About Suicide Screening, Referral, and Imminent Harm in Washington State, 3 units

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Course Summary

This course contains information on the scope of suicide in Washington State and nationally, warning signs, suicide screening and referral, and assessment of issues related to imminent harm via lethal means.

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Course Objectives

When you finish this course you will be able to:

- Explain the scope of suicide in the United States and Washington State.
- Relate 5 warning signs for suicide.
- Describe 3 principles of effective suicide screening.
- Describe one appropriate referral resource each for high, medium, and low-risk clients.
- Define imminent harm.
- Describe the 2 responsibilities of pharmacists related to suicide prevention.

The Scope of Suicide

Mental health has traditionally been the purview of psychiatrists and specifically trained mental health practitioners. But over the last two to three decades, family practice physicians, nurse practitioners, allied health professionals, and other healthcare providers are increasingly responsible for identifying and managing chronic mental health problems including suicidal ideation and behaviors.

Now it is not uncommon for a variety of healthcare providers to find themselves at the front lines of identifying serious mental health issues that require screening and referral. Because of these changes, it is important that all healthcare providers are knowledgeable about suicide risk factors and warning signs, understand suicide screening tools, and know when, where, and how to 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: CDC, 2016.

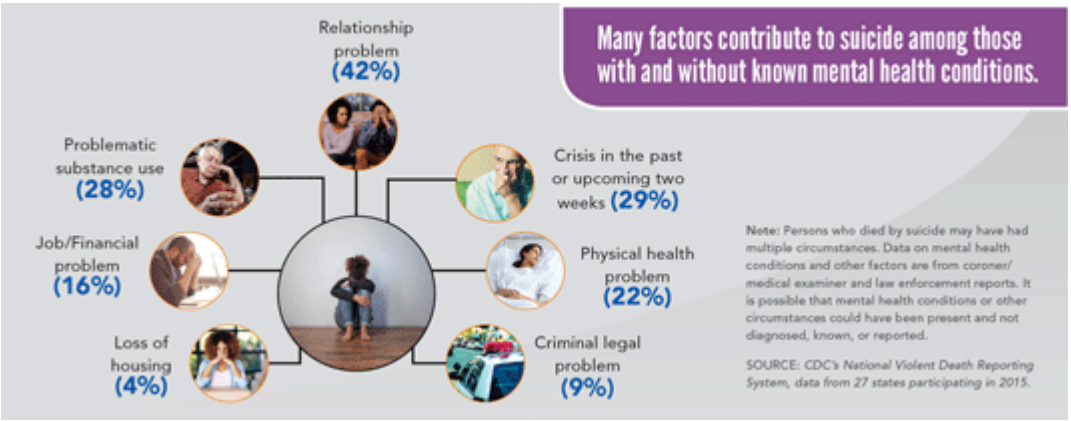
Suicide Is a Major Public Health Concern

In the United States, approximately 45,000 people die from suicide each year, making it the country's tenth leading cause of death. It is not limited to any one age, socioeconomic or ethnic group, or to one gender (CDC, 2018).

A web of biological, psychological, social, environmental, and situational concerns influence suicidal ideation and behavior. Childhood trauma, substance abuse, poverty, and untreated mental health problems are common risk factors. Unfortunately, many people cannot get help because of provider shortages, stigma associated with mental illness, and the cost of care (WSDOH, 2016).

A CDC *Vital Signs* report examined state-level trends in suicide rates from 1999 to 2016, which found that more than half of people who died by suicide did not have a known diagnosed mental health condition at the time of death. Relationship problems or loss; substance misuse; physical health problems; and job, money, legal or housing stress often contributed to risk for suicide. Firearms were the most common method of suicide used by those with and without a known diagnosed mental health condition (CDC, 2018).

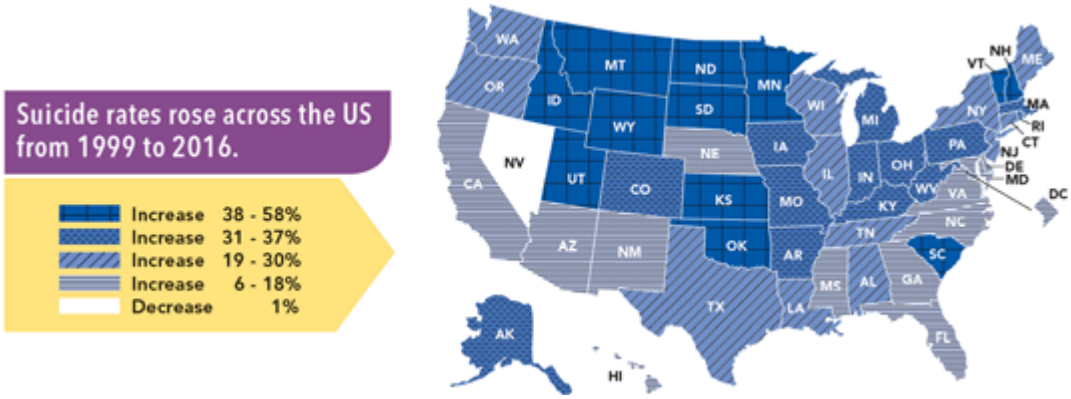
Factors Contributing to Suicide



Source: CDC's National Vital Statistics System. Public Domain. Original (larger) image is at this URL: https://www.cdc.gov/vitalsigns/suicide/

Washington State, along with other Western states (excluding California), has some of the highest rates of suicide in the country. Over the past 20 years, Washington has experienced a nearly 19% increase in suicides (CDC, 2018). Strikingly, in 2016 there were many more suicides (45,000) in the United States than homicides (17,793) (CDC, 2017a).

U.S. Suicide Rates, 1999–2016

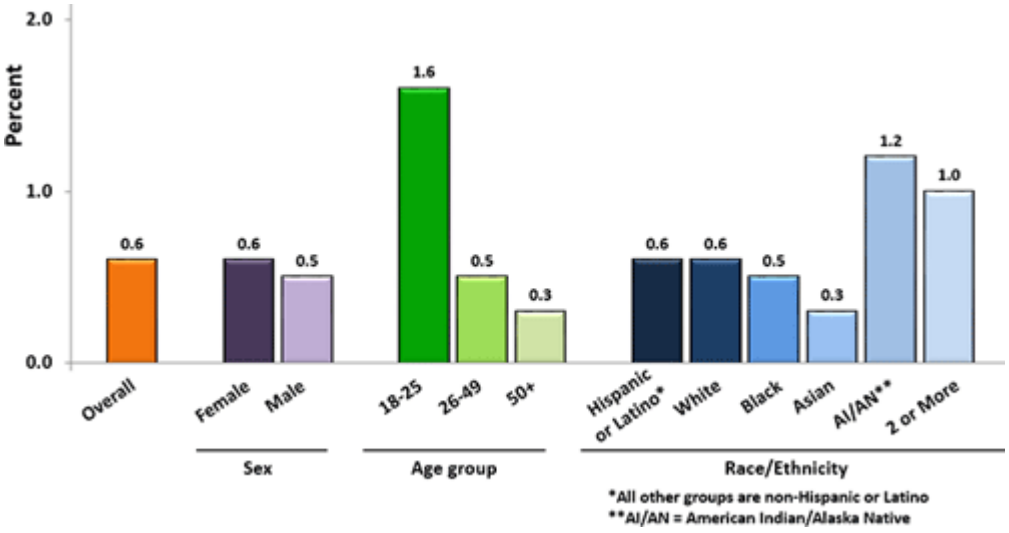


Source: CDC's National Vital Statistics System. *CDC Vital Signs. June 2018.* Original (larger) image is at this URL: https://www.cdc.gov/vitalsigns/suicide/

Among children age 10 to14, suicide is the **third** leading cause of death. Among older teenagers and young adults age 15 to 34, suicide is the **second** leading cause of death (CDC, 2017a).

Suicide **attempts** are more frequent among women, although men have a higher rate of **completed** suicides. Men often use particularly lethal methods such as shooting, hanging, or suffocation, while women often attempt suicide by poisoning, wrist cutting, or falling from heights (Mendez-Bustos et al., 2013).

Prevalence of Suicide Attempts Among U.S. Adults (2015)



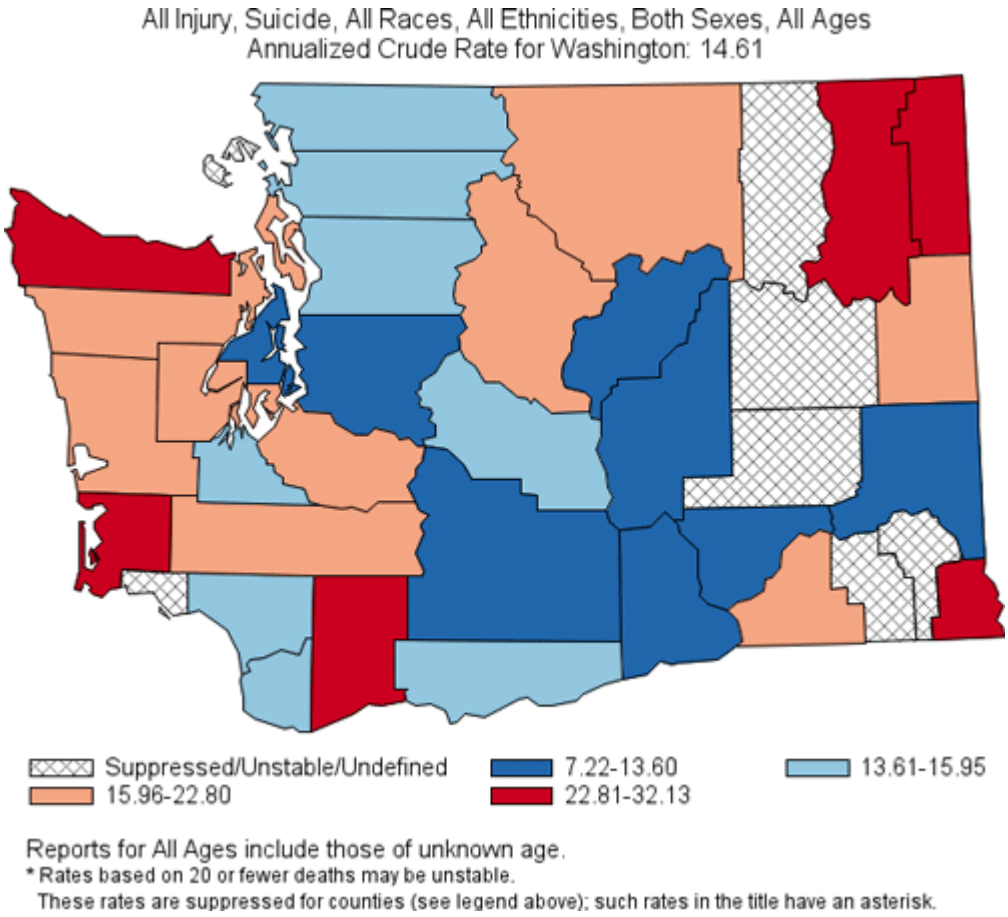
Source: Data courtesy of SAMHSA, 2015.

In Washington State the suicide rate is 11% higher than the national average: from 2010 to 2014, over 5,000 people died as a result of suicide (WSDOH, 2016). Three Washingtonians die by suicide every day, and in an average week there are 65 hospitalizations from self-inflicted injury.

From 2010 to 2014, suicide rates were higher than the state rate in six counties:

1. Clallam
2. Grays Harbor
3. Okanogan
4. Pierce
5. Skamania
6. Stevens (WSDOH, 2016)

2008–2014, Washington Death Rates per 100,000 Population



Produced by: the Statistics, Programming & Economics Branch, National Center for Injury Prevention & Control, CDC.
Data sources: NCES National Vital Statistics System for numbers of deaths; US Census Bureau for population estimates.

Although the suicide **rate** in King County (Washington's most populated county) is lower than the state rate, it has the largest population and the highest number of suicides in the state (WSDOH, 2016).

Seven counties in Washington have small populations and had too few suicides to calculate a suicide rate. This does not mean that there are not suicides in these counties; county-level data do not always accurately reflect suicide losses in communities.* For example, in 2013 both the Spokane Tribe of Indians and the Colville Confederated Tribes declared a suicide state of emergency because of high numbers of suicide deaths. Clark County's Battle Ground School District, located in a town of fewer than 18,000 residents, lost seven students to suicide between 2011 and 2013. Neither pattern of loss was clear from a glance at county data (WSDOH, 2016).

*Suicide rates vary in different parts of Washington but because of the way rates are compared, a small difference may be statistically significant while a larger one is not. Statistical significance means the difference is very **unlikely** to be due to chance.

Key Points About Suicide

- Suicide is a preventable public health problem, not a personal weakness or family failure.
- Prevention is not the responsibility of the health system alone.
- Silence and stigma about suicide harm individuals, families, and communities.
- Suicide does not affect all communities equally or in the same way.
- Prevention programs should reflect community needs and local cultures.

Source: Washington State Department of Health, 2016.

Firearm Fatality and Suicide Prevention: A Public Health Approach

On January 6, 2016, Governor Jay Inslee issued Executive Order 16-02 (EO 16-02) recognizing the need to take a public health approach to reduce firearm fatalities and suicides. The Executive Order also introduced the Washington State Suicide Prevention Plan and highlighted how it would play a role in addressing this need.

The executive order directs state government agencies to:

1. Collect, review, and disseminate data on deaths and injury hospitalizations attributed to firearms and make recommendations as to specific prevention and safety strategies to reduce these fatalities and serious injuries.
2. Conduct a gap analysis to determine the effectiveness of statutorily mandated information sharing between the courts, local jurisdictions, and law enforcement.
3. Begin implementation of the Statewide Suicide Prevention Plan.
    a. Promote depression and suicide risk screening tools.
    b. Begin a social marketing campaign prioritizing populations with the highest risk to raise suicide awareness and prevention.
    c. Focus on recommendations coming from a gap analysis of existing programs specific to our schools, Veteran, and Native American and Alaskan Native communities to provide effective, culturally appropriate crisis intervention and treatment services.
4. Update a 2007 white paper on firearm access by persons prohibited from possessing a firearm due to involuntary commitment.

Source: Washington State Department of Health, 2018.

Suicide Rates by Race/Ethnicity, Age, and Gender

In Washington, suicide rates are highest among American Indian, Alaska Native, and white populations, consistent with national rates. For American Indian youth, the suicide rate is more than double the white non-Hispanic rate and more than triple the rates for the other racial/ethnic groups (CSAT, 2015).

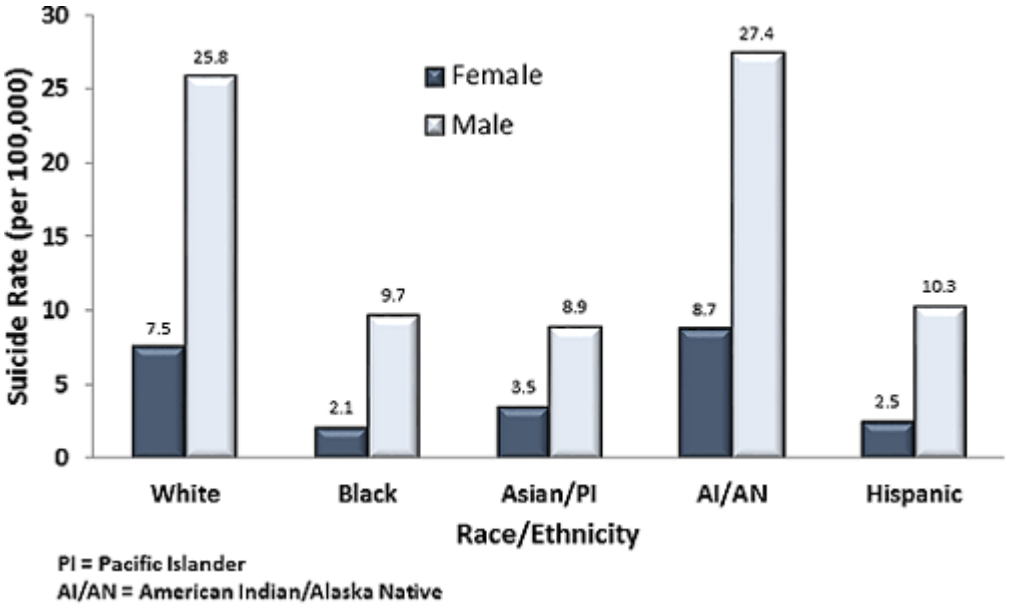
Among African Americans nationwide, the suicide rate is 70% lower than that of the non-Hispanic white population. The suicidedeath rate for African American men was more than four times greater than for African American women (OMH, 2017). Suicide risk peaks in the early twenties for African American males and the late twenties for females (Wang et al., 2016).

Among the six largest Asian American subgroups,* Korean males have more than twice the frequency of death due to suicide (5%) compared to non-Hispanic whites (2%). Suicide rates in Korean Americans have nearly doubled from 2003 to 2012 and exceed rates for all other Asian American subgroups (Kung et al., 2018). Suicide is the fifth leading cause of death for Korean males, higher than every other Asian subgroup as well as non-Hispanic Whites (Hastings et al., 2015).

*Asian Indians, Chinese, Filipinos, Japanese, Koreans, and Vietnamese.

Hispanics/Latinos have fairly similar rates of suicidal behaviors compared with white, non-Hispanic individuals. The prevalence of suicidal behavior increases among youth and young adults who are more acculturated to mainstream American culture, particularly among females (CSAT, 2015). A nationwide survey of high school students found Hispanic youth were more likely to report attempting suicide than their African American or white, non-Hispanic peers (CDC, 2017b).

Suicide Rates by Race/Ethnicity in the United States (2014)



Source: Data courtesy of CDC.

Nationally, the suicide rate for teens and young adults has nearly tripled since the 1940s. Throughout the United States, suicide is the third leading cause of death for youth between the ages of 10 and 24 (approximately 4,600 lives lost each year). Of the reported suicides in the 10 to 24 age group, 81% of the deaths were males and 19% were females. Boys are more likely than girls to die from suicide while girls are more likely to *attempt* suicide (CDC, 2017b).

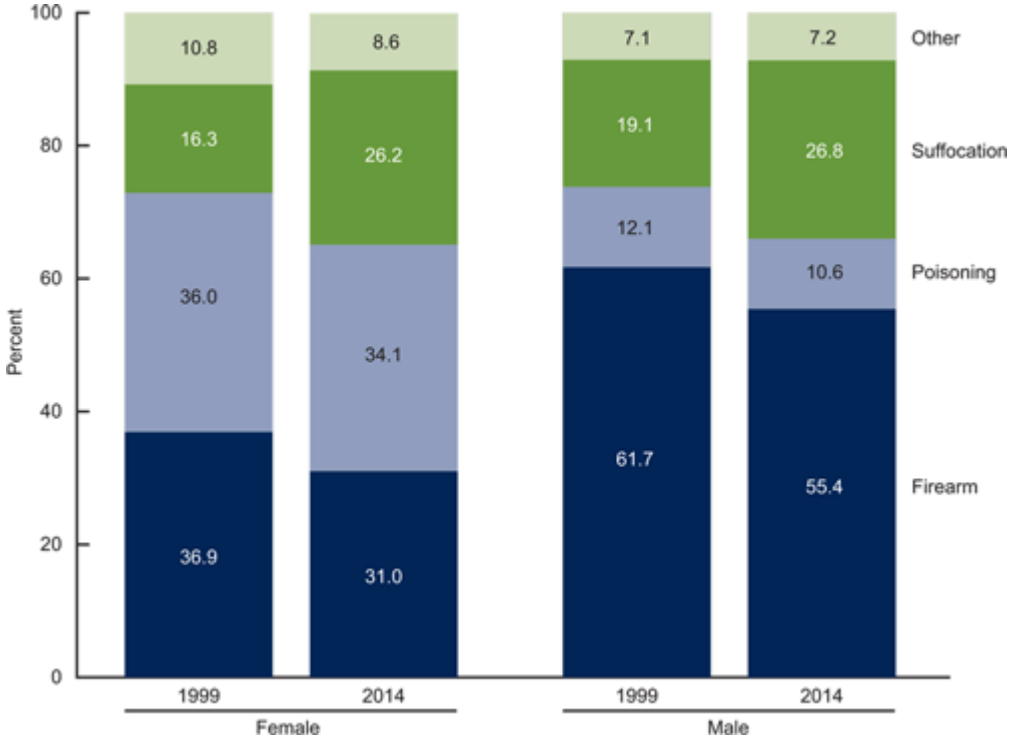
Be Alert to Signs of Suicide Ideation

Self-injury is deliberate harm inflicted on a person's own body.
Source: Military OneSource.

Among youth, non-suicidal, self-injurious behaviors such as cutting, burning, hitting oneself, scratching to the point of bleeding, or interfering with healing can occur together with suicidal behaviors. It is important to consider the nature of the link between these two types of behavior (Grandclerc et al., 2016).

In Washington, men account for more than three-quarters of suicide deaths. From 2012 to 2014, men 75 and older had the highest **rate** of suicide while men 45 to 64 had the highest **number** of suicides. For older men, contributing factors include economic insecurity, loss of significant relationships, loneliness, fear of being a burden, and the physical and mental stresses of aging (WSDOH, 2016).

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

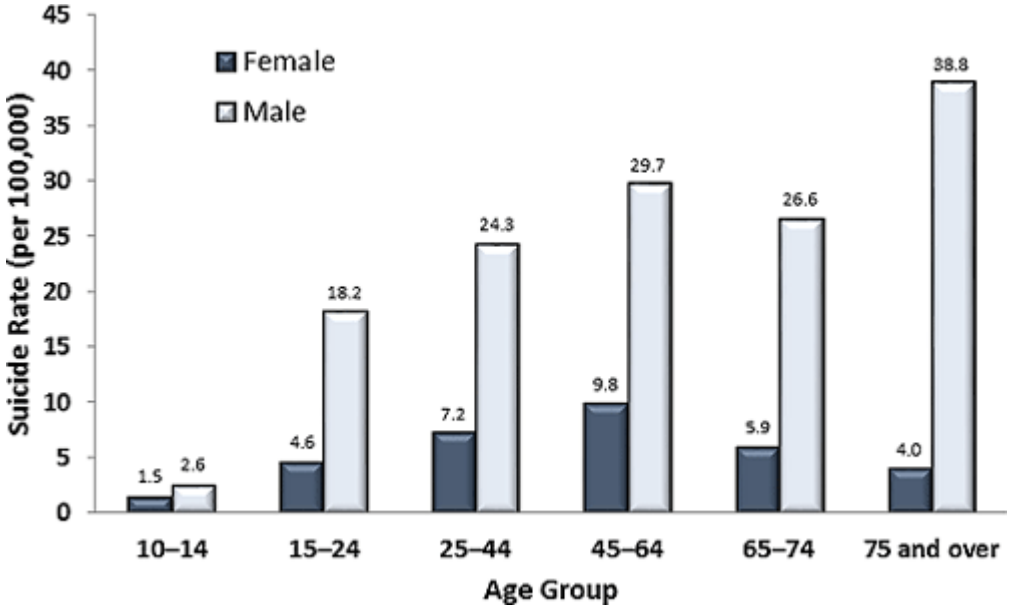


Source: NCHS, National Vital Statistics System, Mortality, 2016.

In recent years, suicide rates for middle-aged women have increased by more than 30%, exceeding the increases observed among middle-aged men. However, using data from the Nurses' Health Study, researchers determined 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 by Age in the United States (2014)



Source: Data courtesy of CDC.

Veterans, Immigrants, and Refugees

When compared to other Americans, there are some differences in the rates and patterns of suicidal behavior among U.S. veterans. This includes:

- Increases in rate of suicide among younger veterans (18–29 years of age)
- Gender-based differences (changes in rates among women veterans)
- A comparatively high prevalence (approximately 66%) of suicides resulting from a firearm injury (USDVA, 2016a)

Among veterans returning from the current wars, one of the most common mental health diagnoses is posttraumatic stress disorder (PTSD), which is a known risk factor for both 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).

For people migrating to the United States, stress associated with migration can be a risk factor for suicidal ideation and behaviors (Ratkowska & De Leo, 2013). Roughly 1 in 7 residents of Washington State is an immigrant, accounting for nearly 14% of the state's population (American Immigration Council, 2017). From 2010 to 2016, Washington State admitted more than 16,000 refugees from 46 countries. Seventy-two percent of the state's refugees came from just five countries: Iraq, Myanmar, Somalia, Bhutan, and Ukraine (McDermott, 2016).

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. Migration can also pose a risk for the families who remain in the country of origin. Emigration 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).

Refugees, one of the most vulnerable groups of all immigrants, are often fleeing war, torture, and persecution, and suffering with PTSD, depression, and anxiety. Lack of adequate preparation, the way in which they 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 pathologic symptoms due to trauma, may be a strong risk factor for suicide (Ratkowska & De Leo, 2013).

Warning Signs and Risk Factors

> A key strategy in suicide prevention is the implementation of a minimum amount of training for suicide risk assessment and for treatment of suicidal behaviors. Suicide-specific training enhances the level of care that people who experience mental illness and suicide risk receive while also increasing provider competence and ability to provide effective, life-saving treatment.
>
> American Foundation for Suicide Prevention, 2016

Suicide **warning signs** are indications of suicidal ideation and behavior that are observed by or reported to another, and indicate risk for suicide within minutes, hours, or days. **Risk factors** are characteristics, attributes, or exposures within an individual that increase the likelihood of developing a disease or injury (WHO, 2018). Most commonly, several risk factors act cumulatively to increase an individual's vulnerability to suicidal behavior (WHO, 2014). Among these various risk factors, three stand out: mental illness, substance abuse, and medical issues.

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 signs. Knowing and recognizing warning signs can help healthcare providers, family, and friends take action before suicidal thinking turns into action (WSDOH, 2016).

In general, suicide **warning signs** can include:

- Anxiety, agitation, sleeplessness, mood swings
- Purposelessness, hopelessness, feeling there is no reason to live
- Rage, anger, or aggression
- Recklessness, engaging in risky activities
- Increasing alcohol or drug abuse
- Withdrawing from family and friends
- Feeling trapped (U.S. Department of Veteran Affairs, 2016a)

Certain **behavioral warning signs** require immediate attention. Presence of one or more of these behaviors is a strong indication referral is acutely needed:

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, and

3. Demonstrating preparatory behaviors such as putting affairs in order (USDVA, 2016b)

For young people increased **risk** has been associated with

- Family history of suicide
- History of depression
- Mental health problems
- Incarceration
- Easy access to lethal means
- Alcohol and drug use
- Exposure to previous suicidal behavior by others
- Loss of residential mobility (CDC, 2017b)

Individuals at a greater risk for **completed** suicide have been found to be

- Male
- Older
- Impulsive
- Having multiple physical ailments
- Prior suicide attempts
- Psychiatric illness
- History of violence
- Family history of suicide (Hassamal et al., 2015)

Clients admitted for inpatient treatment in specialized mental health facilities have a 50 to 200 times increased suicide risk compared to the population at large. In psychiatric inpatients, an array of risk factors for suicide has been identified:

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

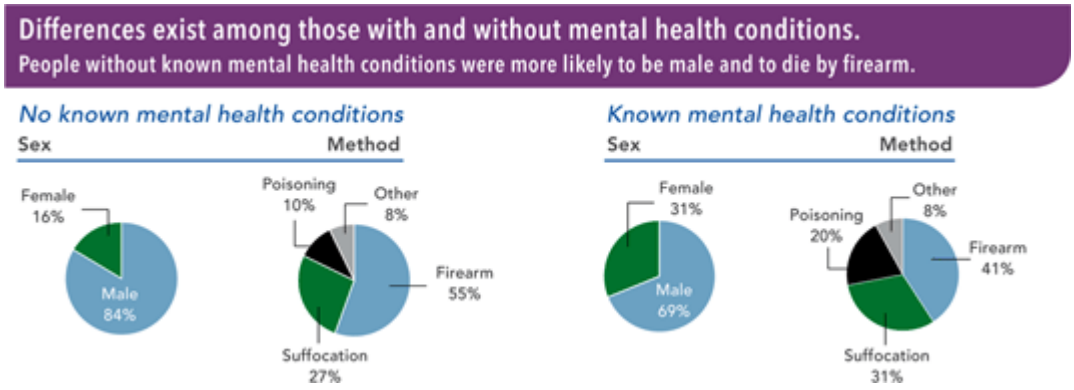
Single studies have reported additional risk factors such as command hallucinations, delusions, mental disorders other than depression, coexisting physical illness, family history of mental illness, multiple admissions to inpatient treatment, unplanned discharge, and prescription of antidepressants (Fosse et al., 2017).

Mental Health Issues and Mental Illness

Suicide is overrepresented in people with mental illness (Fosse et al., 2017). The odds for suicide in severe depression, schizophrenia, and bipolar disorder are approximately 3 to 10 times that of the general population, with a higher increased risk in males than females. However, keep in mind that despite these statistics, suicide does not occur in 95% to 97% of people with mental illness (Fosse et al., 2017).

Impulsivity and disinhibition are overarching issues related to suicidal ideation and behavior. In fact, **angry impulsivity** has been repeatedly identified as a risk factor for suicidal behavior. Impulsivity is highly associated with bipolar disorder, substance abuse, and certain personality disorders as well as a history of early child abuse (Fawcett, 2012).

However, differences exist among those with and without mental health conditions. People without known mental health conditions were more likely to be male and to die by firearm. More than half of people who died by suicide did not have a known mental health condition (CDC, 2018).



Source: CDC, 2018. Public domain.

Substance Abuse

People with substance use disorders often seek treatment at times when their substance use difficulties are at their peak—a vulnerable period that may be accompanied by suicidal thoughts and behaviors. Clients in treatment for substance abuse should be screened for suicidal thoughts and behavior routinely during intake and at specific points during the course of treatment. Compared with the general population, people being treated for alcohol use disorder are at about 10 times greater risk for suicide, while people who inject drugs are at about 14 times greater risk (CSAT, 2015).

Substance Use Disorder

The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) refers to *substance use disorders* as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. The most common substance use disorders in the United States include:

- Alcohol Use Disorder (AUD)
- Tobacco Use Disorder
- Cannabis Use Disorder
- Stimulant Use Disorder
- Hallucinogen Use Disorder
- Opioid Use Disorder

Source: SAMSHA, 2015a.

Abstinence should be 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 (CSAT, 2015).

Key Point

Although a large proportion of suicides could be avoided with effective treatment of mental disorders, 50% to 75% of those in need receive inadequate treatment. The under-recognition of mental conditions seriously limits the potential to identify and appropriately treat individuals at risk for suicide.

Source: DVA/DOD, 2013).

Medical Issues and Physical Illness

Clients referred to physical or occupational therapy may be dealing with Illness, trauma, stressful life events, and injury. Chronic pain, cognitive changes, and challenges related to long-term conditions and limitations are associated with in increased risk of suicidal behavior (HHS, 2012).

Physical illness is a commonly overlooked risk factor for suicide. Medical patients often experience significant stressors, such as feeling like a burden to family, having concerns such as potential loss of employment or medical bills, or feeling alone and isolated. These powerful stressors can increase suicidal thoughts in vulnerable patients, particularly individuals who have a history of suicidal thoughts or behaviors. Thoughts of suicide are important to assess, especially in patients without known mental health disorders. For example, the vulnerability for suicide risk among individuals with cancer is highest in the first month after diagnosis, highlighting the critical need for early detection (Horowitz et al., 2016).

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.

Warning Signs and Risk Factors for Suicide	
Individual	▪ Previous attempt(s) ▪ History of mental disorders, esp. clinical depression ▪ History of alcohol and substance abuse ▪ Feelings of hopelessness ▪ Impulsive or aggressive tendencies ▪ Losses ▪ Illness and disability
Relationship	▪ Family history of suicide ▪ Family history of child maltreatment ▪ Isolation or feelings of isolation
Community	▪ Local epidemics of suicide ▪ Barriers to accessing mental health services
Societal	▪ Easy access to lethal means ▪ Cultural and religious beliefs ▪ Unwillingness to seek help because of stigma

Source: WSDOH, 2016.

Screening for Suicide Risk

> Prompt assessment of potentially suicidal patients by individual clinicians is imperative and requires knowledge of risk factors for suicide, skill in establishing a rapport with an extremely distressed patient, and clinical experience in assessing the degree of risk.
>
> Laura Bonner et al., n.d.
> VA Puget Sound Healthcare System

Because suicide is exceedingly rare in comparison to associated risk factors, predicting who may be at risk is extremely difficult. Nevertheless, healthcare providers should be aware of warning signs and risk factors and be prepared to screen, refer, and document suicide risk (DVA/DOD, 2013). Screening by healthcare professionals takes on particular importance because it is estimated that 75% of individuals who die by suicide are in contact with a primary care physician in the year before their death, and nearly 45% within one month of their death (Health and Human Services, 2012).

Screening for suicidal ideation and behavior can ensure that those requiring services get the help they need (CSAT, 2015). Washington State recommends that clients be screened for suicidal ideation and behavior. A screening tool can help a clinician gauge the immediacy of the risk, the need for a more thorough assessment, and the need for referral.

How and When to Screen

Screening for suiciderisk in a clinic or community setting (such as an outpatient pharmacy) requires a caring, non-judgmental approach. 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. If the screen indicates increased risk, be prepared to make an immediate referral, **making sure your client transitions safely from your office or clinic to the point of actual service**.

Any healthcare provider in any setting may be called upon to ask a client about suicide. Because this is not easy, it is recommended that providers use a simple screening tool and practice the questions until they are comfortable leading a client through a suicide screen. Understanding when a referral is needed is a critical part of the screen—anyone thought to be at risk for suicide should be referred.

Something as simple as a waiting room questionnaire or a quick, two-question screening tool can identify high-risk individuals who otherwise may not be identified. In fact, 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).

For those working in outpatient clinics, social services, counseling services, dental offices, or community pharmacies, clients should be screened regularly, preferably at each visit. For these individuals, the prevalence of suicidal ideation and suicide attempts is higher than the general population.

For screening to be effective, healthcare providers must:

- Use a simple screening tool.
- Practice questions ahead of time.
- Understand suicide warning signs, risk factors, and protective factors.
- Be empathic and nonjudgmental.
- Understand how your own attitudes impact your clients.
- Check that referral appointments are kept.
- Coordinate services with mental health providers, other practitioners, and family members. (CSAT, 2015)

Did You Know . . .

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 has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk (Joint Commission, 2016).

Screening Tools

According to The Joint Commission, all patients should be screened for suicide ideation, using a brief, standardized, evidence-based screening tool (JC, 2016).

Patient Health Questionnaire 2 (PHQ2)

One widely used, validated screening tool is the *Patient Health Questionnaire 2 (PHQ2)*. It is simple and quick tool used by many large hospital organizations, including Washington's Kaiser Hospital system. This tool was originally designed to screen for depression but is being widely used as a suicide screen. The *PHQ2* asks a client to answer 2 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 (NYSDOH, 2016). 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 Screen

Another commonly used, brief screening tool is the *Columbia Suicide Screen*. It is an 11-item measure validated by the National Institute of Mental Health and 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 (NREPP, 2015).

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:

- Over the last 2 weeks, have you felt down, depressed, or hopeless?
- 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?

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?

University of Washington Behavioral Health and Therapy Clinics

The *University of Washington Behavioral Health and Therapy Clinics* offers a variety of assessment instruments for screening and assessment of suicide risk. These tools can be found at this link: http://depts.washington.edu/uwbrtc/resources/assessment-instruments/.

Using Screening Information

> All persons addressing suicidality among patients at risk must have full knowledge of screening and assessment results, and knowledge of steps taken to work with the patient. 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.
>
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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).

A client in acute suicidal crisis must be kept in a safe healthcare environment under one-to-one observation. Do not leave these clients by themselves. Provide immediate access to care through an emergency department, inpatient psychiatric unit, respite center, or crisis resources. Check these clients and their visitors for items that could be used to make a suicide attempt or harm others. Keep them 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).

For clients 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).

For clients 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).

Valeria Cuts Her Wrists (Again)

Joanna is a physical therapist working in a small rural outpatient rehab clinic in northern Washington. 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 often 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 Learning

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

A. She is very calm and articulate.
B. She seems upset but not depressed.
C. Her suicide attempts have become more sophisticated.
D. She doesn't seem to really want to harm herself.

Answer: C

Screening for Suicidal Ideation and Behaviors

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 Valerie: "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.

Because Valeria has no family living nearby and Joanna feels she is a danger to herself, she decides to call the police to transport Valeria 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.

Referral

> Positive screens result in a referral to a trained behavioral health expert for a comprehensive assessment. This may involve establishing relationships with local behavioral health providers, including crisis centers.
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Suicidal ideation and behavior occurs on a continuum, beginning with suicidal thoughts, evolving into a wish to die, consolidated into an intention to act, and resulting in a plan to end one's life. The evolution of these steps can occur over minutes or years. Each step along the continuum provides an opportunity for intervention and referral. The first opportunity to intervene often occurs because of warning signs that are identified by a healthcare provider, caregiver, gatekeeper, or loved one (DVA/DOD, 2013).

Any provider with an ethical duty to assess client safety can initiate the referral process; however the outcome is dependent on providers with the legal and medical expertise required. If clients are referred for hospitalization and agree to be hospitalized, they must be placed in the least restrictive environment.

In extreme circumstances, if a client is judged to meet the criteria as a "danger to self," a legal process can be initiated whereby a client can be held against his or her wishes in a locked facility for up to 72 hours. During this time a more thorough medical assessment is completed and medication management and other safety strategies are initiated.

For providers working in large healthcare organizations, psychiatric services are usually readily available. High-risk clients might be admitted to inpatient care; those at intermediate and low acute risk may be referred to an outpatient care setting. With appropriate support and safety plans, lower risk clients may be able to be followed up in the community (DVA/DOD, 2013).

Key Point

All health and behavioral health organizations should have specific written policies and procedures focused on the detection and response to persons presenting for care with suicide risk. Staff must be trained on how to employ the policies and procedures, with regular (eg, annual) scheduled refreshers.

Source: National Alliance for Suicide Prevention, 2011.

Connecting Clients to Appropriate Referral Resources

> Because many persons seek care only when they are in crisis, behavioral health systems must provide 24-hour, 7-day availability to individuals trained in assessment, supportive counseling, and intervention. Crisis hotlines, online crisis chat/intervention services, self-help tools, crisis outreach teams, and other services can ensure that individuals can obtain help when they need it—eliminating barriers related to cost, distance, and stigma.
>
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Screening and referral are different for each person and each situation. Although often lacking, specialized services are essential—particularly in situations of unique vulnerability, such as suicidal crises. When the risk of suicide and self-harm is acute, services must be offered in a compassionate manner that honors a person's human dignity (Liljedahl et al., 2017).

If you have clients (or are providing medications to clients) who have recently attempted to harm themselves, keep in mind that the period after discharge from an emergency department or acute psychiatric ward is a time of high risk when support services are critical. During this time, a client will likely come in contact with many outpatient service providers who do not have easy access to psychiatric services. For this reason, it is imperative that each organization or agency have policies and procedures in place outlining what to do if a screen indicates a client is at risk of self-harm.

Reductions in subsequent suicide deaths have occurred by engaging clients in timely treatment and referral services after discharge from the ED. 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 (Crane, 2016).

Following discharge from an ED, hospital, or mental health facility, a client typically comes in contact with a variety of outpatient healthcare providers. This can include pharmacists, physical therapists, psychologists, occupational therapists, and other healthcare providers. Each provider must be prepared to ask their client about suicide and be ready to refer if needed. At a minimum, providers must have contact information for local and national suicide hotlines.

Referrals by Level of Risk

The majority of identified suicidal patients are referred to acute or crisis settings (usually the nearest hospital emergency department) for assessment and care by mental health providers. In an urgent or emergent high-risk crisis situation, the primary purpose of clinical evaluation is to make a determination that balances risk and protective factors. Can the patient be discharged with an adequate safety plan? Does the patient require admission to a higher level of care, on either a voluntary or an involuntary basis (DVA/DOD, 2013)?

For **high acute risk** clients, providers should ensure constant observation and monitoring before arranging for immediate transfer for psychiatric evaluation or hospitalization. This may prevent a fatal act, but does not necessarily resolve the suicidal impulse or crisis (DVA/DOD, 2013).

Intermediate acute risk clients with suicidal ideation and a plan but with no intent or preparatory behavior should be evaluated by a behavioral health provider. The decision whether to urgently refer a client to a mental health professional or emergency department depends on the client's presentation. If closer evaluation reveals that the level of illness or other clinical findings warrant a higher level of care, the patient may be hospitalized. If, in conjunction with the provider, a client feels he or she is capable of maintaining safety using non-injurious coping methods and a safety plan, the patient may be managed in outpatient care (DVA/DOD, 2013).

For **low acute risk** clients who have no specific plans or intent to engage in lethal self-directed violence and have no history of active suicidal behavior, consider consultation with a behavioral health specialist to determine the need for referral to treatment that will address symptoms and safety issues (DVA/DOD, 2013).

If a client is **not at an elevated risk** for suicide, there is no indication to consult with behavioral health specialists, and the client should be followed in routine care, continue to receive treatment for their disorder, and be re-evaluated periodically for thoughts and ideation (DVA/DOD, 2013).

Level of Risk and Appropriate Action in Primary Care			
Risk of suicide attempt	Indicators of suicide risk	Contributing factors†	Initial action based on level of risk
High acute risk	▪ Persistent suicidal ideation or thoughts ▪ Strong **intention** to act or plan ▪ Not able to control impulse **or** ▪ **Recent suicide attempt** or **preparatory behavior**††	Acute state of mental disorder or acute psychiatric symptoms ▪ Acute **precipitating** event(s) ▪ Inadequate **protective factors**	▪ Maintain direct observational control of the patient ▪ Limit access to lethal means ▪ Immediately transfer with escort to Urgent/ED care setting for hospitalization
Inter-mediate acute risk	▪ Current suicidal **ideation** or thoughts ◦ **No intention** to act ◦ Able to contol the **impulse** ▪ **No recent attempt** or **prepratory behavior** or rehearsal of act	▪ Existence of warning signs or risk factors†† **and** ▪ Limited protective factors	▪ Refer to Behavioral Health provider for complete evaluation and interventions ▪ Contact Behavioral Health provider to determine acuity of referral ▪ Limit access to lethal means

Level of Risk and Appropriate Action in Primary Care			
Risk of suicide attempt	Indicators of suicide risk	Contributing factors†	Initial action based on level of risk
Low acute risk	▪ Recent suicidal **ideation** or thoughts ▪ **No intention** to act or plan ▪ Able to contol the **impulse** ▪ No planning or rehearsing a suicide act ▪ No previous attempt	▪ Existence of **protective factors and** ▪ Limited **risk factors**	▪ 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 fact

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

Source: (VA/DOD, 2013).

Daniel Breaks His Sobriety

Daniel is a 42-year-old male who was referred to occupational therapy following a motor vehicle accident in which he broke his right femur and left clavicle. He is non-weight bearing on his right leg and is using a wheelchair to get around. Daniel is participating in OT in order to regain strength, for treatment of his left upper extremity, and for assessment of his activities of daily living (ADLs).

During the subjective evaluation, Daniel tells you that after the accident his work truck was impounded and he lost his driver's license. He tells you that he was also arrested for driving under the influence. Additionally he struck another vehicle and the driver of the other car broke her hip and sustained a severe concussion.

Daniel expresses tremendous guilt because another person was injured. He expresses remorse for drinking after being sober for more than two years. He says he doesn't know how he'll be able to pay his bills and is worried about his health insurance. His says that his wife has asked for a divorce and is kicking him out of the house as soon as he is able to walk.

Daniel tells you that he feels depressed, hopeless, and angry and finds no pleasure in life. He is unable to work, has lost his truck, and (despite saying that he loves his 9-year-old daughter) says he wishes he had never impregnated his wife. He says he feels this way every day. He marks a 3 on both PHQ2 screening questions. He tells you "I'm not sure if it's worth it anymore."

He tells you he has thought about ending his life in the past but has never acted on this thought. In response to your question, "What stopped you from acting on these thoughts in the past?" He replies, "My daughter—I don't want to hurt her."

Screen Results

Your clinic screens all clients for suicide, knowing that injuries and illness increase the risk of depression, which can lead to an increased risk of suicidal ideation and behaviors. Your clinic uses a screening tool called the Patient Health Questionaire-2 (PHQ2). It is clinic policy to repeat this screening at the beginning of each of Daniel's visits.

Your hospital-based clinic has an established protocol for identifying staff responsibilities and procedures for responding to PHQ2 scores. The results are reviewed by the team (primary care provider and behavioral health staff). This is then embedded into the electronic health record as part of the standard care delivery process.

What Action Should You Take?

Because Daniel provides a positive answer to both of the PHQ2 screening questions, you decide to:

A. Make an appointment for him the next day to make sure he's doing okay.
B. Call social services and ask for a more thorough evaluation.
C. Reassure him that he's okay and send him home.
D. Chart the results of the PHQ2 and continue with your treatment.

Answer: B

Discussion

Your role is to screen your client and determine whether there is a need for immediate referral. You must be familiar with the resources available in your area. Your hospital has mental health services directly available so you make an immediate referral to social services. You assign an aide to sit with Daniel in a quiet room until a social worker arrives.

If Daniel is at immediate risk of harming himself, he can be held against his will. However, only police and mental health workers or providers with specialized training can detain Daniel against his will. Police can hold Daniel until a crisis worker arrives and can transport him to a psych facility, if needed. Because of Daniel's expressed anger toward his wife, you decide that asking a family member to transport Daniel to the emergency department is not a good idea.

A social worker arrives and escorts Daniel to a quiet room. You follow up later in the day and learn that Daniel has voluntarily admitted himself to the hospital's inpatient psych unit.

Referral Resources

Providers should be familiar with community agencies, mental health organizations, senior services, veterans support groups, and peer support programs. These programs foster a sense of connection and belonging and provide critically needed services, including employment and vocational help, housing assistance, and social interactions that are not focused on illness (HHS, 2012). Cooperation, collaboration, and communication are critical components of patient referral and recovery.

Recognition and referral training— also called *gatekeeper training*—plays a critical role in suicide prevention. It teaches educators, coaches, clergy, as well as emergency responders, primary and urgent care providers, pharmacists, allied health professionals, and others in the community how to identify and refer people who may be at risk of suicide (WSDOH, 2016).

Recognition and referral training can be a valuable training tool even for a provider who already has mental health training. It provides additional education, support, access to resources, and opportunities to practice assessment skills. Despite the comorbidity of mental health disorders and suicide, the vast majority of mental health professionals—a group that includes psychiatrists, psychologists, social workers, licensed counselors, and psychiatric nurses— do not typically receive routine training in suicide assessment, treatment, or risk management (AFSP, 2016).

Crisis lines provide immediate access, often 24 hours a day, to crisis intervention. 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 (WSDOH, 2016).

In an evaluation of the effectiveness of the **National Suicide Prevention Lifeline** to prevent suicide, more than a thousand suicidal individuals who called the hotline completed a standard risk assessment for suicide, and 38% of those completed a followup assessment between 1 and 52 days after the initial assessment (Stone et al., 2017).

Source:CDC.

Researchers found that over half of the initial sample was seriously considering suicide when they called, and they had a plan for their suicide. 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).

The **Veterans Crisis Line** provides specially trained and experienced responders to help veterans of all ages and circumstances. Since its launch in 2007, the Veterans Crisis Line has answered nearly 2.8 million calls and initiated the dispatch of emergency services to callers in crisis nearly 74,000 times. An anonymous online chat service, added in 2009, has engaged in more than 332,000 chats. In November 2011, the Veterans Crisis Line introduced a text-messaging service to provide another way for veterans to connect with confidential, round-the-clock support, and since then has responded to more than 67,000 texts (DVA, nd).

Source: Department of Veterans Affairs.

New technologies have created new possibilities for suicide prevention and referral. For some mental health problems, such as depression, online tools and mobile applications provide resources for self-help, which can detect symptoms of distress and offer contact to hotlines or referral to other resources (Pauwels et al., 2017).

Online and mobile tools can be used along with traditional medical treatments and can be helpful for those who are reluctant or unable to find professional treatment. These tools provide an additional source of support and can lower the barrier to seeking professional help. Online tools and programs for suicide prevention create new possibilities due to their discretion, accessibility, availability, and low cost, which are important barriers for help seeking (Pauwels et al., 2017).

The Importance of Continuity of Care

> Caring for suicidal persons requires that the suicidal risk be addressed directly, not merely as a symptom of an underlying disease. That care will most likely require multiple levels of services in a team environment. Discharge decisions from one level of care must incorporate linkages to other necessary levels of care. Organizations must recognize, accept, and implement shared service responsibilities both among various clinical staff within the organization and among providers in the larger community.
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Once a referral is made, care transitions and continuity of care are very important. The risk of suicide is 3 times as likely (200% higher) the first week after discharge from a psychiatric facility and continues to be high, especially within the first year and through the first four years after discharge (JC, 2016). The risk is particularly high in the weeks and months following the attempt, including the period after discharge from acute care settings and inpatient psychiatric units. Having survived a suicide attempt is one of the most significant risk factors for later death by suicide (HHS, 2012).

If a referral results in admission to an inpatient mental health unit, followup mental health services after discharge are important, as well as connections to community-based supports. Healthcare providers should seek to shorten the time between inpatient discharge and followup outpatient treatment. For example, EDs and others providing services should set a goal of ensuring that followup occurs within 48 hours or, at most, within a week of discharge (HHS, 2012).

If acute inpatient care is not needed, each at-risk client should be informed about risks and be referred to mental health services. Although referral is necessary, it may not be sufficient. There is increasing evidence that specific outreach programs are highly effective in increasing the proportion of patients who engage in mental health care after hospitalization (HHS, 2012).

Strategies to improve continuity of care may include telephone reminders of appointments, providing a "crisis card" with emergency phone numbers and safety measures, or sending a letter of support. Motivational counseling and case management can also be used to promote adherence to the recommended treatment (HHS, 2012). Unfortunately, many clients with high suicide risk are not referred for followup care, receive only limited mental health services, and may not receive adequate treatment for underlying mental health or substance use disorders.

Imminent Harm and Lethal Means

Imminent harm means a person is thought to be at **immediate** risk of self-harm or suicide. Healthcare providers working in outpatient clinics, home health, social service centers, rehab therapy clinics, and pharmacies must know what to do if a screen indicates that a client is at immediate risk of self-harm. The overreaching goal is not to diagnose, but to be ready to talk, keep the person safe, and have referral information readily available.

Recognizing if someone is at risk of imminent self-harm requires awareness of a client's current mental status as well as a person's intent (Williams, 2016). All suicide attempts must be taken seriously, including those that involve little risk of death, and any suicidal thoughts must be carefully considered in relation to the client's history and current presentation (CSAT, 2015).

Key Point

In a multi-center 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 5% absolute decrease in the proportion of patients subsequently attempting suicide and a 30% decrease in the total number of suicide attempts over a 52-week followup period.

Source: Coyne, 2017.

Discussing Lethal Means with Your Client

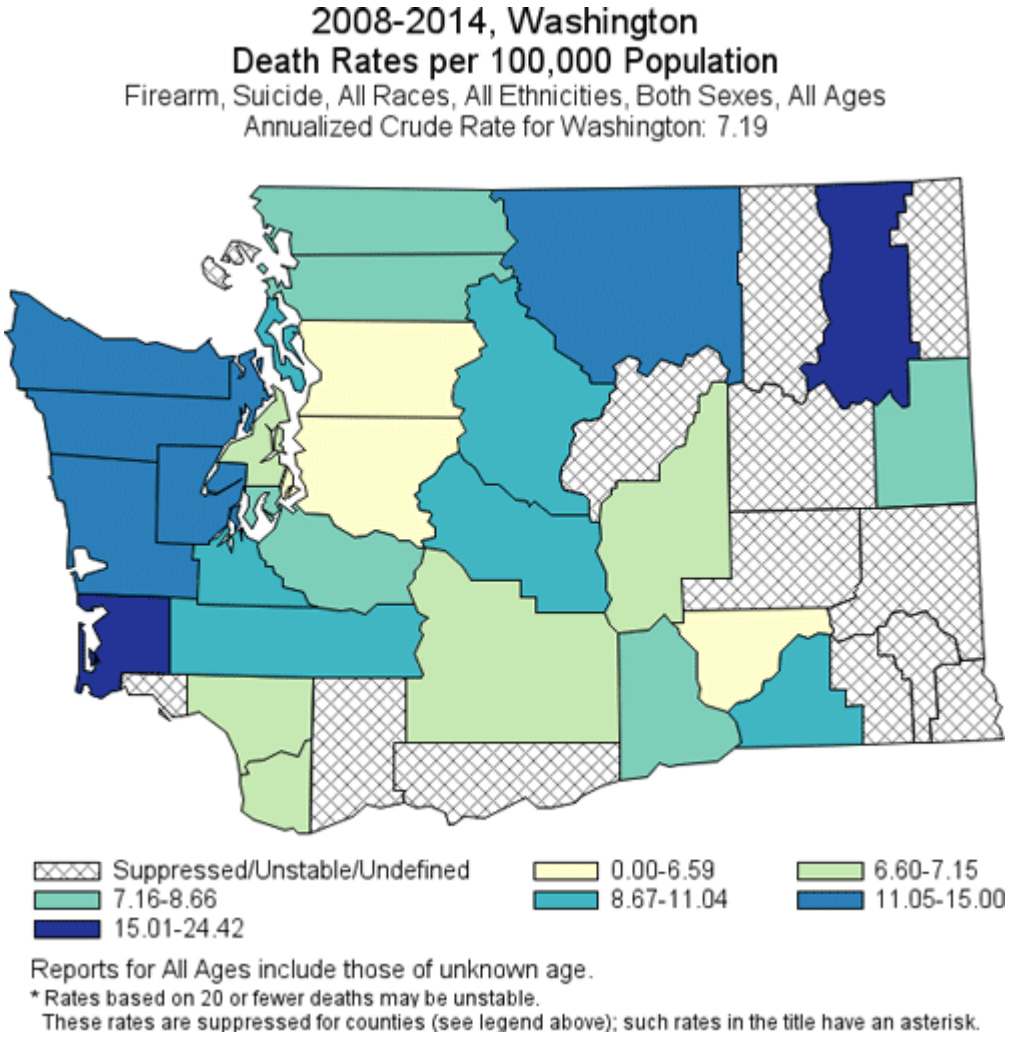
Lethal means are the instruments or objects used to carry out a self-destructive act. The risk of imminent harm is inextricably linked to the availability of lethal means. If a client is experiencing significant distress, appears to be at immediate risk of self-harm, or has a recent history of suicidal behavior, directly ask if he or she has access to lethal means that may be used in a suicide attempt.

When asking about lethal means, be direct with your questions and ask in a non-judgmental manner. For example: "What do you have access to once you leave this office that you can use to harm yourself?" Or, "While you're in this dangerous period, can I call your partner or family member and ask them to remove the guns, poisons, and medications from your house?"

Show concern by saying for example, "I want to let you know I appreciate and am honored that you've shared your concerns with me. I'm worried that you may go to a place of despair when you leave here and I'm concerned for your safety." Try to establish trust—if you think the person is at risk, there is no reason to cover your concern or to lie.

When a person in acute crisis, access to lethal means such as firearms, poisons, prescription medications, chemicals, ropes, and knives can increase the likelihood of self-harm. Firearms are of particular concern and are the most common instrument used in suicides and suicide attempts, especially among men and both male and female veterans. Household firearm ownership rates are a significant positive predictor of both homicides and suicides (Swanson et al., 2015).

Suicide Deaths in Washington by Firearm (2008–2014)



Produced by: the Statistics, Programming & Economics Branch, National Center for Injury Prevention & Control, CDC.
Data Sources: NCES National Vital Statistics System for numbers of deaths; US Census Bureau for population estimates.

Poisoning—predominantly drug overdose—is the leading mechanism for suicide death among adult women and the third leading mechanism for adult men. Nearly all drug-related emergency department visits involving suicide attempts among middle-aged adults involve prescription drugs and over-the-counter medications (Tesfazion, 2014).

About half of emergency department visits involve anti-anxiety and insomnia medications, about a third involve pain relievers, and about a quarter involve antidepressants. For adult men and women, more than a third of all drug-related emergency department visits involving a suicide attempt also involve alcohol, and 11% involve illicit drugs (Tesfazion, 2014).

Number of Suicide Deaths by Method (2015)	
Suicide Method	Number of Deaths (2015)
Total	44,193
Firearm	22,018
Suffocation	11,855
Poisoning	6,816
Other	3,504

Source: Courtesy of CDC.

Restricting Access to Lethal Means

Means restriction is the 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 reducing suicide death rates. Restricting access to firearms is of particular importance, since firearm suicide attempts have a high case-fatality rate and firearms account for 51% of all suicide deaths in the United States (Betz et al., 2016).

Implementation of means restriction is broad and can include:

- Complete removal of a lethal method
- Reducing the toxicity of a lethal method such as reducing carbon monoxide content emissions from vehicles
- Interfering with physical access, for example, using gun locks or locking medicine cabinets
- Enhancing safety by 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)

A suicide attempt often occurs within only minutes of the decision to make an attempt, and approximately 90% of firearm suicide attempts are fatal (compared to as few as 2% of medication overdoses). 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 emergency departments can affect storage behavior (Betz et al., 2016). In Washington State, from 2012 to 2016, firearms were used in 48% of all suicides (WSDOH, 2018).

Although strategies to restrict access to lethal means have focused on at-risk individuals, evidence for means restriction has come from situations in which a universal approach was applied to the entire population. For example, the detoxification of domestic 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 (HHS, 2012).

Counseling on Access to Lethal Means (CALM) is an example of a program designed for those who have training and experience in mental health counseling and is also appropriate for other healthcare providers, substance abuse counselors, and community pharmacists. It emphasizes that restricting access to lethal means should be part of a comprehensive prevention strategy. That is because most suicidal people are ambivalent about wanting to die, and many suicide attempts are made impulsively, during a short-term crisis (SAMHSA, 2014).

Community-Based Pharmacists and Other Healthcare Providers

Pharmacists are educated and trained about medications and their side effects, as well as the effects of polypharmacy. Because pharmacists are located not only in hospitals but also within community-based pharmacies, chain pharmacies, nursing homes, and outpatient hospital pharmacies, they routinely have the opportunity to provide counseling to clients and their families (Yap, 2015).

Pharmacists have two responsibilities related to suicide prevention. At a minimum, they need to be able to talk with clients about suicide and complete a quick screen. The second responsibility is to get the person connected to help—whether to his or her physician, a family member, or the suicide hotline (Yap, 2015).

Pharmacists can educate clients and family members about reducing stocks of medicine to a nonlethal quantity and locking up medicines that are commonly abused (eg, prescription painkillers, benzodiazepines). This approach can be useful in helping to prevent suicide, as well as unintentional overdoses and substance abuse (HHS, 2012).

Given that many of the medications used to treat mental illness can be toxic in an overdose, educating clients about—and reducing access to—potentially toxic medications can be a challenge. Because the majority of suicide attempts are transient and the time between contemplating suicide and the attempt is less than 5 minutes for many attempters (Hassamal et al., 2015), restricting access can mean the difference between life and death. 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).

When highly lethal means are less available to impulsive attempters, the odds are better that they will survive a suicide attempt (SAMHSA, 2014). For more information for pharmacists, see the *Pharmacists Preventing Suicides* website at www.pharmacistspreventingsuicides.com/.

Other community-based healthcare providers may come in contact with at-risk clients either before or after a suicide attempt. In both instances, it is important to understand the reason for screening and referral for suicidal ideation and behaviors. Physical and occupational therapists treat clients with chronic pain, a risk factor for depression and suicidal ideation. Mental health providers and drug abuse counselors provide critical social and psychological support. If a client is at risk of imminent harm, routine screening can provide the support needed to avert self-harm. If a client has been referred following a suicide attempt, screening is particularly important because a client who has attempted suicide remains at high risk following an attempt.

Because of their ongoing and regular contact with their clients, outpatient and community healthcare and mental health providers are in a unique position to provide education about imminent harm and lethal means. However, many may fail to do so, or do so only when a client is identified as being at a very high risk for suicide (HHS, 2012).

Encouraging Safe Storage Practices

Pharmacists and community healthcare and mental health providers play a critical role in encouraging safe storage of potentially lethal products. 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. Recommended practices include education and counseling around storing firearms (unloaded and separate from ammunition) in a gun safe or lock box 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).

Public health campaigns such as **Safer Homes, Suicide Aware** focus on simple steps to prevent suicide deaths and attempts long before a crisis occurs. This type of public health program educates family members, pharmacists and other community healthcare and mental health providers about potential hazards in the home.

For pharmacists and mental health providers, medications are a 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?

1. Little interest or pleasure in doing things?
2. 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 the local emergency department 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 medications along with a screening protocol provided help to a person in acute crisis.

Dental Professionals

Starting in August of 2020, dental hygienists and dentists in Washington State will be required to take a three-hour continuing education course on suicide screening and referral. The course must contain information related to imminent harm and lethal means.

Because dental professionals spend a great deal of time with their clients, often see their clients on a regular basis, and are familiar with their medical history, they are in a good position to screen and refer clients who may be at risk for self-harm. The initial assessment and ongoing, regular appointments provide opportunities to screen for risk factors associated with suicide. The intimate nature of dental work allows oral health professionals to ask about depression, chronic pain, unexplained loss of teeth, mouth lesions, as well as injuries to the head and neck.

Dentistry has a tradition of working to prevent diseases through customized regular examinations and oral healthcare programs. Because of this, medical screenings in dental settings are showing an increasing trend. The benefits of screening in dental settings for early diagnosis and identification of patients at risk are well documented. In a number of surveys, dentists reported that medical screening is a vital public health service and indicated they would be willing to incorporate screenings into their routines, along with additional education and training (Friman et al., 2015).

Studies of patients' attitudes toward screening for medical conditions in a dental setting have indicated that most clients expressed a favorable attitude toward chair-side screening. They also expressed the importance of the dental professionals' having the necessary medical knowledge and, when appropriate, the ability to refer to the other healthcare services (Friman et al., 2015).

Screening for suicidal ideation and behaviors in a dental setting is consistent with screening for other health issues such as diabetes and heart disease. As with other healthcare providers, dental clinics must have policies and procedures in place that describe screening tools, employee training, and referral resources. A simple screening tool such as the Patient Health Questionnaire 2 or another short screening tool (discussed in Module 3) or a waiting room questionnaire can be quick and efficient. Dental professionals must be trained in the use of a screening tool and have pre-screened referral resources readily available that include mental health and social services.

Julio Is Facing 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.

Concluding Remarks

Suicide rates have increased recently in the United States, with an almost 20% increase in Washington State. As healthcare professionals working in outpatient clinics, social service offices, clients' homes, community pharmacies, dental offices, and other community settings, learning how and when to screen clients for suicidal ideation and behaviors can save a life. The goal of screening is to identify people at risk and quickly refer them to the services that can help prevent self-harm.

Washington law recommends that clients be screened for suicidal ideation and behavior. A screening tool such as the Patient Health Questionnaire 2 or the Columbia Suicide Screen can help a clinician gauge the immediacy of the risk, the need for a more thorough assessment, and the need for referral.

Healthcare providers have an ethical duty to assess client safety and understand the referral process. Screening is only the first step in identifying possible suicidal ideation and behaviors in your clients. Be prepared with a plan, know how to activate resources, and make sure to follow up. Staying engaged with a client will give hope and may be helpful in reducing depression and hopelessness.

Understanding when a person is at imminent risk of harm and being ready and willing to talk about lethal means are important aspects of suicide prevention. As in other areas of healthcare, a non-judgmental, kind, patient-centered approach is critically important.

Outpatient providers, physical and occupational therapists, social workers, psychologists, dentists, and community pharmacists can play a key role in reducing suicidal behaviors by routinely screening clients and making timely referrals to mental health resources. These providers also play a key role once a client has been discharged following a suicide attempt. Risk remains elevated during the days and weeks following hospitalization for a suicide attempt, especially for people diagnosed with major depression, bipolar disorder, and schizophrenia. This is a key issue for anyone providing services to a person after a suicide attempt.

References

Action Alliance for Suicide Prevention. (2014). Screening and Assessment for Suicide in Health Care Settings: A Patient-Centered Approach. Retrieved May 15, 2018 from http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/Screening%20and%20Assessment%20for%20Suicide%20in%20Health%20Care%20Settings%2010-27-14%20slides.pdf.

American Foundation for Suicide Prevention (**AFSP**). (2016). State Laws: Training for Health Professionals in Suicide Assessment, Treatment, and Management. Retrieved May 1, 2018 from http://afsp.org/wp-content/uploads/2016/04/Health-Professional-Training-Issue-Brief.pdf.

American Immigration Council. (2017). Immigrants in Washington State. Retrieved March 27, 2018 from https://www.americanimmigrationcouncil.org/sites/default/files/research/immigrants_in_washington.pdf.

Betz ME, Miller M, Barber C, et al. (2016). Lethal means access and assessment among suicidal emergency department patients. *Depress Anxiety* 33(6):502–11. Doi:10.1002/da.22486. Retrieved January 3, 2018 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4800489/.

Bonner L, Felker B, Chaney E, et al. (Nd). Suicide Risk Response: Enhancing Patient Safety Through Development of Effective Institutional Policies. VA Puget Sound Healthcare System. Retrieved March 26, 2018 from https://www.ahrq.gov/downloads/pub/advances/vol3/Bonner.pdf.

Center for Substance Abuse Treatment (**CSAT**). (2015). *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series, No. 50. HHS Publication No. (SMA) 154381. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved January 3, 2018 from https://store.samhsa.gov/shin/content//SMA15-4381/SMA15-4381.pdf.

Centers for Disease Control and Prevention (**CDC**). (2018). Suicide rates rising across the U.S. Retrieved June 8, 2018 from https://www.cdc.gov/media/releases/2018/p0607-suicide-prevention.html.

Centers for Disease Control and Prevention (**CDC**). (2017a). WISQARS Leading Causes of Death Reports, 1981–2015. Retrieved January 3, 2018 from https://webappa.cdc.gov/sasweb/ncipc/leadcause.html.

Centers for Disease Control and Prevention (**CDC**). (2017b). Suicide Among Youth: What's the Problem? Retrieved January 12, 2018 from https://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/SuicideYouth.html.

Centers for Disease Control and Prevention (**CDC**). (2016). Definitions: Self-directed Violence. Retrieved January 3, 2018 from https://www.cdc.gov/violenceprevention/suicide/definitions.html.

Coyne J. (2017). Results of largest trial of suicide intervention in emergency departments ever conducted in U.S. *PLoS Blogs*: Mind the Brain. Retrieved January 3, 2018 from http://blogs.plos.org/mindthebrain/2017/05/17/results-of-largest-trial-of-suicide-intervention-in-emergency-departments-ever-conducted-in-us/.

Crane EH. (2016). Patients with emergency department visits involving drug-related suicide attempts who left against medical advice. *The CBHSQ Report*: September 13, 2016. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD. Retrieved January 3, 2018 from https://www.ncbi.nlm.nih.gov/books/NBK396153/.

DeBeer BB, Kittel JA, Cook A, et al. (2016) Predicting suicide risk in trauma exposed Veterans: The role of health promoting behaviors. *PLoS ONE* 11(12): e0167464. Doi:10.1371/journal.pone.0167464. Retrieved January 3, 2018 from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0167464.

Department of Veterans Affairs/Department of Defense (**DVA/DOD**). (2013). Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide. Retrieved December 22, 2017 from https://www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_Full.pdf.

Department of Veterans Affairs (**DVA**). (n.d.). About the Veterans Crisis Line. Retrieved May 18, 2018 from https://www.veteranscrisisline.net/About/AboutVeteransCrisisLine.aspx.

Emergency Medicine Network (**EMN**). (2017). ED SAFE Materials. Retrieved May 15, 2018 from http://www.emnet-usa.org/ED-SAFE/materials.htm.

Fawcett J. (2012). Diagnosis, traits, states, and comorbidity in suicide. In: *The Neurobiological Basis of Suicide.* Boca Raton (FL): CRC Press/Taylor & Francis. Retrieved May 18, 2018 from https://www.ncbi.nlm.nih.gov/books/NBK107213/.

Fosse R, Ryberg W, Carlsson MK, Hammer J. (2017). Predictors of suicide in the patient population admitted to a locked-door psychiatric acute ward. *PLoS ONE* 12(3): e0173958. Doi:10.1371/journal.pone.0173958. Retrieved May 18, 2018 from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0173958.

Friman G, Hultin M, Nilsson GH, Wårdh I. (2015). Medical screening in dental settings: A qualitative study of the views of authorities and organizations. *BMC Research Notes* 8:580. Doi:10.1186/s13104-015-1543-8. Retrieved July 10, 2018 from https://bmcresnotes.biomedcentral.com/articles/10.1186/s13104-015-1543-8#Sec25.

Grandclerc S, De Labrouhe D, Spodenkiewicz M, et al. (2016). Relations between nonsuicidal self-injury and suicidal behavior in adolescence: A systematic review. *PLoS ONE* 11(4): e0153760. Doi:10.1371/journal.pone.0153760. Retrieved January 3, 2018 from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0153760.

Hassamal S, Keyser-Marcus L, Crouse Breden E, et al. (2015). A brief analysis of suicide methods and trends in Virginia from 2003 to 2012. *BioMed Research International*, Article ID 104036. Doi:10.1155/2015/104036. Retrieved May 18, 2018 from https://www.hindawi.com/journals/bmri/2015/104036/.

Hastings KG, Jose PO, Kapphahn KI, et al. (2015). Leading Causes of Death among Asian American Subgroups (2003–2011). *PLoS ONE* 10(4):e0124341. Doi:10.1371/journal.pone.0124341. Retrieved May 18, 2018 from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0124341.

Health and Human Services **(HHS**). (2012). Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC. Retrieved May 18, 2018 from https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf.

Horowitz LM, Boudreaux ED, Schoenbaum M, et al. (2018). Universal Suicide Risk Screening in the Hospital Setting: Still a Pandora's Box? Joint Commission Journal 44(1): 1–3. Doi/10.1016/j.jcjq.2017.11.001. Retrieved May 11, 2018 from https://www.jointcommissionjournal.com/article/S1553-7250(17)30544-5/fulltext#back-bib0035.

Joint Commission, The. (2016). Sentinel Event Alert. Detecting and Treating Suicide Ideation in All Settings. Retrieved January 18, 2018 from https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf.

Kung A, Hastings KG, Kapphahn KI, et al. (2018). Cross-national comparisons of increasing suicidal mortality rates for Koreans in the Republic of Korea and Korean Americans in the USA, 2003–2012. *Epidemiology and Psychiatric Sciences* (27):62–73. Doi:10.1017/S2045796016000792. Retrieved February 22, 2018 from https://www.cambridge.org/core/services/aop-cambridge-core/content/view/BFC20318D6496657E297D7EA5BD2D541/S2045796016000792a.pdf/crossnational_comparisons_of_increasing_suicidal_mortality_rates_for_koreans_in_the_republic_of_korea_and_korean_americans_in_the_usa_20032012.pdf.

Liljedahl SI, Helleman M, Daukantaité D, et al. (2017). A standardized crisis management model for self-harming and suicidal individuals with three or more diagnostic criteria of borderline personality disorder:The Brief Admission Skåne randomized controlled trial protocol (BASRCT). *BMC Psychiatry* 17:220. Doi:10.1186/s12888-017-1371-6. Retrieved January 3, 2018 from https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-017-1371-6.

McDermott K. (2016). KUOW News and Information. Retrieved March 27, 2018 from http://kuow.org/post/where-seattles-refugees-come-and-other-things-you-should-know.

Mendez-Bustos P, Lopez-Castroman J, Baca-García E, Ceverino A. (2013). Life cycle and suicidal behavior among women. *Scientific World Journal* Article ID 485851. Doi:10.1155/2013/485851. Retrieved May 18, 2018 from https://www.hindawi.com/journals/tswj/2013/485851/.

National Action Alliance for Suicide Prevention. (2011). Suicide Care in Systems Framework. Retrieved June 29, 2018 from http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf.

National Center for Health Statistics (**NCHS**). (2016). Increase in Suicide in the United States, 1999–2014. NCHS Data Brief No. 241, April 2016. Retrieved January 3, 2018 from https://www.cdc.gov/nchs/products/databriefs/db241.htm.

National Registry of Evidenced-based Programs and Practices (**NREPP**). (2015). NREPP Learning Center Literature Review: Suicide Prevention. Retrieved May 18, 2018 from http://nrepp.samhsa.gov/Docs/Literatures/NREPP%20Learning%20Center%20Lit%20Review_%20Suicide%20Prevention.pdf.

New York State Department of Health (**NYSDOH).** (2016). Administering the Patient Health Questionnaires 2 and 9 (PHQ 2 and 9) in Integrated Care Settings. Retrieved February 20, 2018 from https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2016-07-01_phq_2_and_9_clean.pdf.

Office of Minority Health (**OMH**). (2017). Mental Health and African Americans. Retrieved May 18, 2018 from https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=24.

Pauwels K, Aerts S, Muijzers E, et al. (2017). BackUp: Development and evaluation of a smart-phone application for coping with suicidal crises. *PLoS ONE* 12(6):e0178144. Doi:10.1371/journal.pone.0178144. Retrieved May 18, 2018 from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0178144#sec005.

Ratkowska K, De Leo D. (2013), Suicide in Immigrants: An Overview. *Open Journal of Medical Psychology* 2(3): 124–33. Doi:10.4236/ojmp.2013.23019. Retrieved May 18, 2018 from https://file.scirp.org/Html/7-2250046_34019.htm.

Safer Homes Suicide Aware. (n.d.). Training Providers. Retrieved January 16, 2018 from http://depts.washington.edu/safehome/training-provider/.

Stone DM, Holland KM, Bartholow B, et al. (2017). Preventing suicide: A technical package of policies, programs, and practices. Atlanta, GA: National Center for Injury Prevention and Control (**NCIPC**), Centers for Disease Control and Prevention(**CDC**). Retrieved January 3, 2018 from https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf.

Substance Abuse and Mental Health Services Administration (**SAMHSA**). (2014). Counseling on Access to Lethal Means. Retrieved May 1, 2018 from https://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/preventing_suicide/lethal_means.html.

Swanson JW, McGinty EE, Fazel S, Mays VM. (2015). Mental illness and reduction of gun violence and suicide: Bringing epidemiologic research to policy. *Ann Epidemiol* 25(5):366–76. Doi:10.1016/j.annepidem.2014.03.004. Retrieved January 3, 2018 from https://www.ncbi.nlm.nih.gov/pmc/articles/pmc4211925/.

Tesfazion AA. (2014). Emergency Department Visits for Drug-Related Suicide Attempts among Middle-Aged Adults Aged 45 to 64. The CBHSQ Report. Center for Behavioral Health Statistics and Quality (**CBHSQ**), Substance Abuse and Mental Health Services Administration (**SAMHSA**). Retrieved May 18, 2018 from https://www.ncbi.nlm.nih.gov/books/NBK384674/#SR-154_SR-2396.s1.

Tsai AC, Lucas M, Kawachi I. (2015). Association Between Social Integration and Suicide Among Women in the United States. *JAMA Psychiatry* 72(10):987–93. Doi:10.1001/jamapsychiatry.2015.1002. Retrieved January 18, 2018 from https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2398734.

U.S. Department of Veterans Affairs (**USDVA**). (2016a). Suicide Among Veterans and Other Americans 2001–2014. Retrieved May 18, 2018 from https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf.

U.S. Department of Veterans Affairs (**USDVA**). (2016b). Mental Health: Suicide Prevention. Retrieved May 18, 2018 from https://www.mentalhealth.va.gov/suicide_prevention/.

Wang Z, Yu C, Wang J, et al. (2016). Age-period-cohort analysis of suicide mortality by gender among white and black Americans, 1983–2012. *International Journal for Equity in Health* 2016 15:107. Doi:10.1186/s12939-016-0400-2. Retrieved May 18, 2018 from https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-016-0400-2.

Washington State Department of Health (**WSDOH**). (2018). Firearm Fatality and Suicide Prevention: A Public Health Approach. Update on Executive Order 16-02. Retrieved July 26, 2018 from https://www.doh.wa.gov/Portals/1/Documents/Pubs/346-087-FirearmFatalityandSuicidePrevention2018.pdf.

Washington State Department of Health (**WSDOH**). (2016). Washington State Suicide Prevention Plan. Retrieved May 18, 2018 from http://www.doh.wa.gov/Portals/1/Documents/Pubs/631-058-SuicidePrevPlan.pdf.

Williams NJ. (2016). Assessing mental health clinicians' intentions to adopt evidence-based treatments: Reliability and validity testing of the evidence-based treatment intentions scale. *Implementation Science* 11(60). Doi:10.1186/s13012-016-0417-3. Retrieved January 3, 2018 from https://implementationscience.biomedcentral.com/articles/10.1186/s13012-016-0417-3.

World Health Organization (**WHO**). (2018). Risk Factors. Retrieved April 20, 2018 from http://www.who.int/topics/risk_factors/en/.

World Health Organization (**WHO**). (2014). Preventing Suicide: A global Imperative. Retrieved April 18, 2018 from http://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf;jsessionid=5E52CC6E0E299C050F2AD784B3DFFD40?sequence=1.

Yap D. (2015). How pharmacists can help patients at risk for suicide. *Pharmacy Today*. Retrieved April 30, 2018 from http://www.pharmacist.com/article/how-pharmacists-can-help-patients-risk-suicide.

Post Test

Use the answer sheet following the test to record your answers.

1. Suicide is a major public health concern. Each year in the United States:

    a. There are many more homicides than suicides.
    b. Suicide is the leading cause of death.
    c. There are approximately 45,000 suicides.
    d. Suicide rates were highest in the Northeast.

2. In Washington State, suicide rates:

    a. Are much lower than the national average.
    b. Are highest among Asian American adults during their late seventies.
    c. Are highest among American Indian, Alaska Native, and white populations.
    d. Are about the same as the national average.

3. Warning signs of suicide:

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

4. Two of the strongest **individual** risk factors for suicide are:

    a. Local epidemics and access to medical care.
    b. Previous attempt and history of substance abuse.
    c. Cultural and religious beliefs and financial loss.
    d. Willingness to seek help and female gender.

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

    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.

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

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.

7. Key challenges in the referral of people at risk for suicide are:

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.

8. Recognition and referral training:

a. Is a school lunch program.

b. Helps people without formal psychosocial training play a critical role in suicide prevention.

c. Is a classroom volunteer program.

d. Sends at risk youth to military academies.

9. Continuity of care:

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.

10. Imminent harm is:

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 person is thought to be at **immediate** risk of self-harm or suicide.

d. The potential for self-harm sometime in the future.

11. The results of your screen indicate that your client may at risk of imminently harming herself. In terms or lethal means, what should you do:

a. Directly ask if she has access to lethal means that may be used in a suicide attempt.

b. Send the police to her house to remove guns and poisons.

c. Refer her to an outpatient mental health clinic in a nearby town.

d. Refrain from asking about lethal means because you might be planting the seed for a suicide attempt.

12. Reducing access to lethal means:

a. Reduces access to the instruments or objects used to carry out a self-destructive act.

b. Tells a patient to stay away from instruments or objects that can be used to carry out a self-destructive act.

c. Has very little impact on a person’s ability to carry out a self-destructive act.

d. Is important for the first hour after a suicide attempt but not useful in the days and weeks following an attempt.

13. Pharmacists have two main responsibilities related to suicide prevention:

a. Move the person to a private area and call the police.

b. Refuse to fill a person’s prescription and get the person out of the pharmacy.

c. Talk to the person and give them a ride to the hospital.

d. Complete a quick screen and get the person connected to help.

14. Medications are a particular concern because of the potential for abuse, accidental poisonings, and use in suicide attempts. Safe storage practices include:

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.

Answer Sheet

About Suicide Screening, Referral, and Imminent Harm in Washington State, 3 units

Name (Please print your name): _____

Date: _____

Passing score is 80%

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

Course Evaluation

Please use this scale for your course evaluation. Items with asterisks * are required.

- 5 = Strongly agree
- 4 = Agree
- 3 = Neutral
- 2 = Disagree
- 1 = Strongly disagree

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

a. Explain the scope of suicide in the United States and Washington State.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

b. Relate 5 warning signs for suicide.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

c. Describe 3 principles of effective suicide screening.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

d. Describe one appropriate referral resource each for high, medium, and low-risk clients.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

e. Define imminent harm.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

f. Describe the 2 responsibilities of pharmacists related to suicide prevention.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* The author(s) are knowledgeable about the subject matter.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* The author(s) cited evidence that supported the material presented.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* This course contained no discriminatory or prejudicial language.

Yes No

* The course was free of commercial bias and product promotion.

Yes No

* As a result of what you have learned, do you intend to make any changes in your practice?

Yes No

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

* Do you intend to return to ATrain for your ongoing CE needs?

- Yes, within the next 30 days.
- Yes, during my next renewal cycle.
- Maybe, not sure.
- No, I only needed this one course.

* Would you recommend ATrain Education to a friend, co-worker, or colleague?

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

* What is your overall satsfaction with this learning activity?

5 4 3 2 1

* Navigating the ATrain Education website was:

- Easy.
- Somewhat easy.

- ○ Not at all easy.

* 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
- ○ Less than 30 minutes per contact hour

I heard about ATrain Education from:

- ○ Government or Department of Health website.
- ○ State board or professional association.
- ○ Searching the Internet.
- ○ A friend.
- ○ An advertisement.
- ○ I am a returning customer.
- ○ My employer.
- ○ Other
- ○ Social Media (FB, Twitter, LinkedIn, etc)

Please let us know your age group to help us meet your professional needs.

- ○ 18 to 30
- ○ 31 to 45
- ○ 46+

I completed this course on:

- ○ My own or a friend's computer.
- ○ A computer at work.
- ○ A library computer.
- ○ A tablet.
- ○ A cellphone.
- ○ A paper copy of the course.

Please enter your comments or suggestions here: _____

_____

_____

_____

Registration Form

Please print and answer all of the following questions (* required).

* Name: _____

* Email: _____

* Address: _____

* City: _____ * State: _____ * Zip: _____

* Country: _____

* Phone: _____

* Professional Credentials/Designations:

_____

* License Number and State:

* Please email my certificate:

◯ Yes ◯ No

(If you request an email certificate we will not send a copy of the certificate by US Mail.)

Payment Options

You may pay by credit card or by check.
Fill out this section only if you are **paying by credit card.**
3 contact hours: $39

Credit card information

* Name: _____

Address (if different from above): _____

* City: * State: * Zip:

* Card type:

◯ Visa ◯ Master Card ◯ American Express ◯ Discover

* Card number: _____

* CVS#: _____

* Expiration date: _____