with SSRIs must be carefully monitored and managed during the initial treatment phase because of the potential for the possible emergence of suicidal ideation and behaviors during this time. The Food and Drug Administration has recently created a black box warning when prescribing SSRIs for persons under the age of 25.

Key Points

- Antidepressants may benefit suicidal behavior in patients with mood disorders.
- Young adults (18–24) started on an antidepressant for treatment of depression or another psychiatric disorder should be monitored and observed closely for emergence or worsening of suicidal thoughts or behaviors during the initiation phase of treatment.
- Patients of all age groups who are managed with antidepressants should be monitored for emergence or worsening of suicidal thoughts or behaviors after any change in dosage.
- When prescribing antidepressants for patients at risk for suicide, pay attention to the risk of overdose and limit the amount of medication dispensed and refilled.

DVA/DOD, 2013.

Atypical antipsychotics may be used as treatment augmentation in the management of major depressive disorder and treatment of bipolar depressive disorders. Aripiprazole, quetiapine, and olanzapine in combination with fluoxetine include depressive disorders in their label indications. Their labels also include the same box warning as antidepressants for an increased risk of suicidal thinking and behaviors. There is no evidence to support this increased risk in adults, albeit atypical antipsychotics have not been as extensively studied as antidepressants (DVA/DOD, 2013).

Key Points About Antipsychotics

- There is no evidence that antipsychotics provide additional benefits in reducing the risk of suicidal thinking or behavior in patients with co-occurring psychiatric disorders.
- Patients who are treated with antipsychotics should be monitored for changes in behavior and emergence of suicidal thoughts during the initiation phase of treatment or after any change in dosage.
- When prescribing antipsychotics in patients at risk for suicide pay attention to the risk of overdose and limit the amount of mediation dispensed and refilled.

Source: DVA/DOD, 2013.

Patients started, or who are managed with,**antiepileptics** should be monitored for changes in behavior and the emergence of suicidal thoughts. There is no evidence that antiepileptics are effective in reducing the risk of suicide in

patients with a mental disorder (DVA/DOD, 2013).

Anxiety is a significant and modifiable risk factor for suicide and the use of**anti-anxiety agents** may have the potential to decrease this risk. Any one of several rapidly acting, anti-anxiety agents can be used in an emergency to reduce anxiety in patients who exhibit suicidal behaviors. The use of any medications for this purpose must consider the risk of death from suicide versus the risk of serious adverse effects from psychopharmacology (to include disinhibition that could lead to suicide) versus the utility of various psychosocial interventions versus doing nothing (DVA/DOD, 2013).

Benzodiazepines can be effective in treating symptoms of anxiety, insomnia, hypervigilance, and other anxiety symptoms. In general, benzodiazepines are not recommended for long-term use in chronic aggression because of the potential for dependence and tolerance, resulting in an increase in impulsivity and aggression. Benzodiazepines can occasionally disinhibit aggressive and dangerous behaviors and enhance impulsivity. Benzodiazepines taken in excessive amounts can cause dangerous deep unconsciousness. In combination with other central nervous system depressants, such as alcohol and opiates, the potential for toxicity increases exponentially (DVA/DOD, 2013).

Continuity of Care

Continuity of care is critical when dealing with a patient who has attempted suicide. Continuity of care is affected by the many healthcare providers, friends, and family members who are involved with the care of a person at risk for suicide. Shared electronic medical records may help healthcare providers; however, not everyone has access to these records, partly because mental health information has a higher level of consent than other medical records.

Maintaining continuity of care is particularly important when a patient transitions between care settings. Even a transfer within the same organization present risks for discontinuities. Transitions may include:

- Transfers or referrals upon discharge from the emergency department
- Referrals from primary care to behavioral health
- Transfers from inpatient care to a residential treatment settings
- Discharge residential care units to ambulatory services

Continuity of care is enhanced when a provider directly contacts another provider and followup appointments are scheduled. Transition support services—such as telephone contact with behavioral health providers—are strongly recommended. Best practices include telephone reminders of appointments, providing a “crisis card” with emergency phone numbers and safety measures, and sending a letter of support. Counseling and case management also provide support and promote adherence to the recommended treatment.

Patients leaving the emergency department or hospital inpatient unit after a suicide attempt require rapid proactive outreach and followup. The risk is particularly high in the weeks and months following the attempt, including the period after discharge.

For patients who are transferred from the emergency department to medical-surgical services for the treatment of injuries related to a suicide attempt, followup mental health evaluations should be conducted before discharge.

Evaluations should assess the support available from family and friends. Before discharge, followup appointments for mental healthcare should be made and patients, families, or friends should be coached about the importance of keeping these appointments.

Adults who receive medical care immediately after a suicide attempt are more likely to receive mental health treatment compared to those who did not receive medical care. The emergency department provides an important opportunity to assess the patient's mental health needs and provide followup resources at a particularly critical juncture (Crane, 2016).

Having survived a suicide attempt is one of the most significant risk factors for later death by suicide. Continuity of care following a suicide attempt is critically important and should be a collaborative effort between patient and provider that gives the patient a feeling of connectedness.

Julio Faces a Divorce

Julio is a 50-year-old police/firefighter who is facing an unwanted divorce from his wife of 25 years. He has been a client of ABC Dental Services for more than 10 years and is well-known to everyone who works in the office. He has an appointment with Manolo, the dental hygienist, for a cleaning. Keisha, the office manager has asked Julio to fill out a short questionnaire while he is waiting for Manolo.

After a short wait, Manolo escorts Julio into his treatment room. Manolo notices that Julio is very quiet and asks him how he’s doing. Julio tells him that he’s a little depressed because he was recently arrested for drunk driving and he’s been suspended without pay from his job. He says his wife (also a client of ABC Dental) has asked him for a divorce.

As Manolo is prepping for the cleaning, Julio thanks Manolo for the excellent dental care he’s received over the years and asks Manolo to tell the dentist how much he appreciates everyone at the clinic. He tells Manolo that he’s planning a hunting trip and isn’t sure when he’ll be back.

Screening

The ABC Clinic uses the PHQ 2 to screen all clients at each visit and employees have received specialized training in screening and referral for suicidal ideation and behaviors. The clinic maintains a list of pre-screened referral services in the event that a referral is needed for one of their clients.

Manolo excuses himself and asks the office assistant for the results of Julio's waiting room screen. Keisha lets Manolo know that Julio marked "3" on both of the questions on the waiting room questionnaire (little interest or pleasure in doing things and feeling down, depressed, or hopeless). Because of Julio's screening answers, Manolo decides to discuss the results with Julio.

Manolo: You mentioned that you feel depressed. On the waiting room questionnaire you indicated that you also feel hopeless and have little interest in anything anymore. Is this true?

Julio: Yes, I'm losing everything that's important to me—my wife, my job, my driver's license—even my kids are mad at me.

Manolo: You sound pretty unhappy.

Julio: I am. I just want to get away from all this pressure and try to get my head straight.

Manolo: Sometimes, when people feel hopeless and depressed, they don't see any reason to go on living. Have you thought about suicide?

Julio: Well, sometimes I do. I have guns, and sometimes think it isn't worth it anymore. But I don't think I could really pull the trigger—I'm not that kind of guy.

Manolo: Have you ever tried to hurt yourself in the past?

Julio: Well, about 10 years ago, when I failed the firefighter training exam I was so depressed I downed a bottle of Vicodin and passed out. My roommate at the time called an ambulance and I had to have my stomach pumped. I didn't really want to die—I just wanted to turn off my brain for a while.

Manolo: I want to thank you for sharing all of this with me. Right now, I'm concerned that you might try to hurt yourself when you leave the office. Are you planning to go back home before you go on your trip?

Julio: Yes, I want to say goodbye to my wife and kids.

Manolo: Would it be okay with you if I called your wife and let her know what's going on? I'd like to have her to remove your guns and medications from the house. Is that okay with you? I'd also like to have you talk to some people who can help you with your depression and thoughts of suicide. Is that okay? I can ask someone to come over to the clinic right now to talk to you.

Julio: Yes, I would appreciate that.

Discussion

Manolo stays with Julio in a private room while the office manager contacts social services. She also informs the dentist. The office assistant also calls Julio's wife to let her know the situation and to ask her to remove any guns and narcotic medication from the house. Julio's wife agrees to do this but refuses to come to the clinic.

The fact that Julio tried to harm himself 10 years ago by overdosing on a narcotic pain medication is a red flag. Manolo discusses the situation with the dentist and they decide that Julio should be seen immediately for a more thorough assessment. The clinic has a list of pre-screened mental health providers who are willing to come to the clinic and talk to Julio. Manolo reaches a social worker who agrees to meet with Julio. Manolo stays with Julio in a private room until the social worker arrives.

When Manolo follows up the next day he learns that Julio has voluntarily admitted himself to the local hospital's mental health ward.

7. Lethal Means

Lethal means are items or actions that might be used in a suicide attempt that are likely to result in death. Lethal means can be divided into two main categories: violent and nonviolent methods. *Violent methods* can include firearms, cutting or piercing with a sharp object, hanging, jumping from high places, or stepping in front of a train or other vehicle. *Nonviolent methods* include ingestion of pesticides, poison by gases, suffocation, and overdose. Access, availability, and social acceptability of certain suicide methods and some location-specific factors such as access to firearms or tall buildings can factor into the choice of a lethal means (Sun & Jia, 2014).

Objects Used in Suicide Attempts

Household gun ownership rates are a significant positive predictor of both homicide and suicide. A substantial proportion of Americans—over 50% in some states—live in households with guns and may not need to purchase a new firearm to carry out a violent act (Swanson et al., 2015). More than half of male suicides are firearm-related (NCHS, 2016).

Although individuals who own firearms are **not** more likely than others to have a mental disorder or to have attempted suicide, the risk of a death is higher among this population because **individuals who attempt suicide using a firearm are more likely to die** in their attempts than those who use less lethal methods.

The use of firearms is particularly prevalent among veterans, with approximately 41% of female and 68% of male suicide deaths resulting from a firearm. Poison is the second-most common means of suicide among female veterans while suffocation is the second-most common cause of death among male veterans (USDVA, 2016a).

Substances Used in Suicide Attempts

Among middle-aged adults (aged 35 to 64) poisoning (predominantly drug overdose) is the leading cause of suicide death among females and the third leading cause for males. Suicide attempts (and suicide deaths) among middle-aged adults have increased in recent years, which underscores the importance of understanding risk factors for suicide in this age group (Tesfazion, 2014).

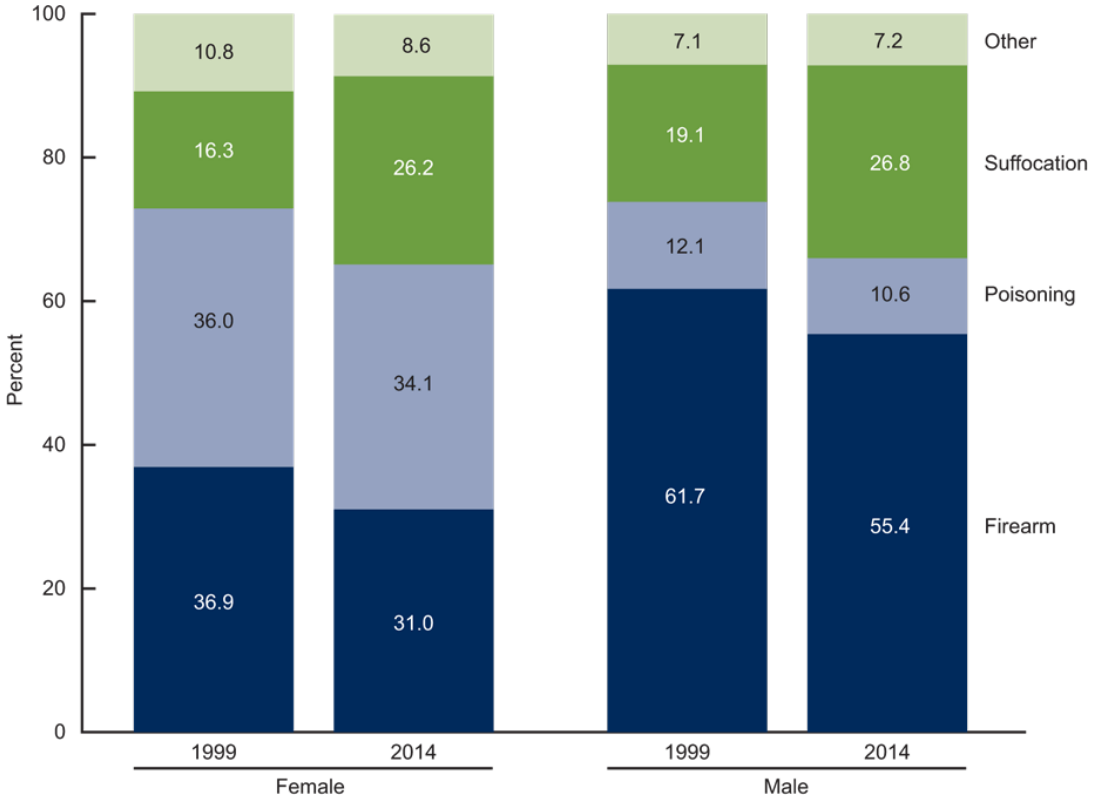
Nearly all drug-related emergency department visits involving suicide attempts among middle-aged adults involve prescription drugs and over-the-counter medications. About half of visits involve anti-anxiety and insomnia medications, a third involve pain relievers, and 22% involve antidepressants. Among middle-aged adults, more than a third of all drug-related ED visits involving a suicide attempt also involved alcohol, and 11% involved illicit drugs (Tesfazion, 2014).

Inert gas asphyxiations using helium have been on the increase in the United States. The increasing familiarity with this gas is partly the reason for the rise in suicide by helium. Helium suicides have also been publicized on internet websites as simple and painless. More formal recommendations regarding suicides with inert gas asphyxiations need to be developed as well as restricting access to helium (Hassamal et al., 2015).

The most frequent “other” suicide methods for females are falls and drowning. For males, the most frequent “other” methods are falls and cutting or piercing (NCHS, 2016). Although falling from buildings or bridges is a relatively small percentage of suicide attempts, it is very often lethal (Hemmer et al., 2017)

For both females and males, about a quarter of suicides in 2014 were attributable to suffocation (includes hanging, strangulation, and suffocation), an increase over previous years (NCHS, 2016). The high prevalence of asphyxiations can be attributed to the widespread availability of means for hanging. Currently, there are no formal proposals on how to reduce asphyxiation suicides. Research indicates that those who attempted suicide by hanging viewed it as a quick, simple, and painless death. One way to reduce hanging suicides would be to challenge perceptions of hanging as a quick, simple, and painless suicide method (Hassamal et al., 2015).

Suicide Deaths, by Method and Sex: United States, 1999 and 2014



Source: NCHS, National Vital Statistics System, Mortality.

Talking About Lethal Means

Individuals experiencing significant distress or who have a recent history of suicidal behavior should not have easy access to means that may be used in a suicide attempt. This includes access to firearms, weapons, medications, illicit drugs, chemicals used in the household, other poisons, or materials used for hanging or suffocation.

Healthcare providers are in a unique position to ask about lethal means. Providers have the opportunity to educate patients and families about safe firearm storage and access, as well as the appropriate storage of alcoholic beverages, prescription drugs, over-the-counter medications, and poisons. Many healthcare providers avoid these discussions or ask about lethal means only when a patient is identified as being at a very high risk for suicide.

About Lethal Means—A Nurse Practitioner's Guidance

Once you have identified that your patient is at risk for self-harm, try to identify any lethal means that your patient might be able to access once he or she leaves your office. Ask direct questions: "While you're in this dangerous period, may I call your partner or family member and ask them to remove the guns or poisons from the house?"

Ask permission and show concern in a non-judgmental manner—this is more likely to elicit information from your patient. You can continue by saying "I want to let you know that I appreciate and am honored that you've shared your thoughts with me. I'm just concerned that you may go again to a place of despair when you leave and I'm thinking of your safety."

Try to establish and maintain trust with your patient—if you think the person is at risk, there is no reason to cover your concern or to lie.

Restricting Access to Lethal Means

Means restriction involves techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm. Among suicide prevention interventions, reducing access to highly lethal means of suicide has a strong evidence base and is now considered a key strategy to reduce suicide death rates (Betz et al., 2016).

Lethal means restriction can include:

- Complete removal of a lethal method
- Reducing the toxicity of a lethal method, for example, reducing carbon monoxide content emissions from vehicles
- Interfering with physical access, for example, using gun locks or placing barriers on bridges
- Enhancing safety, for example, encouraging at-risk families to remove lethal suicide means from the home
- Reducing the appeal of a more lethal method, for example, changing the perception of hanging as a quick and painless death.(Hassamal et al., 2015)

The majority of suicide attempts are transient and the time between contemplating suicide and the attempt is less than 5

minutes for many attempters. Success or failure depends on what method is readily available (Hassamal et al., 2015).

Restricting access to firearms is of particular importance because a suicide attempt using a firearm is fatal about 90% of the time. Patients with access to firearms at home might be considered at particularly high risk for discharge to home, given that firearm access is a risk factor for suicide (Betz et al., 2016).

While access to firearms and other lethal means does not mandate psychiatric admission, restricting access to firearms is a key component of home safety planning that should be addressed with all patients being discharged. Safe storage of firearms and other lethal means has been associated with less risk for suicide among adults and youth, and lethal means counseling in EDs might affect storage behavior (Betz et al., 2016).

Reducing access to potentially toxic medications is also important but can be a challenge, given that many of the medications used to treat mental illness can be toxic in an overdose. In one sample, 60% of patients reported currently taking at least one medication for an emotional or psychological problem, and medication overdose was the suicide method most commonly reported as having been considered (Betz et al., 2016).

Access to other lethal means of suicide—such as sharp objects or supplies for hanging—is also difficult to control given their widespread availability for other purposes. Installing bridge barriers or otherwise restricting access to popular jump sites may prevent deaths, depending on specific local conditions.

In times of crisis or during stressful transitions, research indicates that:

- The interval between deciding to act and attempting suicide can be as short as 5 or 10 minutes.
- People tend not to substitute a different method when a highly lethal method is unavailable or difficult to access.
- Increasing the time interval between deciding to act and the suicide attempt by making it more difficult to access lethal means, can be lifesaving. (Stone et al., 2017)

If a lethal method is not immediately available, the crisis will often pass, and the person may never attempt suicide. It is important to understand that most people who attempt suicide once and survive, never attempt again. Putting time, distance, and other barriers between a person at risk and the most lethal means can make the difference between life and death (WSDOH, 2016).

For patients at *highest risk*, make sure firearms are inaccessible. For patients at *intermediate to high acute risk*, discuss the possibility of safe storage of firearms with the patient and family. When possible, limit access to medications that carry risk for suicide, at least during the periods when patient is at acute risk. This may include prescribing limited quantities, supplying the medication in blister packaging, providing printed warnings about the dangers of overdose, or ensuring that currently prescribed medications are controlled by a responsible party. Also provide information on how to secure chemical poisons, especially agricultural and household chemicals, to prevent accidental or intentional ingestions. Many of these chemicals are highly toxic.

Restricting Access to Suicide Hotspots

Suicide hotspots, or places where suicides may take place relatively easily, include tall structures such as bridges, cliffs, balconies, and rooftops; railway tracks; and isolated locations such as parks. Efforts to prevent suicide at these locations include erecting barriers or limiting access to prevent jumping, and installing signs and telephones to encourage individuals who are considering suicide to seek help (Stone et al., 2017).

A meta-analysis examining the impact of suicide hotspot interventions implemented in combination or in isolation, both in the United States and abroad, found reduced rates of suicide. For example, after erecting a barrier on the Jacques-Cartier Bridge in Canada, the suicide rate for jumping from the bridge decreased from about 10 suicide deaths per year to about 3 deaths per year. Moreover, the reduction in suicides by jumping was sustained even when all bridges and nearby jumping sites were considered, suggesting little to no displacement of suicides to other jumping sites. Further evidence for the effectiveness of bridge barriers was demonstrated by a study examining the impact of the removal of safety barriers from the Grafton Bridge in Auckland, New Zealand (see box) (Stone et al., 2017).

Unintended Consequences—The Grafton Bridge

In 1996, after having been in place for 60 years, safety barriers to prevent suicide by jumping were removed from Grafton Bridge in Auckland, New Zealand. The barriers were reinstalled in 2003.

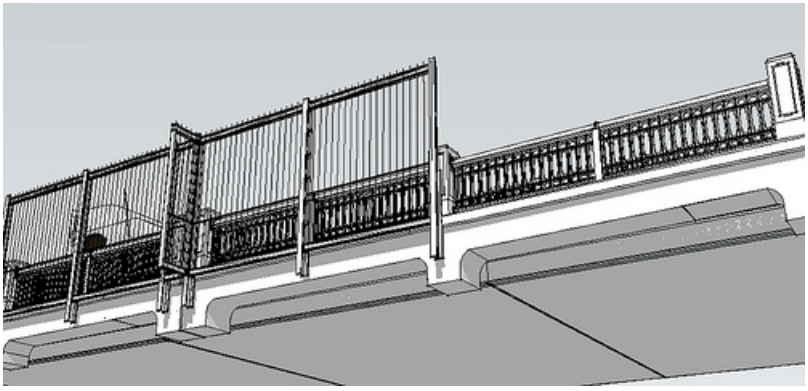
Removal of barriers was followed by a **fivefold increase** in the number and rate of suicides from the bridge. Since the reinstallation of barriers, there have been no suicides from the bridge. This natural experiment shows that safety barriers are effective in preventing suicide: their removal increases suicides; their reinstatement prevents suicides.

Source: Harvard School of Public Health, 2017.

Public jump sites are well-suited for suicide prevention, given that a great number of suicides are often limited to a few structures. At these hotspots, substantial suicide preventive effects can be achieved by a few prevention efforts. Most interventions for suicide prevention on bridges are of a structural nature (Hemmer et al., 2017).

Did You Know. . .

The Aurora Bridge in Seattle had the second highest suicide death toll in the United States (behind the Golden Gate Bridge). In 2006 emergency call boxes and signs with a suicide hotline number were installed on the bridge. Suicides continued to occur at an average of about five per year until a fence was installed in 2011. In the 18 months afterward, only one suicide occurred (Draper, 2017).



Designer view of the Aurora Bridge Fence suicide barrier in Seattle prior to its construction in 2010. Source: Washington State Department of Transportation.

Some interventions to prevent jumps from hotspots or other methods of suicide are not feasible for bridges. Although blocking access roads to hotspots have been shown to deter suicide jumps, this is not a viable measure for most bridges. There is evidence that the number of suicides by carbon monoxide poisoning in public parking lots has been reduced by installing aid signs. However, no studies exist that evaluate the effectiveness of aid signs as the sole intervention when used on bridges or other jumping sites, although they are widely installed (Hemmer et al., 2017).

Some research has shown that, if in addition to aid signs, emergency helpline phones are directly available on bridges, the phones are used on a regular basis. Another research project found that, in combination with increased police presence, emergency helplines led to a decrease in the number of suicides at the Sunshine Skyway Bridge in Florida (Hemmer et al., 2017).

Safe Storage Practices

Safe storage of medications, firearms, and other household products can reduce the risk for suicide by separating vulnerable individuals from easy access to lethal means. Such practices may include education and counseling around storing firearms locked in a secure place, unloaded and separate from the ammunition; and keeping medicines in a locked cabinet or other secure location away from people who may be at risk or who have made prior attempts (Stone et al., 2017).

In a case-control study of firearm-related events identified from 37 counties in Washington, Oregon, and Missouri, and from five trauma centers, researchers found that storing firearms unloaded, separate from ammunition, in a locked place or secured with a safety device was protective of suicide attempts among adolescents. Further, a systematic review of clinic and community-based education and counseling interventions suggested that the provision of safety devices significantly increased safe firearm storage practices compared to counseling alone or compared to the provision of economic incentives to acquire safety devices on one's own (Stone et al., 2017).

Pharmacists and community healthcare and mental health providers play a critical role in encouraging safe storage of potentially lethal products. For pharmacists and mental health providers, medications are of particular concern because of the potential for abuse, accidental poisonings, and use in suicide attempts. *Safer Homes Suicide Aware* recommends:

1. Lock up prescription medications.
2. Limit the supply of in-home, over-the-counter medications.
3. Return unused medications.
4. Dispose of medications in cat litter or coffee grounds and place in the trash. (Safer Homes Suicide Aware, n.d.)

Source: Safer Homes Suicide Aware Training Materials. Used with permission.

ED CALM

The Emergency Department Counseling on Access to Lethal Means (ED CALM) trained psychiatric emergency clinicians in a large children's hospital to provide lethal means counseling and safe storage boxes to parents of patients under age 18 receiving care for suicidal behavior. In a pre-post quality improvement project, researchers found that at post-test 76% reported that all medications in the home were locked up as compared to fewer than 10% at the time of the initial emergency department visit. Among parents who indicated the presence of guns in the home at pre-test (67%), all (100%) reported guns were currently locked up at post-test.

Source: Stone et al., 2017.

Francoise Gets Help from Her Pharmacist

Francoise is a 45-year-old woman who was previously stable on medications (lithium) for bipolar disorder. She stopped filling her prescription for lithium about 3 months ago.

On the day the pharmacist is conducting screening, Francoise arrives at the Rite Aid Pharmacy with prescriptions for opioids and benzodiazepines from a different provider in a nearby town. She appears nervous and agitated with evidence of thought disorder. She also smells of alcohol, which the pharmacist knows further increases risk of death—intended or unintended—from the combination of disturbed thought process along with certain medications and alcohol.

Screening

The Rite Aid Pharmacy uses the Patient Health Questionnaire 2 to screen clients for suicidal ideation and behavior. The screening is activated when a client has a sudden change in medications, has a prescription from another pharmacy, is filling a prescription for high-risk medications, or when a client's behavior causes staff concern. The pharmacist asks Francoise, "Over the last 2 weeks, how often have you been bothered by either of the following problems?

- Little interest or pleasure in doing things?
- Feeling down, depressed, or hopeless?

Although appearing quite nervous and agitated, Francoise answers in the negative to each question.

What Should You Do?

The pharmacist is concerned that Francoise is denying or minimizing her feelings. Because of the combination of medications and behaviors, she is worried that Francoise is in acute danger. She decides to ask some more direct followup questions. She uses another screening tool, the **Emergency Medicine Network's EDSAFE Patient Safety Screener** that she's familiar with from working in a hospital-based pharmacy. She asks Francoise:

- Over the last 2 weeks, have you had thoughts of killing yourself?
- In your lifetime, have you ever attempted to kill yourself? If so, when?

Francoise says she feels fine and hasn't had any thoughts of harming herself. She says she did try to commit suicide in the past but refused to say when or how. She asks when she can get her prescriptions.

The pharmacist asks Francoise if she can contact a family member for additional information. She agrees. If Francoise had declined consent, HIPAA permits a clinician to make these contacts without the patient's permission when the clinician believes the patient may be a danger to self or others.

Because the pharmacist has a “duty to protect” her client, she asks Francoise to wait with her in a private room and directs a cashier to call her family. Francoise’s husband arrives quickly and agrees to take his wife to the ED. The pharmacist follows up with local emergency and learns that Francoise has arrived at the hospital and is being evaluated.

Discussion

Relapsing bipolar disorder places a person at increased risk for suicide. Because Francoise stopped taking lithium and succeeded in getting prescriptions for a supply of medications from a different pharmacy, she now had the means (and perhaps the motive) to self-harm. The pharmacist and her staff were able to help Francoise through a combination of engagement, screening, concern, and a nonjudgmental attitude. They kept Francois in a safe environment under one-to-one observation until someone arrived to take her to the hospital. The system set up by the pharmacy to flag high-risk mediations along with a screening protocol provided help to a person in acute crisis.

Policy-Based Strategies

Policy-based strategies that restrict access to lethal means have led to positive results. For example, limiting access to suicide methods such as carbon monoxide has resulted in decreases in suicide by carbon monoxide. Restriction of other suicide methods has also shown positive results. The implementation of enhanced restrictions to purchase firearms in the District of Columbia led to reductions in firearm-related suicides (Hassamal et al., 2015).

Although this goal focuses on reducing access to lethal means among individuals at risk, evidence for means restriction has come from situations in which a universal approach was applied to the entire population. For example, the detoxification of household gas in the United Kingdom and discontinuation of highly toxic pesticides in Sri Lanka were universal measures associated with 30% and 50% reductions in suicide, respectively.

8. Safety Plans

Safety planning is a provider-patient collaborative process—a prevention tool designed to help an individual manage suicidal thoughts. The safety planning process produces a written plan that restricts access to means for completing suicide, encourages problem-solving and coping strategies, enhances social supports, and identifies a network of emergency contacts. Safety plans should be tailored to the individual, identifying specific warning signs as well as coping strategies that have been effective in the past.

Developing the Plan

Although no universally accepted safety planning method exists, the**safety planning intervention** has gained widespread acceptance in the suicide prevention community and has been incorporated into numerous treatment guidelines and interventions. The plan is collaboratively built by the clinician and patient and encourages individuals to engage in six sequential steps when feeling suicidal:

1. Identify early warning signs
2. Employ internal coping strategies
3. Distract with social engagement or change of environment
4. Access suicide-protective social support
5. Seek help through crisis resources
6. Restrict access to lethal means (Boudreaux et al., 2017)

The Safety Planning Intervention has a strong empirical foundation supporting each of its six steps, as well as evidence that it improves the average number of outpatient mental health visits for suicidal patients during the 6 months following the index ED visit, when compared with treatment as usual (Boudreaux et al., 2017).

The plan and the process of developing it should be included in the medical record, and the patient should receive a copy. The safety plan should be specific and should list situations, stressors, thoughts, feelings, behaviors, and symptoms that suggest periods of increased risk, as well as a step-by-step description of coping strategies and help seeking behaviors.

Monitoring the Plan

A common misconception is that suicide risk is an acute problem that, once dealt with, ends. Unfortunately, individuals who are suicidal commonly experience a return of suicide risk following setbacks, including relapse to substance use, a distressing life event, increased depression, or any number of other situations. Sometimes suicidal behavior even occurs in the context of substantial improvement in mood and energy. Therefore, monitoring for signs of a return of suicidal thoughts or behavior is essential (CSAT, 2015).

Monitoring emphasizes the importance of watching for a return of suicidal thoughts and behaviors, following up with referrals, and coordinating with providers who are addressing the patient’s suicidal thoughts and behaviors. There is a tendency to refer a patient to another provider and assume that the issue has been taken care of. This is a mistake. It is essential that you follow up to determine that the person kept the appointment. It is also critical to coordinate ongoing care and to alert other providers when a patient has relapsed and may be vulnerable to suicidal thoughts (CSAT, 2015).

Monitoring can include following up with the ED when a patient has been referred for acute assessment as well as continual coordinating with mental health providers, case managers, or other professionals. The client’s condition and your responses should be documented, including referrals and the outcomes of the referrals. Monitoring actions include:

- Confirming that the client still has a safety plan in effect.
- Monitoring and updating the treatment plan.
- Confirming that a client has kept referral appointments.
- Following up if a recurrence of suicidal thoughts or attempts is observed.
- Keeping family members engaged in the treatment process.
- Confirming that the client and the family have an emergency phone number to call.
- Confirming that the client does not have access to a method of suicide.
- Completing a formal treatment termination summary when this stage of care is reached. (CSAT, 2015)

These approaches typically include followup contact and use diverse modalities (home visits, mail, telephone, e-mail) to engage recent suicide attempt survivors in continued treatment to prevent re-attempts. Treatment may focus on improved coping skills, mindfulness, and other emotional regulation skills, and may include case management home visits to increase adherence to treatment and continuity of care; and personal therapy and group therapy. Approaches that engage and connect people to peers and providers are especially important because many attempters do not present to aftercare; 12% to 25% re-attempt within a year, and 3% to 9% of attempt survivors die by suicide within 1 to 5 years of their initial attempt (Stone et al., 2017).

9. Social and Community Support

I attempted to take my life because of a breakup when I was 16. I woke up and I was fine, but I was really mad. I just didn't want to live! I'd been trying to get a gun, and word got around. The school called my mom and a social worker came to talk to me. But what really changed my mind was my dad. I could feel his love, and it felt like he would lay down his life for me. Thinking about that would snap me out of it—suicide would hurt my family more than I'm hurting now.

In my worst moments the thought lingers, but now I know I could never go through with suicide. My faith gets me through those times—knowing that something bigger is out there and I shouldn't rob myself of what is yet to come. My kids give me a sense of purpose. I'm able to say to myself, "No, that's not an option, you can't do that." And I was really lucky to have that connection with my dad.

Annie Ost, Spokane
Source: WSDOH, 2016

A person's support network can be a source of strength in times of crisis as well as during recovery. Strong social and familial ties decrease stress and increase a person's ability to cope with a traumatic events or situations. Social support is a strong protective factor, which can diminish the risk of suicide:

- **General support**—such as positive contact, transportation and childcare, and messages of love and concern—is an important part of any social network.
- **Crisis support**—such as transport to a hospital or crisis center and assistance with children or pets—provides critical support during a new crisis.

Peer Support Programs

Peer norm programs seek to normalize protective factors for suicide by encouraging help-seeking, talking to trusted adults, and promoting peer connectedness. By leveraging the leadership qualities and social influence of peers, these approaches can be used to shift group-level beliefs and promote positive social and behavioral change. Peer norm programs typically target youth and are delivered in school settings but can also be implemented in community settings (Stone et al., 2017).

Programs such as *Sources of Strength* can improve school norms and beliefs about suicide that are created and disseminated by student peers. In a trial of *Sources of Strength* involving 18 high schools, researchers found that the program improved adaptive norms regarding suicide, connectedness to adults, and school engagement. Peer leaders were also more likely than controls to refer a suicidal friend to an adult. For students, the program resulted in increased perceptions of adult support for suicidal youths, particularly among those with a history of suicidal ideation, and the acceptability of help-seeking behaviors. Trained peer leaders also reported a greater decrease in maladaptive coping attitudes compared with untrained leaders (Stone et al., 2017).

Video: What Is Sources of Strength? [3:10]

https://www.youtube.com/watch?v=Rgi9GjhW3Ss

Gatekeeper Training

Gatekeeper suicide intervention training, which dates back to the late 1960s, teaches people to identify others at high risk for suicide and refer them to treatment. In essence, gatekeepers “open the gate” to get help for people at risk of suicide (Nasir et al., 2016).

Gatekeeper training (also referred to as “recognition and referral training”) teaches people with no formal psychosocial training to identify people who may be at risk of suicide. It provides information on how to respond, including encouraging the at-risk person to seek treatment and support services. Research shows that many at-risk people show warning signs that family, friends, or other gatekeepers may first notice.

Gatekeepers can be divided into two groups. **Designated gatekeepers** are professionals in healthcare, social work, nursing, and psychology. **Emergent gatekeepers** are community members who may not have been formally trained in suicide prevention, but who may have contact with people who have suicidal intent. Family, friends, and peer-helpers may be appropriate gatekeepers because of their close relationships with those at risk for suicide (Nasir et al., 2016).

One closely studied gatekeeper program, **Applied Suicide Intervention Skills Training (ASIST)**, helps hotline counselors, emergency workers, and other gatekeepers identify and connect with suicidal individuals and direct them to available resources. Research has shown that callers who spoke with ASIST-trained counselors feel less depressed, less suicidal, less overwhelmed, and more hopeful by the end of their call, compared to callers who spoke to non-ASIST trained counselors. Counselors trained in ASIST were also more skilled at keeping callers on the phone longer and establishing a connection with them (Stone et al., 2017).

Gatekeeper training is a primary component of the**Garret Lee Smith (GLS) Suicide Prevention Program**, which has been implemented in 50 states and 50 tribes. A study assessing the impact of this training on suicide attempts and deaths compared the change in suicide rates and nonfatal suicidal behavior among young people (aged 10–24) in counties implementing GLS trainings, compared to similar counties that did not implement these trainings. Counties that implemented GLS trainings had significantly lower youth suicide rates one year following the training implementation. This equates to a decrease of 1 suicide death per 100,000 youth ages 10 to 24, or the prevention of approximately 237 deaths in the age group, between 2007 and 2010 (Stone et al., 2017).

Counties implementing GLS program activities also had significantly lower suicide attempt rates among youth (aged 16 to 23) in the year following implementation of the GLS program than did similar counties that did not implement GLS activities. More than 79,000 suicide attempts may have been prevented during the period examined (Stone et al., 2017).

Crisis Lines

National Suicide Prevention Lifeline. Source: CDC.

Crisis intervention programs provide support and referral services, typically by directing a person in crisis (or a friend or family member of someone at risk) to trained volunteers or professional staff via telephone hotline, online chat, text messaging, or in person. Crisis interventions can put space or time between an individual who may be considering suicide and harmful behavior (Stone et al., 2017).

Crisis lines provide immediate access, often 24 hours a day. They are an access point for emergency care, clinical assessment, referral, and treatment. When other providers are closed and personal support networks are unavailable, crisis lines can be a lifeline for people at risk of suicide.

Veterans Crisis Line. Source: Department of Veterans Affairs.

In an evaluation of the effectiveness of the**National Suicide Prevention Lifeline**, 1,085 suicidal individuals who called the hotline completed a standard risk assessment for suicide, and 380 of those completed a followup assessment between 1 and 52 days after the initial assessment. Researchers found that over half of the initial sample had a plan for their suicide when they called. Among followup participants, there was a significant decrease in psychological pain, hopelessness, and intent to die between initiation of the call (time 1) to followup (time 3). Between time 2 (end of the call) to time 3, the effect remained for psychological pain and hopelessness, but was not significant for intent to die, suggesting that greater effort at outreach during and following the call is needed for callers with high levels of suicide intent (Stone et al., 2017).

Community Engagement

Community engagement approaches may involve residents participating in a range of activities, including religious activities, community clean-up and greening activities, and group physical exercise. These activities provide opportunities for residents to become more involved in the community and to connect with other community members, organizations, and resources, resulting in enhanced overall physical health, reduced stress, and decreased depressive symptoms, thereby reducing risk of suicide (Stone et al., 2017).

Among communities disproportionately affected by suicidal behaviors, a one-size-fits-all approach to suicide prevention and community engagement does not work. **Messages, interventions, and programs must be tailored to each community**:

- Involve community members and leaders from the beginning and respect them as experts on their own community.
- Become familiar with the community's history, risk and protective factors, cultural norms around language and communication, beliefs about death, and definition of the problem.
- Avoid viewing one or a few members of a community as representative of an entire demographic group.
- Put values of inclusion and equity front and center in decision making and program design.
- Include accessibility concerns such as transportation, cost, language translation, location, space, and materials for people with disabilities.

A recent workshop held in Iqaluit, Nunavut (Arctic Canada) provided guidance on ways to prevent suicide among Indigenous peoples—much of which can be applied to any community engagement effort. Key themes included:

- Acknowledge the impact of colonization.
- Recognize the effects of rapid social and environmental changes on mental wellness and suicide that have taken place in the recent past.
- Be aware of the great variation of suicide rates across communities, even within a single jurisdiction, and the importance of understanding the role of resilience.
- Understand that successful prevention strategies must be community-based and should integrate Indigenous ways of knowing.
- Recognize the importance of involving youth in developing solutions, tightening their relation to the land, and creating strong linkages with Elders and culture.
- Acknowledge the need to move from intention to action and from action to impact. (NIMH, 2017)

Healing of the Canoe

A good example of a program stressing community involvement while respecting local customs and beliefs is the**Healing of the Canoe Project**, a collaborative project between the Suquamish Tribe, the Port Gamble S'Klallam Tribe, and the Alcohol and Drug Abuse Institute at the University of Washington. It is a curriculum for Native youth focused on suicide and substance abuse prevention. The program uses the Canoe Journey as a metaphor, providing youth the skills needed to navigate their journey through life without being pulled off course by alcohol or drugs—with tribal culture, tradition, and values as compass to guide them and anchor to ground them (Healing of the Canoe, 2019).

Suquamish

Port Gamble S'Klallam

Video: What Is the Healing of the Canoe? [3:34]

https://www.youtube.com/watch?v=waQ4eK7wfb8

Rising Sun

Another innovative, community-based suicide prevention program is **Rising Sun** (Reducing the Incidence of Suicide in Indigenous Groups—Strengths United through Networks). The program has developed a toolkit, identifying common outcomes to be used in evaluating suicide prevention efforts and interventions across Arctic states. Common outcomes and their measures, developed through engagement with Indigenous peoples' organizations and community leaders, as well as mental health experts, facilitate data sharing, assessments, and interpretation of interventions across communities in the Arctic region (NIMH, 2017).

The goal of *Rising Sun* is to generate shared knowledge to help health workers better serve their communities and help policy-makers measure progress, evaluate interventions, and identify regional and cultural challenges. Arriving at common outcomes, is especially important in the Arctic, where the vast geography, high number of remote communities, and breadth of cultural diversity pose challenges for systematic approaches to suicide prevention (NIMH, 2017).

10. Suicide in Veteran Populations

The rates and patterns of suicidal behavior among U.S. Veterans differ from those of non-Veteran Americans. Although Veterans make up just over 8% of the adult population, they account for 14% of all deaths by suicide. In the last decade, there has been an increase in the rate of suicide among younger Veterans as well as gender-based differences in suicide rates (USDVA, 2019).

When service members leave the military, they lose the structure and support they experienced during their service. Missing one's team and no longer having a mission can lead to feelings of isolation, inadequacy, unrest, alienation, anxiety, and lack of purpose. During deployment, family members may have become more independent and self-reliant and service members may feel less needed, believing the family can survive just fine without them. Close, intense relationships that are formed within units become disrupted and lost when deployment ends.

VA Experience with Suicide

Users of Veteran's Administration services account for about 5 suicides per day. Approximately half had a diagnosis of a mental health condition recorded in their medical records in the year prior to their death, and approximately three-fourths, within the past five years.

Source: DVA/DOD, 2013.

According to U.S. Department of Veterans Affairs data:

- Firearm injuries accounted for about 67% of all veteran deaths by suicide.
- Veterans over the age of 50 accounted for about 65% of all deaths by suicide.
- Veterans had a 21% higher risk for suicide compared to civilian adults.
- Male veterans had an 18% higher risk for suicide compared to civilian adult males.
- Female veterans had a 2.4 times higher risk for suicide compared to civilian adult females. (USDVA, 2016a)

A 2009 Department of Defense reportfound that only 7% of military suicides occurred among service members with multiple deployments. While half of those who committed suicide had been deployed at some time to Iraq or Afghanistan, only 17% experienced combat. Most suicides occurred among junior enlisted troops (WSDOH, 2016).

Among male veterans, suicide rates are highest in younger and older men. Among female veterans, suicide rates are highest in younger women. However, because the age distribution of the living veteran population is heavily weighted toward middle-aged adults, the resulting burden of suicide, in terms of the number of lives lost, is highest among middle-aged veterans, despite the lower rates of suicide observed for this sub-population (USDVA, 2016a).

Risk and Protective Factors

In a recent survey, veterans identified suicide as the most formidable challenge they face (DeBeer et al., 2016). Factors that appear to *increase* the risk of suicide among service members and veterans include:

- Being a young, unmarried male of low rank
- Having recently returned from deployment, especially if experiencing health problems
- Having had an adverse deployment experience
- Having experienced lack of advancement or reduction in rank
- Having a perceived loss of honor, sense of injustice, or betrayal
- Having difficulty with heavy drinking or other substance use problems
- Having been disciplined
- Experiencing mental health problems
- Experiencing a career-threatening change in fitness for duty
- Feeling command/leadership stress
- Feeling a sense of isolation from one's unit
- Transferring to a new duty station
- Deploying to a combat theater (WSDOH, 2016)

Being a child in a military family is a risk factor for suicidal ideation. A higher percentage of tenth-graders with parents in the military reported symptoms of depression compared to tenth-graders from civilian families. They also answered yes more frequently to questions about serious consideration of suicide, making a suicide plan, and attempting suicide, and fewer than half answered yes when asked if there were adults to whom they could turn for help when feeling sad or hopeless (WSDOH, 2016).

PFC Shania Wilson

Private First Class Shania Wilson serves in the Washington State Army National Guard. A mother of three, she was stationed at Joint Base Balad, Iraq, for eight months, providing security for the hospital and Iraqi business on base, escorting local nationals working on base, and providing personal security detail services.

A second deployment sent PFC Wilson to Afghanistan. “I wasn't supposed to be on that deployment, but I was called to duty and had to go,” reported Shania. She pulled security duty in a variety of places and on several occasions experienced firefights; she also witnessed the death of three members of her unit, applied first aid to the severely wounded, and experienced two blasts from IED. She recalls being lightheaded with ringing in her ears. Since that time Shania has had problems thinking and remembering, has become more irritable, and experiences sleep disturbances.

After her deployments, Shania enrolled in college. On her arrival to school, she felt isolated and uncomfortable. She felt hopeless, as if there was no reason to live other than her children and unit, and she began to drink heavily. Several students in one of her classes surmised she was in the military and Shania overheard them refer to her one day as a “baby killer.”

Recently, a video was shown in her science course that made her feel uncomfortable and since that time she’s had more difficulty concentrating on her studies. She has not sought any medical or behavioral health assistance for fear that it could interfere with her career in the National Guard and also remove her from the chance to support her unit on another upcoming deployment. In fact, her team received notices that they could be tapped for an upcoming deployment.

Source: Schmidt, 2012.

Some factors appear to *decrease* the risk of suicide among service members and veterans. These**protective factors** are anything that makes it *less likely* for a person to develop a disorder. For service members and veterans, protective factors include:

- Strong interpersonal bonds
- Community support
- Employment
- Intact marriage
- Child-rearing responsibilities
- Responsibilities or duties to others
- A reasonably safe and stable environment

Personal traits can also act as protective factors against suicide:

- Willingness to seek help
- Good impulse control
- Skills in problem solving, coping, and conflict resolution
- Sense of belonging, sense of identity, and good self-esteem
- Cultural, spiritual, and religious beliefs about the meaning and value of life
- Optimistic outlook—identification of future goals
- Constructive use of leisure time
- Resilience

Access to healthcare, participation in treatment, and a sense of the importance of health and wellness are also important protective factors for service members and veterans.

Treating PTSD and Depression

Among veterans returning from the current wars, one of the most common mental health diagnoses is**post traumatic stress disorder (PTSD),** which is a known risk factor for suicidal ideation and behavior. Major depressive disorder, which is highly comorbid with PTSD, independently increases risk for suicidal ideation and attempts (DeBeer et al., 2016).

Veterans with PTSD who feel they have purpose and meaning in life have better outcomes than those who do not. Social support is associated with lower PTSD symptom severity in trauma-exposed individuals. Disrupted sleep is a core symptom of PTSD, and research demonstrates that cognitive-behavioral treatments that reduce insomnia and nightmares can reduce other symptoms of PTSD (DeBeer et al., 2016).

A relationship exists between health-promoting behaviors—such as regular exercise and good nutrition—and PTSD symptoms. Adults who participated in an exercise intervention program showed decreased levels of PTSD symptoms compared to baseline, and this reduction lasted after the intervention was completed (DeBeer et al., 2016).

Major depressive disorder, which is highly comorbid with PTSD, independently increases risk for suicidal ideation and attempts. Identifying modifiable factors such as depression that could reduce the association between PTSD symptoms and suicidal ideation is a high research priority (DeBeer et al., 2016).

The **VA Translating Initiatives for Depression into Effective Solutions (TIDES** projectuses a depression care liaison to link primary care and mental health services. The depression care liaison assesses and educates patients and follows up with both patients and providers to optimize treatment between primary care visits. This brings mental health care to the primary care setting, where most patients are first evaluated. An evaluation of TIDES found significant decreases in depression severity scores among 70% of primary care patients. TIDES patients also demonstrated 85% and 95% compliance with medication and followup visits, respectively (Stone et al., 2017).

The TIDES project has provided guidelines for collaboration between mental health and primary care specialists with support for assessment and triage, patient education, and proactive followup of patients with symptoms of depression. The guidelines have helped VA integrate collaborative care for depression into primary care settings throughout the VA healthcare system (USDVA, 2016b).

The Veterans Administration has developed a number of additional suicide prevention programs.

For more information on these and other VA programs, click here.

The **United States Air Force Suicide Prevention Program** has been particularly successful in addressing and changing the culture surrounding suicide. The program uses leaders as role models and agents of change, establishes expectations for behavior related to awareness of suicide risk, develops population skills and knowledge, and investigates every suicide. The program represents a fundamental shift from viewing suicide and mental illness solely as medical problems and instead sees them as larger service-wide problems impacting the whole community (Stone et al., 2017).

The suicide prevention program has been associated with a 33% relative risk reduction in suicide. It has also been associated with relative risk reductions in related outcomes, including moderate and severe family violence, homicide, and accidental death. An assessment comparing suicide rates before and after the launch of the program found significantly lower rates of suicide after the program was launched (Stone et al., 2017).

A Soldier’s Story

A soldier who had joined the Washington National Guard after returning from deployment came into the Joint Services Support (JSS) office at Camp Murray, WA asking for help finding a job. While talking with the Employment Transition Team, the soldier revealed financial struggles, fear of returning home because of domestic violence, overwhelming depression, and suicidal thoughts.

The JSS multidisciplinary team sprang into action. Five weeks later the soldier had a regular therapy schedule, gift cards for food and gas, an electronic benefits card, a refreshed resume, a suicide prevention mentor, an order of protection against the abusive partner, and safe transitional housing. Outstanding disability claims were resolved, and, as the soldier was about to move into an apartment, a job offer came through from a prominent Washington company. The soldier’s life moved from a place of desperation to a place of stability.

Source: WSDOH, 2016.

It is not unique for a person seeking help to have multiple needs spanning many systems. What is unique is that this soldier had the ability to get all of these needs met in one place by a collaborative, supportive team of professionals, each of whom was well-trained and attuned to depression and suicide risk.

The JSS states that its purpose is to “enhance the quality of life for all Guard members, their families, and the communities in which they live and contribute to readiness and retention in the Washington National Guard.” The JSS at Camp Murray combines strong and supportive leadership, cross-system teamwork, and attention to soldiers’ emotional needs and ability to thrive at work—a program model that improves job performance and saves lives.

11. Concluding Remarks

Suicide and suicide attempts are serious public health and societal concerns. Annual suicide rates have been on the rise for more than a decade with associated costs stretching well into the billions of dollars. While suicide is statistically rare, its effects are far-reaching. Each of us interacts with suicide survivors and with those who think of suicide on a daily basis—at home, at work, and in our communities.

Suicide affects certain groups differently, with high rates of suicidal behaviors in the American Native population, among teens and young adults, and among older men and women. There are gender differences also: women are more likely than men to attempt suicide although men are likely to use deadlier methods. Although research is lacking, nurses appear to be at higher risk for suicide than the general population due to demanding and stressful work, frequent exposure to human suffering, ethics-related stress, and perceived limited respect in their work.

Healthcare providers should become aware of risk factors, levels of risk, and warning signs. Suicide is overrepresented in people with mental illness and a large percentage of suicide victims have a diagnosable mental health disorder. Compared with the general population, individuals who abuse alcohol or drugs are at greater risk for suicide. Depression—a common co-occurring diagnosis among people who abuse substances—also confers risk for suicidal behavior.

Suicide screening and assessment is becoming a common part of many healthcare providers' initial assessment. And this is not only limited to physicians and nurse practitioners. In many states physical and occupational therapists, social service professionals, chiropractors, nurses, dentists, speech pathologists, and other front-line providers are expected to screen for suicidal ideation and behaviors, provide information and support, and make timely referrals when needed. A number of simple screening and assessment tools are available to screen for suicidal thoughts and behaviors.

Management includes therapeutic interventions and, when indicated, psychiatric medications. Once a patient is thought to be at increased risk for suicidal behavior, continuity of care, restriction of lethal means, and a comprehensive safety plan are crucial. Tapping into social and community support services and identifying community engagement programs are critical elements of the plan of care.

Suicide in military and Veteran populations requires special consideration. Healthcare providers must familiarize themselves with military culture, including psychosocial issues that can lead to isolation, depression, and a loss of purpose. Service members and Veterans are particularly susceptible to PTSD and depression—potentially treatable conditions.

Reducing the rates of suicide in the United States and around the world is hampered by stigma, fear, and inadequate treatment of mental illness. Fortunately, suicide is preventable. Public health campaigns, healthcare provider education, and social support programs are succeeding in getting people in crisis the help they need.

12. References

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Quiz: Suicide in America

- **A passing score is 80% or above.**
- **You can take the test as many times as needed to pass.**
- **The system will remember your progress if you leave and return.**

Question 1

1. Suicide is a major public health concern. In the United States:

Choose one

- a. There were fewer suicides than homicides.
- b. There were more than twice as many suicides as homicides.
- c. Suicide is the tenth leading cause of death.
- d. Suicide rates were highest in the Northeast.

Question 2

2. Key challenges in the identification of people at risk of self-harm are:

Choose one

- a. The lack of psychiatric services in large healthcare organizations.
- b. The lack of police services in rural areas.
- c. The lack of police services in rural areas.
- d. Identifying at-risk individuals, accessing services, and relying on evidence-based care.

Question 3

3. Warning signs of suicide:

Choose one

- a. Are present in about 80% of people who attempt suicide.
- b. Are poor indicators of suicidal ideation and behavior.
- c. Are not evident in most people who are considering suicide.
- d. Do not generally include common emotions such as anger or rage.

Question 4

4. A risk factor for suicide is:

Choose one

- a. Good access to medical care and good mental healthcare.
- b. Anything that makes it more likely for a person to develop a disorder.
- c. Strong personal ties to family and community.
- d. Impossible to predict because suicide is such as rare event.

Question 5

5. Alcohol and drug abuse or dependence:

Choose one

- a. Decreases suicide rates because an intoxicated person tends to fall asleep.
- b. Have very little effect on suicide ideation and suicide attempts.
- c. Significantly increases suicide rates because of impulsivity and disinhibition.
- d. Increases the risk of suicide only among heroin users.

Question 6

6. For immigrants, severing links with their country of origin, the loss of status and social network, a sense of inadequacy because of language barriers,
unemployment, financial problems, a sense of not belonging, and feelings of exclusion can lead to loneliness, hopelessness, and suicidal behaviors.

Choose one

- True
- False

Question 7

7. The suicide rate for American Indian juveniles is:

Choose one

- a. About the same as the suicide rate for middle-aged white women.
- b. More than double the white non-Hispanic rate and more than triple the rates for the other racial/ethnic groups.
- c. Not related to historical trauma, poverty and isolation, cultural taboos around suicide, and lack of access to mental healthcare.
- d. 70% lower than that of the non-Hispanic white population.

Question 8

8. When comparing death from suicide and death by homicide:

Choose one

- a. For white youth, homicide is much more common than suicide.
- b. Suicide is virtually unknown among Hispanic youth.
- c. Suicide is much less common among American Indian youth than white youth.
- d. Among youth, in recent years suicide has become more prevalent than homicide.

Question 9

9. The loss of a nurse colleague to suicide is:

Choose one

- a. Unrelated to stigma related to mental health and its treatment.
- b. So uncommon that policies related to nurse suicide are not needed.
- c. Partly related to ethical conflicts, organizational deficits, role ambiguity, shift-work, social disruption, team conflict, and workload.
- d. Less common than generally acknowledged.

Question 10

10. Accurately determining who is at risk for suicide using tests or clinical judgment:

Choose one

- a. Has been proven to be highly effective in predicting suicides.
- b. Can in itself be the start of suicide prevention efforts.
- c. Has been particularly successful within military organizations.
- d. Has no value and should be avoided.

Question 11

11. The overall goal of screening for suicide risk is:

Choose one

- a. To make sure a high-risk person is held until the police arrive.
- b. To identify people who have thoughts of self-harm but have not yet formulated a plan or acted on those thoughts.
- c. Stop a suicidal person from harming another person.
- d. Thoroughly assess a client's mental state and provide immediate psychosocial counseling.

Question 12

12. Imminent harm is:

Choose one

- a. A situation in which a person's actions could lead to harming another person.
- b. The amount of harm or injury that occurs following a suicide attempt.
- c. A situation in which a person's risk status may indicate actions that could lead to his or her suicide.
- d.The potential for self-harm sometime in the future.

Question 13

13. When interviewing a person you suspect may be at risk for suicide:

Choose one

- a. Ask about safety and lethality.
- b. Remember that asking people about suicide may plant the idea in their head.

- c. Ask yes/no questions to keep things simple.
- d. Avoid questions about previous suicide attempts.

Question 14

14. If a client appears to be at low risk for self-harm in an outpatient, pharmacy, office, or home setting, a provider must:

Choose one

- a. Counsel the client about lethal means and assure them that everything will be all right.
- b. Leave the person alone and seek help from the nearest emergency department.
- c. Call the police and ask to have the person taken into custody.
- d. Make a personal and direct referral to outpatient behavioral health.

Question 15

15. Intentions are:

Choose one

- a. Not useful in assessing a person's desire to commit suicide.
- b. Instructions from another person that guide a behavior or lead to an outcome.
- c. Common passing thoughts that rarely lead to an action or outcome.
- d. Self-instructions that guide engagement in a behavior or lead to an outcome.

Question 16

16. Which of the following actions can reduce the risk of suicide?

Choose one

- a. Management of mental health conditions, particularly major depression.
- b. Limiting access to mental health services.
- c. Exercise, such as running a marathon.
- d. Entering the military, which provides structure in a person's life.

Question 17

17. Psychiatric medications:

Choose one

- a. May be helpful in managing underlying mental disorders.
- b. Are highly successful in reducing suicidal thoughts and behaviors.
- c. Are completely ineffective for managing suicidal thoughts and behaviors.
- d. Should never be used in patients with suicidal thoughts and behaviors.

Question 18

18. Although there is limited evidence that psychiatric medications reduce suicidal thoughts and behaviors:

Choose one

- a. Clozapine increases the risk of recurrent suicidal behavior in patients with schizophrenia or schizoaffective disorder.
- b. Lithium increases the risk of relapse of mood disorders.
- c. There is strong evidence that antipsychotics reduce the risk of suicidal thinking or behavior in patients with co-occurring psychiatric disorders.
- d. A decrease in the long-term suicide rate for patients with mood disorders treated with lithium, neuroleptics, and antidepressants has been reported.

Question 19

19. Continuity of care:

Choose one

- a. Is most important for patients at low risk for suicide.
- b. For privacy purposes, should not involve family or friends.
- c. Should involve both the patient and the provider.
- d. Has not been shown to help people at risk for suicide.

Question 20

20. Key challenges in the assessment, management, and referral of people at risk for suicide are:

Choose one

- a. The lack of psychiatric services in large healthcare organizations.
- b. The lack of police services in rural areas.
- c. The high percentage of suicidal patients admitted to EDs across the country.
- d. Identifying at-risk individuals, accessing services, and relying on evidence-based care.

Question 21

21. Among males, guns are the most common object used is suicide attempts, while in females:

Choose one

- a. Inert gas asphyxiation is the leading mechanism for suicide.
- b. Poisoning (predominantly drug overdose) is the leading mechanism for suicide.
- c. Falling from buildings or bridges is the leading mechanism for suicide.
- d. Hanging is the leading mechanism for suicide.

Question 22

22. Reducing access to lethal means involves:

Choose one

- a. Reducing access to the instruments or objects used to carry out a self-destructive act.
- b. Telling a patient to stay away from instruments or objects that can be used to carry out a self-destructive act.
- c. Understanding that reducing access has very little impact on a person's ability to carry out a self-destructive act.
- d. Explaining that reducing access in the first hour after a suicide attempt is helpful but not useful in the days and weeks following an attempt.

Question 23

23. Restricting access to lethal means can be accomplished by:

Choose one

- a. Reducing access to potentially toxic medications.

- b. Locking guns in lock boxes or gun safes.
- c. Erecting barriers on bridges and buildings or limiting access to prevent jumping.
- d. All of the above.

Question 24

24. Medication safe storage practices include:

Choose one

- a. Lock up prescription medications.
- b. Limit the supply of in-home, over-the-counter medications.
- c. Return unused medications.
- d. All of the above.

Question 25

25. Implementation of means restriction can include:

Choose one

- a. Reducing the toxicity of a lethal method—for example, reducing carbon monoxide content emissions from vehicles.
- b. Improving with physical access, for example, removing gun locks.
- c. Encouraging at-risk families to make a list of lethal suicide means in the home.
- d. Having the police remove guns people’s homes.

Question 26

26. A safety plan:

Choose one

- a. Works best if it is not shared with family and loved ones.
- b. Is a prevention tool designed to help an individual manage suicidal thoughts.
- c. Should be developed after the patient has been discharged to home.

- d. Typically does not need followup once a patient is discharged from the hospital.

Question 27

27. Peer norm programs:

Choose one

- a. Teach that help-seeking is ineffective.
- b. Encourage people with suicidal thoughts to talk to a trusted adult or friend.
- c. Discourage peer connectedness.
- d. Encourage people with suicidal thoughts to call the police.

Question 28

28. A particularly effective psychosocial intervention shown to significantly lower youth suicide rates is:

Choose one

- a. School lunch programs with discussion sessions.
- b. Gatekeeper training—also referred to as recognition and referral training.
- c. Classroom volunteer programs with question an answer.
- d. Sending at risk youth to military academies.

Question 29

29. Among female veterans, suicide rates:

Choose one

- a. Are highest in the older years.
- b. Are highest in the younger years.
- c. Are the same as for male veterans.
- d. Are highest for female veterans with children.

Question 30

30. Clinicians working with active duty military or veterans should keep in mind that:

Choose one

- a. Their practice must include an understanding of military culture.
- b. Service members are taught that self comes before service.
- c. Service members leaving the military almost never experience feelings of anxiety or lack of purpose.
- d. Service member and veterans understand the dangers associated with firearms and are unlikely to use them in a suicide attempt.

Question 31

31. In veterans, protective factors against suicide include:

Choose one

- a. Going it alone.
- b. Developing good skills in problem solving, coping, and conflict resolution.
- c. Seeing help from a general practitioner rather than a mental health specialist.
- d. Avoiding contact with other veterans.

Question 32

32. Intervention strategies that have been shown to be effective in preventing suicide in veterans are:

Choose one

- a. Providing training in the safe use of guns and other lethal means.
- b. Avoiding physical activity, going to church, and keeping quiet about PTSD.
- c. Placing at-risk veterans on a psychiatric hold and prescribing an antipsychotic.
- d. Engaging in physical activity and stress management and addressing PTSD and depression.

Answer Sheet

Name (Please print your name)_____

Date_____

Passing score is 80%

1. _____

2. _____

3. _____

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ATrain EDUCATION Continuing Education for Healthcare Professionals

Evaluation: Suicide in America

Evaluation: Suicide in America

Upon completion of the course, I was able to:
*

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Describe the recent scope of suicide nationally and worldwide.	○	○	○	○	○
Relate 3 warning signs and 3 risk factors related to suicidal ideation and behaviors.	○	○	○	○	○
Describe 5 demographic groups disproportionately impacted by suicide.	○	○	○	○	○
List 3 gender differences related to suicidal ideation and behaviors.	○	○	○	○	○
Explain the 4 main components of suicide risk screening and assessment.	○	○	○	○	○
Describe the 2 main components of management of suicidal patients.	○	○	○	○	○
Define lethal means.	○	○	○	○	○
Relate 3 reasons why safety planning is a critical part of care for suicidal patients.	○	○	○	○	○
Describe 4 main components of social and community support.	○	○	○	○	○
Explain 3 aspects of military culture that may affect the incidence of suicide in active-duty military and veterans.	○	○	○	○	○

Please rate the following statements:
*

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
The author(s) are knowledgeable about the subject matter.	○	○	○	○	○
The author(s) cited evidence that supported the material presented.	○	○	○	○	○

Please answer Yes or No to these statements:
*

	Yes	No
Did this course contain discriminatory or prejudicial language?	○	○
Was thos course free of commercial bias and product promotion?	○	○
As a result of what you have learned, do you intend to make any changes in your practice?	○	○

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

please type response here

Do you intend to return to ATrain for your ongoing CE needs?
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○ Yes, within the next 30 days.
○ Yes, during my next renewal cycle.
○ Maybe, not sure.
○ No, I only needed this one course.

Navigating the ATrain Education website was:
*

○ Easy.
○ Somewhat easy.
○ Not at all easy.

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○ Yes, definitely.
○ Possibly.
○ No, not at this time.

What is your overall satsfaction with this learning activity?
*

○ Very satisfied
○ Satisfied
○ Neutral
○ Dissatisfied
○ Very dissatistied

How long did it take you to complete this course, posttest, and course evaluation?
*

○ 60 minutes (or more) per contact hour
○

50–59 minutes per contact hour

40–49 minutes per contact hour

30–39 minutes per contact hour

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*CVS#: _____ *Expiration date: _____