About Suicide Screening, Referral, and Imminent Harm in Washington State, 3 units (325)

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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.

Course Objectives

When you finish this course, you will be able to:

1. Describe the scope of suicide in the U.S. and Washington State.
2. Relate 5 warning signs for suicide.
3. Describe 3 principles of effective suicide screening.
4. Discuss the importance of connecting patients to appropriate referral resources.
5. Describe recognition and referral training.
6. Understand how the risk of imminent harm is linked to lethal means.
7. Describe 2 responsibilities of pharmacists, dental, and allied health professionals related to suicide screening and prevention.
8. Understand the 4 basic tenets of safe storage practices.

Instructions for Mail Order

When you have finished studying the course material:

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

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1. The Scope of Suicide

Mental health has traditionally been within the purview of psychiatrists and specifically trained mental health practitioners. 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 to be knowledgeable about suicide risk factors and warning signs, understand suicide screening tools, and know when, where, and how to refer a patient who is at risk for self-harm.

A web of biological, psychological, social, environmental, and situational concerns influences suicidal ideation and behaviors. Childhood trauma, substance abuse, poverty, and untreated mental health problems are common risk factors. Unfortunately, many people are not able to get help because of provider shortages, stigma, and the cost of care.

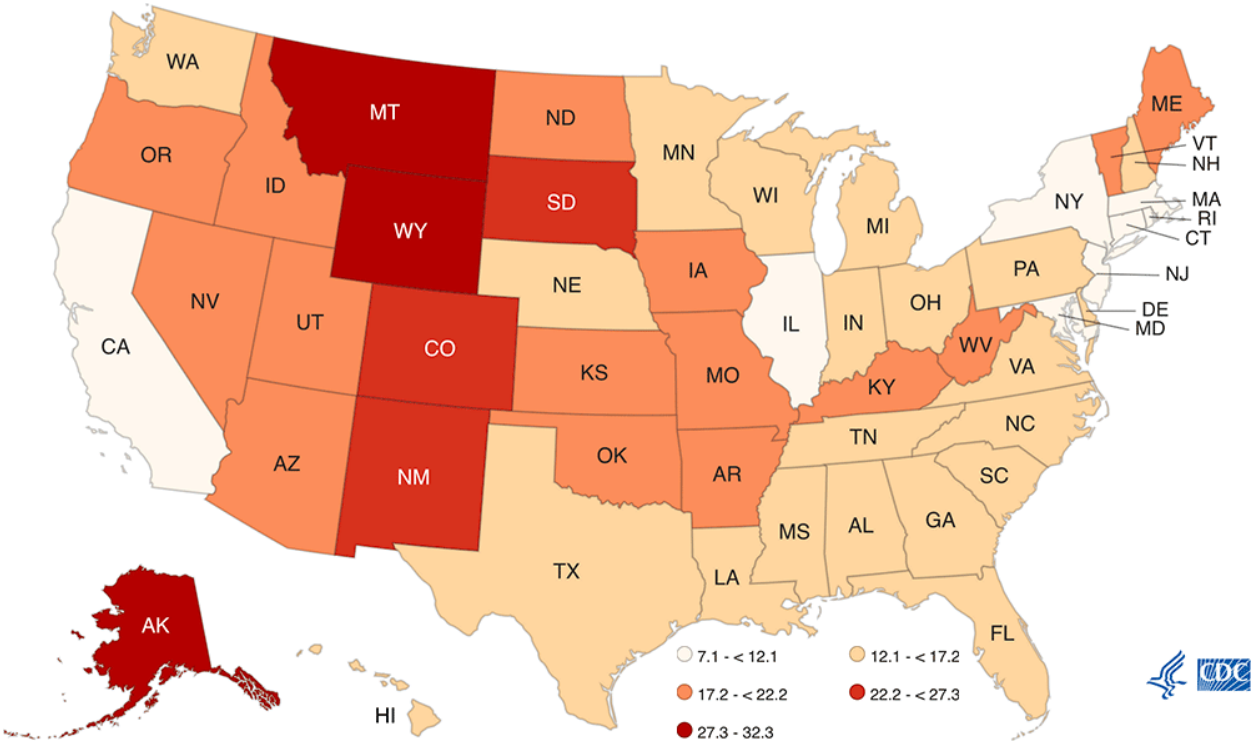
In 2022, more than 49,000 Americans died from suicide—the highest number ever recorded in the U.S.—making it the eleventh leading cause of death overall. Remarkably, each year there are more than twice as many suicides as homicides in the United States (NCHS, 2023).

Source: CDC, 2023, May 8.

During the COVID pandemic, there was a record increase in homicides and a spike in the number of drug overdose deaths. It was assumed that suicide rates would follow a similar pattern—particularly after the number of suicides had risen every year between 2004 and 2019. However, between 2018 and 2019, there was a minor decline in suicide, and this decline continued both males and females into the pandemic year of 2020 (CDC, 2021, November 5).

Suicide Rates in the United States

(by state; per 100,000 population; 2021)



Suicide rates vary from state to state. In general, the Western states (excluding California), have some of the highest rates of suicide in the country. Source: CDC, 2023, May 1.

Suicide is not limited to any gender, age, socioeconomic, or ethnic group. Among children, teenagers, and young adults, suicide is the **second** leading cause of death, while among middle-aged adults (age 35 to 54), suicide is the **fifth** leading cause of death (NCHS, 2022, March 3).

Definitions

Suicide: death caused by self-directed injurious behavior with intent to die.

Suicide attempt: when someone harms themself with any intent to end their life but does not die.

Suicidal ideation: thinking about, considering, or planning suicide.

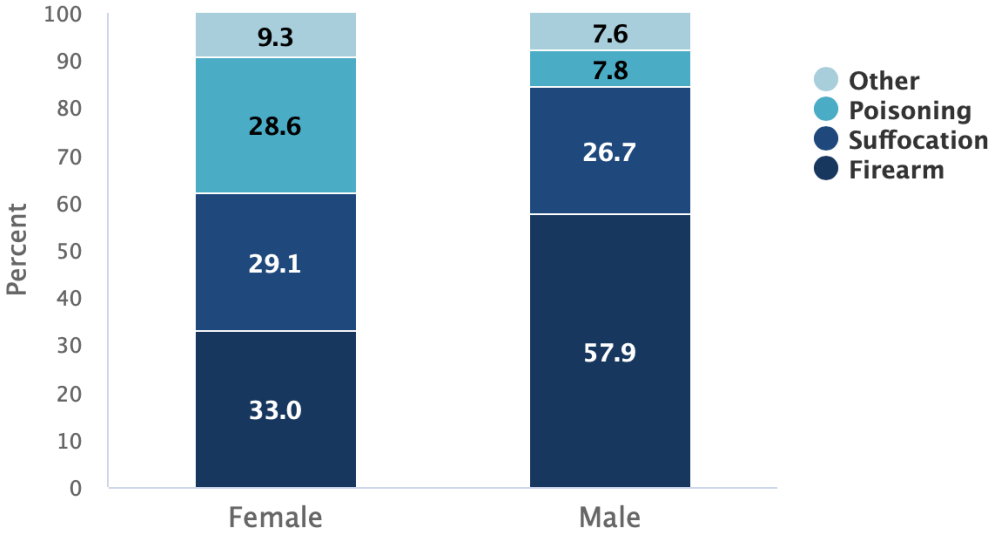
1.1 Suicide is a Major Public Health Concern

Many factors contribute to suicide among people with and without mental health concerns. More than half of people who die by suicide **do 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 contribute to an increased risk for suicide.

In the United States, among youth and young adults aged 10-34, suicide is the second leading cause of death. Suicide rates for females in all age groups over age 25 showed recent declines, while rates for those aged 10–14 and 15–24 have generally increased (Garnett et al., 2022).

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 by firearm, hanging, or suffocation, while women often attempt suicide by poisoning, wrist cutting, or falling from heights. From 2000-2020, the suicide rate for males was 3–4 times the rate for females (Garnett et al., 2022).

Percentage of Suicide Deaths by Method in the United States (2020)



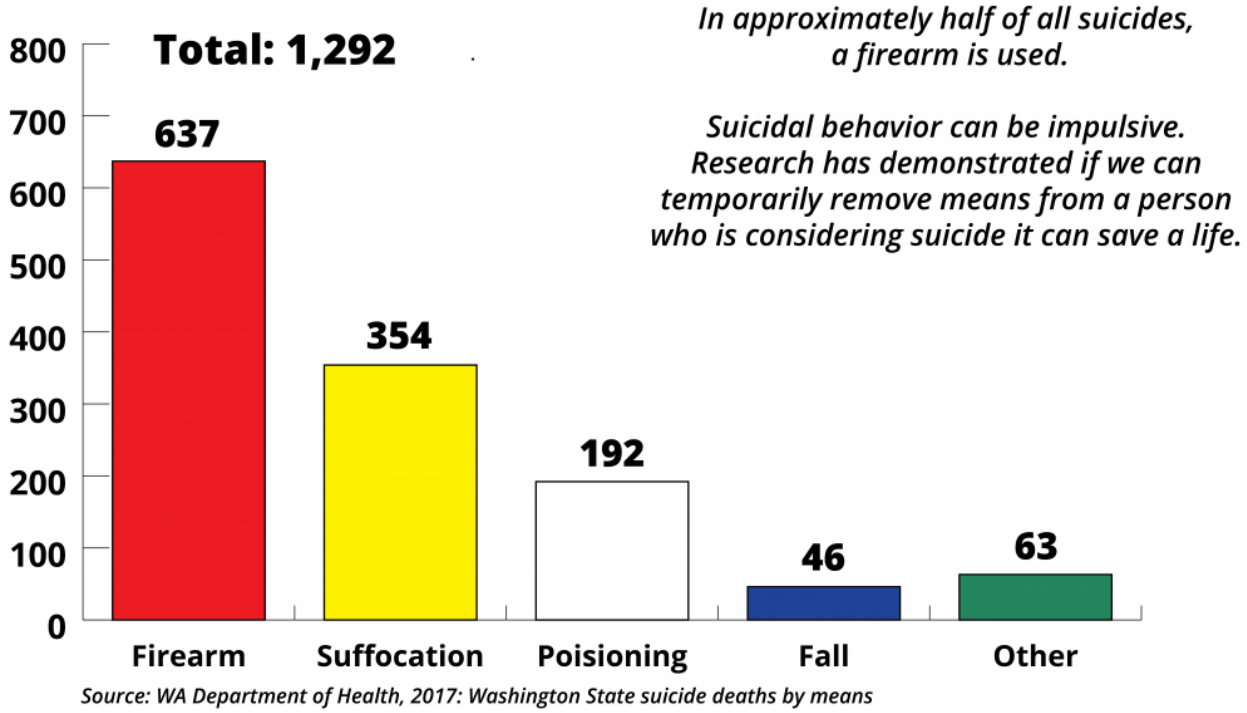
Source: nimh.nih.gov. 2023, May.

In Washington State, the suicide rate has been higher than the national average for more than 10 years. From 2010 to 2019, over 11,000 people in the state died as a result of suicide. The most common means were firearms, followed by suffocation and poisoning (deGrauw, 2021).

Statistics from 2018 showed that more than 40% of people who died by suicide in Washington State had a history of suicidal thoughts. About 19% had served in the military. About a third of those who died by suicide left a note. Additionally:

- 75% were male
- 65% occurred at home
- 48% involved a firearm (WSDOH, 2020, November)

Washington State Suicide Deaths by Means, 2017



Source: WA Department of Health, 2017: Washington State suicide deaths by means

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. From 2013 to 2017, 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)

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 (WSDOH, 2016).

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. The suicide rate in King County is lower than the state rate, but it has the largest population and the highest number of suicides in the state (WSDOH, 2016).

Key Points about Suicide

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

Source: Washington State Department of Health, 2016

1.2 Suicide Rates by Race/Ethnicity, Age, and Gender

Suicide rates vary significantly by race, ethnicity, age, and gender. In 2019, Native American Indian and Alaska Native people had a suicide rate 60% greater than the general population (CDC, 2021 February 24).

The rates of suicide are highest for American Indian males, followed by White, non-Hispanic males. Among females the rates of suicide are highest for American Indian females and White, non-Hispanic females (NIMH, 2023, May).

For Native American Indian and Alaska Native peoples, sovereignty, community control, autonomy, cultural identification, language, spirituality, healing ways, kinship models, and family connectedness are all important protective factors in addressing high rates of suicide among Indigenous populations (Zero Suicide, 2022).

Did You Know. . .

Compared to non-Hispanic Whites, non-Hispanic Indigenous people who die by suicide are younger, live in more rural areas, are more likely to have a friend or family member who died by suicide, and are more likely to use alcohol (Leavitt, et al, 2018).

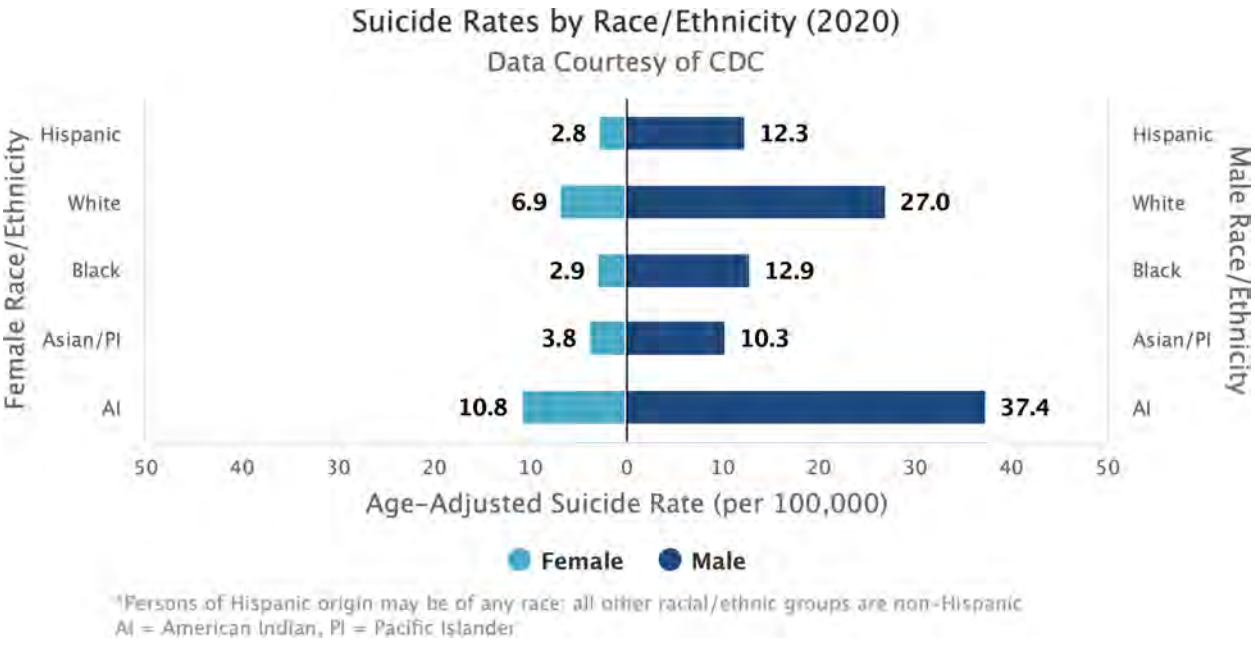
For Black Americans, rates are lower than that of the non-Hispanic White population. Nevertheless, in 2020, suicide was the third leading cause of death for Blacks Americans, ages 15 to 24. The suicide death rate for Black men was more than four times greater than for Black women (OMH, 2022).

Among Asian Americans, suicide rates are generally lower than for other racial/ethnic groups although rates are high for Korean Americans. 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).

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

The suicide rate for Hispanics/Latinos in the United States has increased significantly over the past decade. For Hispanic children 12 and younger, the rate increased 92.3% from 2010 to 2019 (KFF, 2024).

The COVID pandemic hit young Hispanics especially hard. Immigrant children are often expected to take more responsibility when their parents don't speak English—even if they themselves are not fluent. Many reside in poorer households with some or all family members without legal residency. And cultural barriers and language may prevent many from seeking care in a mental health system that already has spotty access to services (KFF, 2024).



Source: https://www.nimh.nih.gov/health/statistics/suicide. May, 2023.

Youth and young adults ages 10–24 years account for 15% of all suicides. Although the suicide rate is lower than for other age groups, suicide is the second leading cause of death for this age group. Additionally, suicide rates for youth and young adults increased more than 50% between 2000-2021 (CDC, 2023, May 9).

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 types of behavior (Grandclerc et al., 2016).

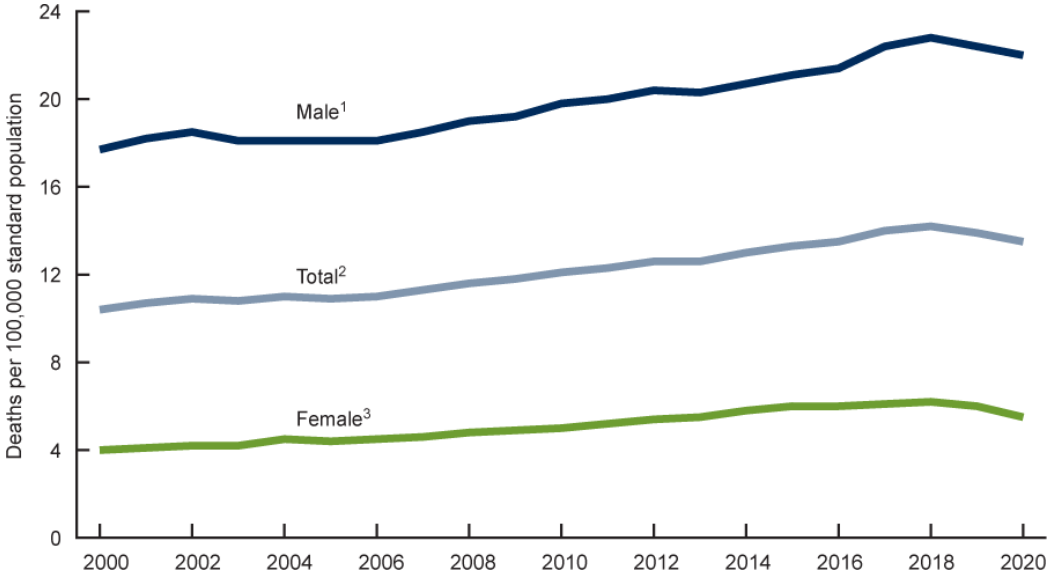
***Self-injury** is deliberate harm inflicted on a person's own body.

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).

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 follow-up (Tsai et al., 2015). Although more men die from suicide, more women **attempt** suicide.

***Social integration**: 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 Sex in the United States (2000–2020)



Source: Garnett et al. (2022).

2. Warning Signs and Risk Factors

The vast majority of people who attempt suicide show some sort of warning sign or risk factor. Knowing and recognizing warning signs and risk factors allows healthcare providers, family, and friends to intervene before suicidal thinking turns into action.

2.1 Overview of Warning Signs

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.

In general, suicide warning signs are often accompanied by increased anxiety, agitation, sleeplessness, and mood swings. A previous suicide attempt and a history of substance abuse are red flags for another attempt. Feelings of hopelessness, feeling there is no reason to live, and withdrawing from family and friends are often present. Other general warning signs might include:

- increasing alcohol or drug abuse
- expressing feelings of rage, anger, or aggression
- engaging in risky activities
- feeling trapped

2.2 Overview of Risk Factors

Risk factors are characteristics, attributes, or exposures within an individual that increase the likelihood of developing a disease or injury. Risk factors can accumulate to increase an individual's vulnerability to suicidal behavior.

Especially for young people, increased risk has been associated with a family history of suicide, exposure to previous suicidal behavior by others, a history of depression, or mental health problems. Additional risk factors associated with completed suicide include:

- incarceration
- easy access to lethal means
- alcohol and drug use
- loss of residential mobility

Among these various risk factors, three stand out:

1. mental illness
2. substance abuse
3. medical issues

Individuals at a greater risk for **completed** suicide have been found to be older men, those with a family history of suicide, and people who have previously attempted suicide. Other risk factors include:

- impulsiveness
- multiple physical ailments
- psychiatric illness
- history of violence (Hassamal et al., 2015)

Patients 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 including a family history of suicide, prior suicide attempts, and social or relationship problems. Other risk factors include:

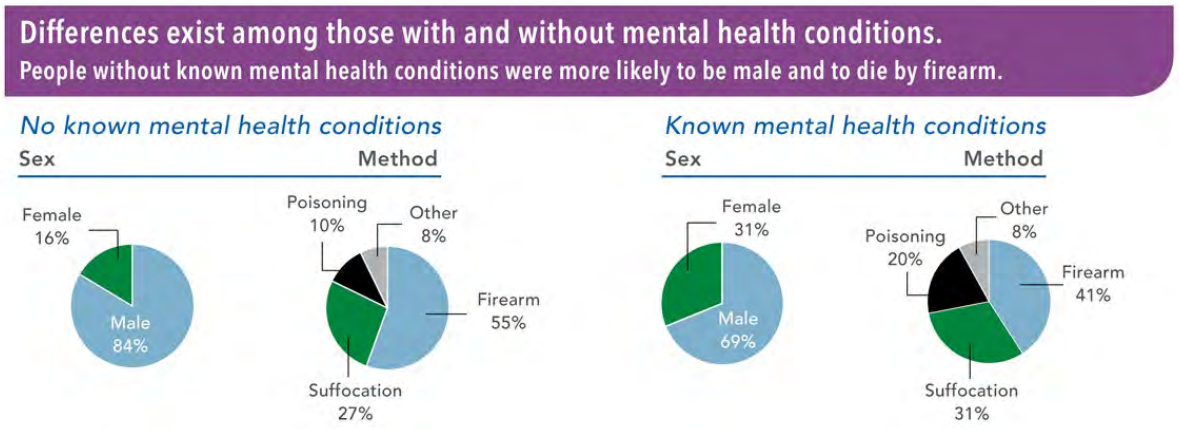
- deliberate self-harm
- suicidal ideation
- depression, hopelessness
- agitation (Fosse et al., 2017)

2.3 More Information About Suicide Risk Factors

2.3.1 Having Mental Health Issues or a Mental Illness

Suicide is overrepresented in people with mental illness although most people with mental health conditions do not commit suicide. Impulsivity (particularly angry impulsivity) and disinhibition are strongly related to suicidal ideation and behaviors. Impulsivity is associated with bipolar disorder, substance abuse, and certain personality disorders as well as a history of early child abuse.

The odds for suicide in severe depression, schizophrenia, and bipolar disorder are approximately 3–10 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).



Source: CDC, 2018, June 7. Public domain.

2.3.2 Being a Survivor of Human Trafficking

Survivors of human trafficking and sexual violence are at increased risk of developing substance use disorders to cope with the traumatic experience and symptoms of post-traumatic stress disorder. For these individuals, treating the substance use disorder without addressing the PTSD is ineffective. PTSD symptoms frequently reappear when people stop using drugs or alcohol, leading to relapse. Survivors of human trafficking are at higher risk of suicidal ideation, suicide attempts, and suicide (Akee et al., 2024).

2.3.3 Having a Substance Abuse Disorder

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. Screening for suicidal thoughts and behaviors is important 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).

Abstinence should be a primary goal of any patient with a substance use disorder and suicidal thoughts or behaviors. For most patients, abstinence reduces risk, although some individuals remain at risk even after achieving this goal (CSAT, 2015).

Substance Use Disorder (SUD)

The presence of a substance use disorder in the past year is assessed based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5).

Drugs include marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, methamphetamine, and any use of prescription stimulants, tranquilizers or sedatives, and pain relievers. The DSM-5 SUD criteria in 2021 for prescription drugs applied to people who used but did not misuse prescription drugs in the past year, in addition to people who misused them.

Source: SAMSHA, 2023 January 4

2.3.4 Experiencing Medical Issues and Physical Illness

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 about potential loss of employment, cost of medical care, and 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 (Horowitz et al, 2018).

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.

In patients without known mental health disorders, thoughts of suicide are important to assess. 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, 2018).

2.3.5 Being an Immigrant, Asylum Seeker, Refugee, or ICE Detainee

For immigrants, asylum seekers, and refugees, suicidal ideation and behaviors arise from a complex interaction between vulnerabilities and risk factors. Temporary visa status, exposure to trauma, exposure to detention settings, and social isolation can contribute to increased risk. The term “lethal hopelessness” has been used to describe the increased suicide risk in asylum seekers due to the combination of limited access to mainstream services, financial support, culturally safe healthcare, and working rights (Ingram et al., 2022).

Immigrants migrating to an unfamiliar country lose links with their country of origin and often experience language barriers, a loss of status and social network, and a sense of inadequacy. Unemployment, financial problems, a sense of not belonging, and feelings of exclusion can negatively affect a person’s desire and ability to enter relationships with others. This can lead to depression, anxiety, post-traumatic stress disorder, and abuse of alcohol or drugs. Feelings of isolation, loneliness, and hopelessness can increase the risk of suicidal behaviors (Ratkowska & De Leo, 2013).

Roughly one in seven residents of Washington State is an immigrant, accounting for nearly 14% of the state’s population (AIC, 2020). From 2010 to 2016, Washington State admitted more than 16,000 refugees from 46 countries; 72% came from just five countries: Iraq, Myanmar, Somalia, Bhutan, and Ukraine (McDermott, 2016). In 2018, the top countries of origin for immigrants to the state were Mexico (23%), India (8%), China (7%), the Philippines (6%), and Vietnam (6%) (AIC, 2020).

Immigrant population has increased by 29% in Washington state during 2010 to 2021, with a larger increase in the immigrant group of naturalized citizens (37%). In 2021, the total immigrant population was 1,149,000 (Yen, 2023).

The migration of a family member poses a risk not only for immigrants but also for their families who remain in the country of origin. For example, the next of kin of Mexican immigrants in the U.S. were at greater risk of suicidal ideation and suicide attempts than Mexicans without a family history of emigration. Emigration of a close family member can weaken family ties, cause feelings of loneliness and insecurity, and increase the risk of suicide among family members who remain at home (Ratkowska & De Leo, 2013).

A study of Chinese immigrants in the U.S. found that older adults experiencing linguistic and cultural barriers rely heavily on their adult children to have access to healthcare and social services. Their social networks predominantly consist of family members, and they are isolated from the community. Their perceived burdensomeness to children and their social isolation can lead to suicidal ideation (Li et al., 2022).

Refugees are perhaps the most vulnerable group of immigrants: they are often fleeing war, torture, and persecution, and suffer with PTSD, depression, and anxiety. Lack of adequate preparation, the way in which they are received in the destination country, poor living conditions, and lack of social support and isolation add to these vulnerabilities. Refugees may also feel guilt for leaving loved ones at home or for their death. The sense of guilt, together with isolation and pathologic symptoms due to trauma, can be a strong risk factor for suicide (Ratkowska & De Leo, 2013).

For migrants in U.S. Immigration and Customs Enforcement (ICE) detention, mental healthcare has historically been substandard. ICE detainees suffer from higher rates of anxiety, depression, and post-traumatic stress disorder and are especially susceptible to stressors (Erfani et al., 2021).

Time spent in immigration detention is a particular post-migration stressor. Widespread failures to provide mental healthcare to detainees and critical medical staff shortages put ICE detainees at an increased risk for suicide. Between 2018 and 2020, the proportion of deaths in ICE detention attributed to suicide approximately doubled since cause of deaths were last described in 2015 (Erfani et al., 2021).

2.3.6 Being a Veteran

During the wars in Iraq and Afghanistan, military suicide rates increased and surpassed the rates for society at large. The Marines had had the highest proportional number of suicides compared to the other services followed by the Army. However, the rates in all the services have been increasing in recent years (DVA, 2022, September).

Why U.S. military personnel and veterans are at increased risk for suicide compared to civilians is the focus of ongoing research. They experience both military- and non-military-related trauma, such as combat-related experiences, military sexual assault, difficulty reintegrating into civilian life, and access to guns. Some have a history of childhood abuse and intimate partner violence. Military personnel and veterans also experience high rates of posttraumatic stress disorder, a known risk factor for both suicidal ideation and behaviors (Holliday et al., 2020).

Elevated suicide risk can endure well beyond military service, with veterans carrying a much greater risk for suicide than their civilian counterparts. Veterans have identified suicide as the most formidable challenge they face. Sadly, approximately 17 veterans die by suicide every day (DVA, 2021, September).

PTSD

Posttraumatic Stress Disorder (PTSD) can occur after someone goes through a traumatic event like combat, assault, or disaster. A person experiencing PTSD can feel unsafe, have upsetting memories, feel on edge, or have trouble sleeping.

Research looking specifically at combat-related PTSD in Vietnam era veterans suggests that the most significant predictor of both suicide attempts and preoccupation with suicide is combat-related guilt. Many veterans experience highly intrusive thoughts and extreme guilt about acts committed during times of war. These thoughts can often overpower the emotional coping capacities of veterans (Hudenko, Homaifar, and Wortzel, 2022).

PTSD has been found to be a risk factor for suicidal ideation for veterans of the wars in Afghanistan and Iraq. Even mild PTSD carries risk. Among these veterans, those with subthreshold PTSD* were 3 times more likely to report hopelessness or suicidal ideation than those without PTSD (Hudenko, Homaifar, and Wortzel, 2022).

***Subthreshold PTSD**: a collection of symptoms that aren't complete enough or severe enough to earn a PTSD diagnosis.

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

Depression

Major depressive disorder, which is highly comorbid with PTSD, independently increases risk for suicidal ideation and attempts. Among veterans who died from suicide in 2020, the prevalence of depression diagnoses was more than 35% (DVA, 2021, September).

The risk of suicide is greater in veterans who have been diagnosed with PTSD and/or major depressive disorder. Nearly a third of veterans with PTSD and/or major depressive disorder reported current suicidal ideation and 28% reported a lifetime suicide attempt. Greater purpose in life, curiosity, and optimism were inversely associated with suicidal ideation (Fogle et al., 2020).

2.4 Communication Preferences for Veterans and Service Members

Despite the investment of public resources to address suicide among veterans and service members, little is known about how they communicate suicidal ideations or what interventions they are willing to receive. A survey of communication and intervention preferences for veterans and service members found that nearly 90% of respondents indicated that they were willing to speak to someone when having thoughts of suicide. Most indicated that family members and military friends would be their primary outreach (Beatty et al., 2023).

Many participants were open to receiving resources, suicide-specific mental health treatment, and some sort of lethal means safety intervention. The age, marital status, and the status of participants significantly impacted what interventions they were willing to allow (Beatty et al., 2023).

Veterans and service members indicated they were far less likely to talk about their thoughts of suicide with non-military friends than military friends. Respondents were also considerably less likely to talk about their thoughts of suicide with the Veterans Crisis Line or National Suicide Prevention Line, chaplains, veteran service organizations, other healthcare providers, or their boss. About 10% stated that they would not trust talking with anyone about their thoughts of suicide (Beatty et al., 2023).

3. Screening for Suicide Risk

> Screening is one part of the story. When people screen positive for suicide risk, it's important to follow that with a full assessment and evidence-based approaches for intervention and follow-up care.
>
> Stephen O'Connor, Ph.D.
> Chief of the NIMH Suicide Prevention Research Program

Mental health has traditionally been within the purview of psychiatrists and specifically trained mental health practitioners. But over the last 2-3 decades, family practice physicians, nurse practitioners, allied health professionals, dentists, pharmacists, and other healthcare providers have become increasingly responsible for identifying and managing chronic mental health problems—including suicidal ideation and behaviors.

Now, a wide range of healthcare providers find themselves at the front lines of identifying serious mental health issues that require screening, assessment, and referral. Because of these changes, all healthcare providers need to be knowledgeable about suicide risk factors and warning signs, and suicide screening and assessment tools. Following a screen, they must know when, where, and how to refer a client who is at risk for self-harm. Screening can be the start of successful suicide prevention efforts.

Existing research shows that many individuals who die by suicide consult health services prior to their death: 9% on the day of death, 34% during the week prior, and 61% in the month before their death. Emergency department visits are particularly prevalent among suicide decedents (Scudder et al., 2022). These statistics highlight the importance of screening, assessment, and referrals, not just in emergency departments but in all healthcare setting.

Did You Know. . .

> Fifty-eight percent of military service members who died by suicide in 2016 had contact with the healthcare delivery system in the 90 days prior to their death; roughly a third of those encounters were with outpatient or inpatient behavioral health (VA/DOD, 2019).

In 2022, the *U.S. Preventive Services Task Force* (USPSTF) stated with moderate certainty that screening for *major depressive disorder in adults* (including pregnant and postpartum persons and older adults), has a moderate net benefit. They reiterated their 2014 recommendations however, that the evidence is insufficient on the benefit and harms of screening for suicide risk in adults. In the absence of compelling evidence, the USPSTF nevertheless encourages healthcare professionals to use their judgment—based on individual patient circumstances—when determining whether to screen for suicide risk in adults not showing signs or symptoms (USPSTF, 2022).

Despite the USPSTF recommendations, many professional organizations are moving forward with practice guidelines that encourage or require screening for suicidal ideation and behaviors. In 2022, the *American Association of Pediatrics* published screening recommendations for youth and young adults that state (AAP, 2024):

- Youth ages 12+: Universal screening.
- Youth ages 8-11: Screen when clinically indicated.
- Youth under age 8: Screening not indicated. Assess for suicidal thoughts/behaviors if warning signs are present.

Zero Suicide is another organization that is advocating for universal suicide risk screening in all healthcare organizations. Growing support for the model has led to the implementation of projects across diverse healthcare systems, states, and tribal nations. The goal is to prevent all patient suicides and to provide a framework for suicide prevention within healthcare settings (Layman et al., 2021).

In a *Zero Suicide* approach (Zero Suicide, 2022):

- All individuals are screened for suicide risk at their first contact with the organization and at every subsequent contact.
- All staff members use the same tool and procedures to ensure that individuals at risk of suicide are identified.
- Clinicians conduct a thorough suicide risk assessment when an individual screens positive for suicide risk.
- All staff members use a standardized tool and procedure to gather information to fully assess an individual's suicide risk and create a plan to address that risk.

Within military organizations, universal screening for suicide risk is reportedly controversial and has received mixed support. Nevertheless, the Veteran's Administration has identified screening as a key part of their *Community-Based Intervention for Suicide Prevention* program. The program has 3 components (USDVA, 2021, September):

1. Identifying service members, veterans, and their families and screening for suicide risk.
2. Promoting connectedness and improving care transitions.
3. Increasing lethal means safety and safety planning.

3.1 How and When to Screen

> It's not realistic to expect healthcare providers to be able to figure out who they should screen and who they shouldn't. When screening is universal, it becomes standardized, and it sets the expectation that every patient will be screened.
>
> Stephen O'Connor, Ph.D.
>
> Chief of the NIMH Suicide Prevention Research Program

Suicide prevention starts with a screen, which allows a screener to identify and intervene before a person acts on their desire to die. Screening provides an opportunity for a person at risk to share their feelings of despair and allows the person doing the screening to discuss alternatives to suicide.

By definition, screening is an informal process. It compares the before to the now by asking questions, determining risk factors, and if needed, referring the person to someone who can screen and assess at a higher level, usually a mental health professional.

Screening can be completed by anyone in the community, including peer support and employee support personnel, gatekeepers, crisis line volunteers, family and friends, teachers, clergy, law enforcement personnel, firefighters, and non-mental health medical providers and workers. Although screening can be done by anyone, it is vital that anyone doing a suicide screen be aware of the absolute need to refer a high-risk person to a higher level of care.

A suicide screen uses a standardized instrument or protocol to identify individuals who may be at risk for suicide. Suicide screening can be done independently or as part of a more comprehensive health or behavioral health screening. Screening may be done orally (with the screener asking questions), with pencil and paper, or using a computer (SPRC, 2014).

On the surface, asking every patient who receives care in a medical setting to complete a suicide risk screening may seem unnecessary or excessive. But research shows that this approach, known as *universal screening*, identifies many people at risk who might otherwise be missed (NIMH, 2023).

Healthcare providers and workers should become familiar with a simple screening tool and, importantly, practice the screening questions until they are comfortable leading a client through a screen. If a 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. The overreaching goal is not to diagnose, but to be ready to talk, keep the person safe, and have referral information readily available.

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. A brief screening tool may be able to identify individuals at risk for suicide more reliably than leaving the identification up to a provider's personal judgment or by asking about suicidal thoughts using vague or softened language.

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

For screening to be effective, healthcare providers must:

- Be knowledgeable about suicide warning signs.
- Learn about risk and protective factors.
- Practice questions ahead of time.
- Understand how your own attitudes and beliefs impact your clients.

3.1.1 Structuring the Interview

> Asking someone about suicide will feel like vinegar on your tongue at first but with practice, it gets easier. Learn to acknowledge the person, not the condition. Questions such as, “Have you had a problem like this in the past?” or, “What have you done in the past that has worked for you?” build a rapport with the person you are interviewing.
>
> Dr. Naomi Paget
>
> Fellow, American Academy of Experts in Traumatic Stress

Screening for suicide risk requires a thoughtful, caring, and non-judgmental approach. Because asking about suicide is not easy, it is essential to practice interview skills at home or with a co-worker—and on a regular basis. Develop and practice questions until you are comfortable leading a patient through a screen. Asking a difficult question does not plant the idea of suicide.

Most healthcare providers are trained in how to assess or evaluate a patient—life history, previous suicide attempts, and a person’s current mental state. But assessment is different than screening, especially for non-mental health providers. Unfortunately, little attention has been paid to *how* to interview or screen patients who are thinking about, considering, or planning suicide. This is important because the way questions are asked—the words and phrasing used by a clinician—can influence a person’s response (McCabe et al., 2017).

3.1.2 Asking About Safety, Lethality, and Intent

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

Safety, lethality, and intent are important aspects of an initial screen. Asking about safety starts with a general, open-ended question. Keep in mind that a person who is depressed may have trouble organizing their thoughts and their responses may be delayed. Be patient and give time for an answer. Develop a series of questions that help you determine the level of care needed for patient safety to be preserved.

If the person refuses to answer or if there is a long pause, ask a direct question such as, “Has something happened recently that has affected your well-being?” The person might respond by saying, for example, “My mother just died—she was my whole life.” You can then ask, “Now that your mother has died, what else in your life will bring you joy?” This might be followed by a question of concern such as: “I wonder—has the thought of hurting yourself entered your mind?”

Although yes/no questions are common in healthcare interactions, they can communicate an expectation in favor of either a yes or no response. For example, “Are you feeling low?” invites agreement to “feeling low.” Conversely, “Not feeling low?” invites agreement to “not feeling low.” Specific positive or negative words can reinforce bias. Words such as “any,” “ever,” or “at all” reinforce negative bias (eg, “Any negative thoughts?”) while words such as “some” reinforce positive bias (eg, “Do you have some pain here?”) (McCabe et al., 2017).

If a patient indicates an immediate (imminent) intention to harm themself, your next act is to refer the patient to someone who is **licensed** to decide about an involuntary hold. In larger organizations, psychiatric services are often directly available. Depending on the level of risk, patients can be held against their wishes. If a person agrees to hospitalization, they must be placed in the least restrictive environment. Determining whether a patient is safe (and whether they can be held against their will) is left to providers who are legally licensed to make that determination.

The next step is to ask about **lethality**. Nonsuicidal self-injury often involves people with borderline personality disorders and self-harm can be an antidote to psychological numbing. Lethality focuses on the method used, the circumstances surrounding the attempt, and the chance of rescue. Lethality is related to the severity of physical consequences as well as the amount of medical intervention needed following an attempt (Kar et al., 2014).

Five Levels of Lethality

The lethality of suicidal behavior can be considered to have five levels: subliminal, low, moderate, high, and extremely high (Kar et al., 2014).

1. **Subliminal**. Death is impossible to highly improbable.
2. **Low**. Death is improbable and is not the usual outcome but may be possible as a secondary complication of factors other than the suicidal behavior.
3. **Moderate**. Probability of death is in the middle order.
4. **High**. Chance of death is high and is the usual or likely outcome of the suicidal act.
5. **Extremely high**. Chance of survival is minimal, and death is considered almost certain.

When asking about lethality, try to determine how well thought out the plan is and whether the person has access to the means to complete the plan. Note any additional circumstances and try to evaluate the “risk tipping point.” Determine if it is necessary to take an action that deprives a patient of his or her rights vs. not taking an action that might result in suicide.

There is often a mismatch between the lethality of the method chosen and the intent of the suicidal act. People who genuinely want to die (and expect to die) may survive because the chosen method was not foolproof or because they were interrupted or rescued. However potentially lethal the chosen method is, a prior suicide attempt is a highly potent risk factor for eventually dying by suicide. 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, 2017).

Determining a person's *intent to die* during a screen is an important indicator of current and future risk. **Intention** reflects how hard a person is willing to try or the likelihood a person will perform—or try to perform—a particular behavior (Williams, 2015). Patients who have a clear intention of taking their life require higher levels of protection than those with less inclination toward dying.

A person's intent may be inferred from how they describe a "wish to live" or a "wish to die." These terms have proven useful in assessing suicide ideation and behavior and are included in *Beck's Scale of Suicidal Ideation* and the *Suicide Status* form. Overall, there is strong evidence that *suicidal affect* can be a valid indicator of current and future risk (Harris et al., 2015).

Beck Suicide Intention Scale

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

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

Source: Grimholt et al., 2017

Case: Valeria Cuts Her Wrists (Again)

Background

Serena 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 Valeria walked in from the waiting room, Serena noticed she was hunched over a little, her head was down, she walked slowly, and she had bandages on both wrists.

Before beginning the physical examination, Serena asked if Valeria ever thought about harming herself. Valeria's direct and frank response startled Serena. 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".

Serena 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 Serena why she was asking her about suicide when she was at the clinic for back pain.

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

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

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.

- 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 Serena do?

Serena'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. Serena's supervisor tells her to either use the *PHQ9* for a more in-depth assessment or refer her client to the local emergency department for assessment by a mental health professional. Because Serena is not a mental health professional and has not been trained on the *PHQ9*, she decides to refer Valeria to the local emergency department.

Valeria tells Serena that she has no family living nearby. Serena feels Valeria is a danger to herself, so 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. Serena followed up with a call the ER and learns that Valeria arrived safely at the hospital.

Bottom Line

Because previous suicide attempts are known to be a strong predictor of future attempts and deaths by suicide, continuity of care is critical. For Valeria, who has survived a suicide attempt, effective clinical care should focus on alternatives to suicide, community and family support, therapy, and lethal means restriction.

3.1.3 Talking About Lethal Means

Talking about **lethal means** is critically important because certain lethal means such as firearms, hanging/suffocation, or jumping from heights provide little opportunity for rescue and have high fatality rates. Lethal means safety, including firearm restrictions, reducing access to poisons and medications associated with overdose, and barriers to jumping from lethal heights, have been shown to reduce population-level suicide rates (VA, DOD, 2019).

If you have identified that your patient is at risk for self-harm during a screen, ask them to identify any lethal means they might be able to access once they leave your office. You are more likely to elicit accurate information by asking permission and showing concern in a non-judgmental manner. Try to establish rapport and trust—if you think the person is at risk, there is no reason to cover your concern or to lie.

You can say, “I want to let you know that I appreciate and am honored that you’ve shared your thoughts with me. I’m just concerned that you may go again to a place of despair when you leave and I’m thinking of your safety.” Involving family, friends, and caregivers can be helpful. You can ask, “While you’re in this dangerous period, may I call your partner or family member and ask them to remove any guns or poisons from the house?”

Despite the importance of discussing lethal means, a study of 800 emergency department charts of patients who screened positive for suicidal ideation and suicide risk revealed that only 18% had any documentation of an assessment of lethal means. For the small group who were asked about lethal means, only 8% had documentation that a safety/action plan to reduce access to lethal means was discussed. The most common discussion involved addressing home storage of dangerous items or moving objects out of the home (Harmer et al., 2022).

Findings from the ED study show the need to document lethal means assessments for all individuals who have a positive screen for suicidal ideation, including a discussion about removal of lethal means. This may require adding prompts for these assessments to the electronic documentation system (Harmer et al., 2022).

A program developed at a large children’s hospital called the *Emergency Department Counseling on Access to Lethal Means* (ED CALM) trained psychiatric emergency clinicians 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 posttest, 76% reported that all medications in the home were locked up as compared to fewer than 10% at the time of the initial ED visit. Among parents who indicated the presence of guns in the home at pretest (67%), all (100%) reported guns were currently locked up at posttest (Stone et al., 2022).

Case: Kathleen

In the two-and-a-half years since my son's death I have learned that his story is, sadly, not uncommon. I have become oddly close with other mystified parents of seemingly successful, engaged, social young men and women who took their lives. They are my partners in grief, and in understanding why suicide is the number two killer of youth in Washington State, just behind accidents.

My son retrieved a gun that was unlocked because it had not been fired in many years and we didn't think there was any ammunition in the house. Although we have learned that he was showing some warning signs, I will never know what he was thinking, because that gun left him with no chance of survival.

My son was a trained marksman who had attended gun camp every summer. He had also taken the hunter safety class, and was, as his hunting mentor said, "safer with a gun than any adult I know." I have great respect for the people who trained my son, but not once did any of the safety materials include warnings for parents of youth that 79% of firearm deaths in Washington State are suicides. I had not dreamed that my son was suicidal, much less that he would consider using a gun to take his life. I sincerely hope that other parents safely store firearms and ammunition out of the reach of children.

Kathleen Gilligan, whose son Palmerston Burk died from suicide by firearm in King County in 2012. Source: WSDOH, 2016.

3.1.4 When Harm Is Imminent

The potential for imminent (immediate) self-harm exists when someone feels they are a burden, when there is no longer a sense of belonging, and when there is a history of self-injury. The risk of imminent harm is elevated during the days and weeks following hospitalization, especially for people diagnosed with major depression, bipolar disorder, and schizophrenia. If a screen indicates that a patient is at immediate risk of self-harm, be ready to talk, keep the person safe, and have referral information readily available. The goal is to keep the patient safe until help arrives.

3.2 Screening Tools

Did You Know. . .

> Beginning July 1, 2019, healthcare professionals are required by the Joint Commission to use a validated tool to assess suicidal risk for all patients whose primary reason for seeking healthcare is the treatment or evaluation of a behavioral health condition.
>
> Harmer et al., 2022

Although there is some disagreement about the effectiveness of screening for suicide, improved identification of suicide risk is recommended by the Surgeon General's office, advocacy organizations, and accreditation bodies and use of standard depression questionnaires for screening and assessing treatment outcomes is now widespread (Simon et al., 2023). A positive screen should always be followed by an in-depth assessment or an immediate referral to someone with the training and skills to conduct an in-depth assessment.

Screeners should be aware that screening can yield unacceptably high false-positive prediction rates. Many people determined to be "at risk" never experience clinically significant suicidal thoughts or behaviors and a substantial portion of individuals who die by suicide were not identified by the screening tools (VA/DOD, 2019).

What follows is a sampling of some of the most commonly used screens for suicidal ideation and suicide risk.

3.2.1 Patient Health Questionnaire 2

The *Patient Health Questionnaire 2 (PHQ2)* is a widely used, validated screening tool. It is used by many large hospital organizations, including Washington's Kaiser Hospital system. It 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 they have been bothered by either of the following problems:

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

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

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

3.2.2 Patient Health Questionnaire 9

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. 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 more likely to attempt suicide than those who did not report those thoughts.

Several studies support the use of the *Patient Health Questionnaire-9* (PHQ9). Item 9 is a universal screening instrument to identify suicide risk:

> **Item 9**: "Over the past two weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?"
>
> **Possible Responses**: "Not at all," "Several days," "More than half the days," or "Nearly every day." (VA/DOD, 2019).

Research at Veteran's Administration hospitals that included all VHA patients who received the PHQ-9 across care settings found that higher levels of suicidal ideation, as identified by responses on item 9, were associated with increased risk of death by suicide. The number of risk days ranged from 1 to 730 (VA/DOD, 2019).

An increased risk for suicide was found in patients reporting they have been bothered by thoughts of self-harm in the last "several days", "more than half the days", and "nearly every day". Nonetheless, 71.6% of deaths by suicide during the study periods were among those who endorsed "not at all," highlighting that use of the item 9 alone is likely to result in a number of at-risk patients being missed (VA/DOD, 2019).

Other researchers have examined the relationship between PHQ-9 item 9 scores and death by suicide among civilian outpatients receiving care for depression in mental health and primary care clinics. They found that responses were predictive of both suicide attempts and deaths within the year post-administration. However, as with the Veteran's Administration study, there were a notable number of suicides among those who denied thoughts of death or self-harm ideation (VA/DOD, 2019).

3.2.3 Columbia Suicide Screen (C-SSRS)

The Columbia-Suicide Severity Rating Scale (C-SSRS) is an evidence-supported screening tool was developed by Columbia University, the University of Pennsylvania, and the University of Pittsburgh. The C-SSRS Triage version features questions that help determine whether an individual is at risk for suicide. There are brief versions of the C-SSRS often used as a screening tool (first two questions) that, based on patient response, can lead to additional questions to triage patients. The protocol and the training on how to use it are available free of charge.

The C-SSRS, supports suicide risk screening through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, determine the severity and immediacy of that risk, and gauge the level of support that the person needs. Users of the tool ask people (The Columbia Lighthouse Project, 2016):

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

3.2.4 EDSAFE Patient Safety Screener

In 2017, the results of the largest ED-based suicide intervention trial ever conducted in the United States was published in *JAMA Psychiatry*. The study examined how screening in emergency departments, followed by safety planning guidance and periodic phone check-ins led to a 30% decrease in suicide attempts over the 52 weeks of follow-up, compared to standard emergency department care. The five-year *Emergency Department Safety Assessment and Follow-up Evaluation* (ED-SAFE) study involved nearly 1,400 suicidal patients in eight hospital emergency rooms across seven states (NIMH, 2017).

The ED-SAFE study allowed researchers to assess the impacts of universal suicide risk screening and follow-up interventions in eight emergency departments over 5 years (NIMH, 2023). In the first phase, adult patients seeking care at a participating emergency department received treatment as usual. The second phase introduced universal suicide risk screening—all emergency department patients completed a brief screening tool called the Patient Safety Screener (NIMH, 2023).

The third phrase added a three-part intervention. Patients who screened positive on the *Patient Safety Screener* completed a secondary suicide risk screening, developed a personalized safety plan, and received a series of supportive phone calls in the following months (NIMH, 2023).

As a result of universal screening, the screening rate rose from about 3% to 84%, and the detection rate of patients at risk for suicide rose from about 3% to almost 6%. Importantly, findings from the third phase showed that it was screening combined with the multi-part intervention that actually reduced patients' suicide risk. Patients who received the intervention had 30% fewer suicide attempts than those who received only screening or treatment as usual (NIMH, 2023).

The *Emergency Medicine Network's EDSAFE Patient Safety Screener* is a brief screening tool, primarily used as part of an initial inpatient nursing assessment in emergency department. 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?

3.2.5 Ask Suicide-Screening Questions (ASQ)

[Unless otherwise noted, the following information is from the National Institutes of Mental Health, 2024]

The *Ask Suicide-Screening Questions (ASQ)* tool is a brief, validated tool for use among both youth and adults. The Joint Commission has approved the use of the *ASQ* for all ages. As there are no tools validated for use in kids under the age of 8 years, if suicide risk is suspected in younger children a full mental health evaluation is recommended instead of screening.

The ASQ is free of charge and available in multiple languages. It contains four screening questions that take 20 seconds to administer. In a *National Institute of Mental Health* study, a "yes" response to one or more of the four questions identified 97% of youth (aged 10 to 21 years) at risk for suicide.

For screening youth, it is recommended that screening be conducted without the parent/guardian present. If the parent/guardian refuses to leave or the child insists that they stay, conduct the screening with the parent/guardian present. For all patients, any other visitors in the room should be asked to leave the room during screening.

Patients who screen positive for suicide risk on the ASQ should receive a brief suicide safety assessment (BSSA) conducted by a trained clinician such as a social worker, nurse practitioner, physician assistant, physician, or other mental health clinician to determine if a more comprehensive mental health evaluation is needed. The BSSA should guide what happens next in each setting.

The ASQ toolkit is organized by the medical setting in which it will be used: emergency department, inpatient medical/surgical unit, outpatient primary care, and specialty clinics.

Ask Suicide Risk Screening Tool (ASQ)

Ask the patient:

1. In the past few weeks, have you wished you were dead? ___Yes ____No

2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ___Yes ___No

3. In the past week, have you been having thoughts about killing yourself?

___Yes ___No

4. Have you ever tried to kill yourself? ___Yes ___No

If yes, how? _____

When? _____

If the patient answers Yes to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? ___Yes ___No

If yes, please describe:

Next steps:

- If patient answers “No” to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If patient answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:
    - “Yes” to question #5 = acute positive screen (imminent risk identified)
        - Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.
        - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s care.
    - “No” to question #5 = non-acute positive screen (potential risk identified)

- Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. If a patient (or parent/guardian) refuses the brief assessment, this should be treated as an "against medical advice" (AMA) discharge.
- Alert physician or clinician responsible for patient's care.

Provide resources to all patients.

- 24/7 National Suicide Prevention Lifeline, 988
- 24/7 Crisis Text Line: Text "HOME" to 741741

To access the *ASQ* screening toolkit click here.

3.3 Gatekeeper Training

[Unless otherwise noted, the following information is from CDC, 2022]

Gatekeeper training programs are peer-support programs that have had success educating the public about suicidal ideation and suicide. Gatekeepers come from all sectors of the community and are trained to identify people who may be at risk for suicide or suicidal behavior and to respond by facilitating referrals to treatment and other support services. Gatekeepers include peers, teachers, coaches, clergy, emergency responders, primary and urgent care providers, and others.

There are many gatekeeper trainings available with varying degrees of evidence. *Applied Suicide Intervention Skills Training* (ASIST) is a widely implemented training program that helps hotline counselors, emergency workers, and other gatekeepers screen and identify individuals with suicidal thoughts or behaviors. The training helps people within the community reach out and assist by safely connecting those in need to available resources.

Gatekeeper training has been a primary component of the *Garrett Lee Smith (GLS) Suicide Prevention Program*, which has been implemented in 50 states and 50 tribes. A multi-site evaluation assessed the impact of community gatekeeper training as a part of GLS implementation on suicide attempts and deaths among young people ages 10–24. Counties that implemented GLS trainings had significantly lower youth suicide rates up to two years following the training when compared with similar counties that did not offer GLS trainings.

3.4 Screening Children and Adolescents

Suicidal thoughts and attempts have risen in recent years among adolescents and young adults, aged 10-24. In the U.S., suicide is now the second leading cause of death for this age group. In response to a publication from the *United States Preventative Services Task Force* (USPSTF), which stated that there is insufficient evidence to weigh the benefits and harms of screening asymptomatic children and adolescents, the *American Academy of Pediatrics* is urging clinicians to screen all adolescents for suicide risk despite the USPSTF's findings that more research is needed to weigh the benefits and harms.

Because of significant age-related racial disparities in childhood suicide, screening has been identified as a health equity issue. Recent research indicates that the suicide rate among those younger than 13 years of age is approximately 2 times higher for Black children compared with white children, a finding observed in both boys and girls (Bridge et al., 2018).

Based on the now substantial evidence base for screening and the recent increase in youth suicidality, there is mounting support for suicide screening as a part of routine healthcare for youth. Currently, there is no standard of care for screening youth for suicidality in emergency department settings, which tend to serve as the frontline of acute healthcare (Scudder et al., 2022).

Common screening tools in the youth population include the Ask Suicide-Screening Questions (ASQ), the Columbia-Suicide Severity Rating Scale (C-SSRS), (both discussed in the previous section), the Suicidal Ideation Questionnaire (SIQ), and the Risk of Suicide Questionnaire (RSQ) (Scudder et al., 2022). The Youth Outpatient Brief Suicide Safety Assessment (BSSA) will also be discussed.

3.4.1 Suicidal Ideation Questionnaire (SIQ)

The SIQ is a 30-item self-reported suicide-risk screening tool that was developed for high school students in grades 10-12. The 15-item SIQ-JR is used for students in grades 7-9. The tool is most often administered via a written self-reported questionnaire in pediatric EDs, typically for patients with both medical/surgical and psychiatric complaints. Some studies apply it as a gold standard against which to test other, shorter, screening tools (Scudder et al., 2022).

The SIQ assesses suicidal ideation on a 7-point scale with statements about frequency of suicidal thoughts or risk factors. For example, a patient would rank “I thought it would be better if I was not alive” on a scale from “I never had this thought” (0) to “almost every day” (7). These point scales are added up to give rise to a score between 0 and 180 for the SIQ, or 0–90 for the SIQ-JR (Scudder et al., 2022).

A score of 41 or greater on the SIQ, a score of 31 or greater on the SIQ-JR, or an endorsement of a recent suicide attempt constitute a positive screen and warrant further psychiatric evaluation. Nine critical items (six on the SIQ-JR) directly assess serious self-destructive behavior, with endorsement of three or more of these items (two on the SIQ-JR) constituting a positive screen for suicidal ideation, regardless of total score (Scudder et al., 2022).

3.4.2 Risk of Suicide Questionnaire (RSQ)

The RSQ is an older four-item screening tool administered by triage nurses in emergency departments to children between the ages of 8–21 years. The tool was originally developed from 14 potential screening questions from several sources, which were validated among several pediatric clinicians and mental health specialists, as well as a sample of pediatric psychiatric patients and nonpatients. The tool is most often administered via a verbal questionnaire in pediatric EDs, typically for patients with both medical/surgical and psychiatric complaints (Scudder et al., 2022).

The RSQ asks four questions. A positive screen is defined as answering “yes” to any question (Scudder et al., 2022):

1. Are you here because you tried to hurt yourself?
2. In the past week, have you been having thoughts about killing yourself?
3. Have you ever tried to hurt yourself in the past (other than this time)?
4. Has something very stressful happened to you in the past few weeks (a situation that was very hard to handle)?

3.4.3 Youth Outpatient Brief Suicide Safety Assessment (BSSA)

[Modified from the National Institute of Mental Health, 2024]

The *Youth Brief Suicide Safety Assessment Guide* (BSSA) is included in the *Ask Suicide Screening Questions* (ASQ) toolkit. It contains suggestions on what questions to ask, examples of how to respond to and ask questions, and what areas should be explored to develop a fuller understanding of an individual’s suicide risk. It also includes ways to safety plan and counsel about access to lethal means. The BSSA is intended to be used when an individual screens positive on the ASQ. When a pediatric patient screens positive for suicide risk:

1. Praise the patient for discussing their thoughts.

2. Assess the patient (review patient’s responses from the ASQ).

    a. Determine the frequency of suicidal thoughts.

    b. Assess if the patient has a suicide plan*.

    c. Ask about past self-injury and history of previous suicide attempts.

    d. Ask about related symptoms (depression, anxiety, hopelessness, lack of joy, isolation, substance or alcohol abuse, sleep patterns, appetite).

    e. Ask about social support and stressors.

*A detailed plan is concerning. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

3. Interview patient and parent/guardian together.

    a. If patient is ≥ 18, ask permission for parents to join.

    b. Ask the parent or guardian if they have noticed changes in their child’s sleep or appetite.

    c. Does your child use drugs or alcohol?

    d. Has anyone in your family/close friend network ever tried to kill themselves?

    e. How are potentially dangerous items stored in your home (guns, medications, ropes, etc.)?

    f. Does your child have a trusted adult they can talk to?

    g. Are you comfortable keeping your child safe at home?

    h. Is there anything you would like to tell me in private?

4. Make a safety plan with the patient (include the parent/guardian, if possible).

5. Determine disposition (for all positive screens, follow up with patient at next appointment).

6. Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline: 1-800-273-TALK (8255), En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741-741

You can access the complete *Youth Outpatient Brief Suicide Safety Assessment* here.

3.4.4 Signs of Suicide, a School-Based Prevention Program

Signs of Suicide (SOS) is a school-based suicide prevention program that uses screening and education to modify behavior in middle and high school students. It includes screening for elevated depression and substance use disorders. The program is designed to (CDC, 2022):

- increase understanding that major depression is an illness,
- improve awareness of the link between suicide and depression,
- improve attitudes toward intervening with peers showing signs of depression and suicidal ideation, and
- increase help-seeking behavior for students personally experiencing depression and suicidal thoughts.

3.5 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.
>
> National Action Alliance for Suicide Prevention

If a patient screens positive for suicide risk, a suicide risk assessment should be completed. A patient in acute suicidal crisis must:

- Be kept in a safe healthcare environment under one-to-one observation.
- Not be left alone.
- Be kept away from anchor points that can be used for hanging.
- Not have access to materials that can be used for self-injury.

Immediate care should be provided through the emergency department, inpatient psychiatric unit, respite center, or crisis management department.

Screeners should assess their work environment and identify any items that might be used in a suicide attempt or to harm others. Items used on a daily basis in a hospitals, offices, or clinics might seem innocuous but bell cords, bandages, sheets, restraint belts, plastic bags, scissors, letter openers, elastic tubing, and oxygen tubing can all be used in a suicide attempt.

Importance of Secondary Suicide Risk Screening

In a multicenter study of 1,376 emergency department patients with recent suicide attempts or ideation, an intervention consisting of secondary suicide risk screening by the ED physician, discharge resources, and post-ED telephone calls resulted in a 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 follow-up period (Miller et al, 2017).

If a screen indicates a person is at risk for suicide, denies or if they minimize risk or decline treatment, ask for permission to contact their friends, family, or outpatient treatment providers. If the event the client declines consent, HIPAA permits a clinician to make these contacts without the person's permission if the clinician believes the client poses a danger to self or others.

For a client considered to be at lower risk of suicide, a screener should make a direct referral to outpatient health services and follow-up to make sure the client actually keeps the appointment. Expecting the client to follow-up usually does not work.

If the screen indicates a person might be at risk for suicide, a *suicide assessment* should be completed. A comprehensive evaluation is usually done by an experienced clinician to confirm suspected suicide risk, estimate the immediate danger to the patient, and decide on a course of treatment (SPRC, 2014).

Although an assessment can involve structured questionnaires, they can also include open-ended conversations with a patient and/or friends and family to gain insight into the patient's thoughts and behavior, risk factors, access to lethal means, history of suicide attempts, protective factors, immediate family support, and medical and mental health history (SPRC, 2014).

Recently, seven new and revised elements of performance (EPs) were applied to all Joint Commission-accredited hospitals, behavioral healthcare, and critical access hospital organizations. One of the requirements states that Joint Commission-accredited organizations must screen for suicidal ideation. The new requirements are intended to improve the quality and safety of care for those who are being treated for behavioral health conditions and those who are identified as high risk for suicide (Joint Commission, 2019).

The new elements of performance are as follows (The Joint Commission, 2019):

1. **Reduce** the risk for suicide by identifying features in the physical environment that could be used to attempt suicide.
2. **Screen** all individuals served for suicidal ideation using a validated screening tool.
3. **Use** an evidence-based process to assess individuals who have screened positive for suicidal ideation. **Directly ask** about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk and factors, and protective factors.
4. **Document** individuals' overall level of risk and the plan to mitigate the risk for suicide.
5. **Follow** written policies and procedures addressing the care of individuals served identified as at risk for suicide.
6. **Follow** written policies and procedures for counseling and follow-up care at discharge.
7. **Monitor** implementation and effectiveness of policies and procedures for screening, assessment, and management of individuals at risk for suicide and improve compliance as needed.

Whether you are a healthcare provider, a mental health professional, or a community member, all of us can make a difference in suicide prevention. The *National Institute of Mental Health* has published "5 actions steps" anyone can take if you think someone might be at risk for self-harm (NIMH, 2024).

1. **Ask**: "Are you thinking about killing yourself?" It's not an easy question, but studies show that asking at-risk individuals if they are suicidal does not increase suicides or suicidal thoughts.

2. **Keep Them Safe**: Reducing a suicidal person's access to highly lethal items or places is an important part of suicide prevention. While this is not always easy, asking if the at-risk person has a plan and removing or disabling the lethal means can make a difference.

3. **Be There**: Listen carefully and learn what the individual is thinking and feeling. Research suggests acknowledging and talking about suicide may reduce rather than increase suicidal thoughts.

4. **Help Them Connect**: Save the 988 Suicide & Crisis Lifeline number (call or text 988) in your phone so they're there if you need them. You can also help make a connection with a trusted individual like a family member, friend, spiritual advisor, or mental health professional.

5. **Stay Connected**: Staying in touch after a crisis or after being discharged from care can make a difference. Studies have shown the number of suicide deaths goes down when someone follows up with the at-risk person.

3.6 Additional Screening and Assessment Tools

Dr. Marsha Linehan and her colleagues at the *University of Washington Behavioral Research and Therapy Clinics* has published a comprehensive list of screening and risk assessment tools. The tools are available for research, clinical, and educational uses at no charge.

- Linehan Risk Assessment & Management Protocol (LRAMP)
- University of Washington Risk Assessment Protocol (UWRAP)
- Borderline Symptom List (BSL)
- The Dialectical Behavior Therapy Ways of Coping Checklist (DBT-WCCL Scale)
- Demographic Data Scale (DDS)
- NIMH S-DBT Diary Card
- Imminent Risk and Action Plan
- Lifetime Suicide Attempt Self-Injury
- Suicide Attempt Self-Injury Interview (SASII)
- Parental Affect Test
- The Reasons for Living Inventory (RFL)
- Social History Interview (SHI)
- Substance Abuse History Interview (SAHI)
- Suicidal Behaviors Questionnaire (SBQ)
- Therapist Interview (TI)
- Treatment History Interview (THI)

To access these screening and assessment tools in their entirety click here.

4. Making a 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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Because risk occurs on a continuum, assessment, management, and referrals are different for each situation. Identifying and supporting at-risk individuals, accessing services, and relying on evidence-based care remain key challenges. Simply improving or expanding services does not guarantee that services will be used, nor will it necessarily increase the number of people who follow recommended referrals or treatment (CDC, 2022).

Washington State has a coordinated approach to suicide prevention, with multiple partners and state agencies utilizing guidance from the Action Alliance for Suicide Prevention (AASP). Formed in 2016, AASP is now the coordinated body that informs policy and programmatic change and makes recommendations for the Washington State Suicide Prevention Plan (WSDOH, 2021).

Any provider with an ethical duty to assess patient safety can initiate the referral process; however, the outcome is dependent on providers with the required legal and medical expertise. In extreme circumstances, if a patient is judged to meet the criteria as a “danger to self”, a legal process can be initiated whereby a patient can be held against their wishes in a locked facility for up to 72 hours. During this time a more in-depth medical assessment is completed, and medication management and other safety strategies are initiated.

If a patient indicates an intention to harm themself, a healthcare provider’s next act is to refer the patient to someone who is licensed to decide about an involuntary hold. In larger healthcare organizations, psychiatric services are directly available. Patients who agree to be hospitalized must be placed in the least restrictive environment. Depending on the level of risk, patients can be held against their wishes. Determining whether a patient is safe (and whether they can be held against their will) is left to providers who are legally licensed to make that determination.

4.1 Connecting Patients to Appropriate Referral Resources

> Because many people only seek care when they are in crisis, behavioral health systems must provide 24-hour, 7-day a week 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.
>
> National Action Alliance for Suicide Prevention

Screenings and referrals 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).

4.2 Actions and Referrals by Level of Risk

For a patient who has recently attempted to harm themself, the period after discharge from an emergency department or acute psychiatric ward is a time of high risk. Support services are critical during this time and reductions in suicide deaths have occurred when patients receive timely treatment and referral services (Crane, 2016).

A range of evidence-based interventions exist that have been shown to reduce the risk of suicide. The interventions are most cost-effective when they target high-risk patients. Unfortunately, it is not clear if providers consistently and accurately identify patients at high risk of suicide based on a clinical interview alone (Nock et al., 2022).

4.2.1 High Acute Risk

High Acute Risk At a Glance

Essential Characteristics

- Suicidal ideation with intent to die by suicide
- Inability to maintain safety, independent of external support and help

Common Warning Signs

- A plan for suicide
- Recent attempt and/or preparatory behaviors
- Acute Major mental illness
- Exacerbation of personality disorder

Action

In such cases, direct observation and monitoring is critical before arranging immediate transfer for psychiatric evaluation or hospitalization.

Source: DVA, 2019.

High acute risk for suicidal ideation and behaviors means a patient has serious thoughts of suicide, a plan, a recent suicide attempt, preparatory behaviors, acute major mental illness, or exacerbation of a personality disorder. In such cases, direct observation and monitoring is critical before arranging immediate transfer for psychiatric evaluation or hospitalization (DVA, 2019).

A person with high risk may be in danger of acting on suicidal impulses when they experience some “last straw,” some unbearable insult or burden that seems to make life unlivable. When a person is in this state of mind, external controls may be needed to prevent a suicidal act. Some interventions, such as restricting access to the means of completing a suicidal act may be necessary. This may prevent a fatal act but does not resolve the suicidal impulse or crisis (DVA, 2019).

Transitions in care are particularly high-risk periods. These transitions include the initial diagnosis with a mental condition, initiation of psychotropic medication, discharge from the hospital, and having a recent life-changing event. Identifying who might be at high risk for self-harm or suicide is challenging; clinicians cannot foresee which patients will act upon suicidal thoughts (Balbuena et al., 2022).

A study of nearly 2,000 patients found that prediction of suicide attempts in the 1 month and 6 months after a patient visited an emergency department was significantly improved using machine learning models applied to data from a brief patient self-report scale, especially when supplemented with data from patients' electronic health records and/or clinicians' assessments. This study suggests that clinicians can improve their ability to identify patients at high risk of suicide by using data from a brief patient self-report scale and electronic health records (Nock et al., 2022).

4.2.2 Intermediate Acute Risk

Intermediate Acute Risk at a Glance

Essential Characteristics

- Suicidal ideation and a plan
- No intent

Action

- Possible psychiatric hospitalization in some circumstances
- Intensive outpatient management

Source: DVA, 2019.

Intermediate acute risk includes patients with suicidal ideation and a plan but with no intent. These individuals may present similarly to those at high acute risk and share many of the same features. The only difference may be lack of intent, based upon an identified reason for living (e.g., children), and ability to abide by a safety plan and maintain their own safety. Preparatory behaviors are likely to be absent (DVA, 2019).

Patients at this level of risk should be evaluated by a behavioral health provider and include treatment of co-occurring mental health conditions. Psychiatric hospitalization may be needed if related risk factors are responsive to inpatient treatment (e.g., acute psychosis). Outpatient management of suicidal thoughts or behaviors should be intensive and include frequent contact, regular re-assessment of risk, and a well-designed safety plan (DVA, 2019).

4.2.3 Low Acute Risk

Low Acute Risk at a Glance

Essential Characteristics

- No current suicidal intent AND
- No specific and current suicidal plan AND
- No recent preparatory behaviors AND
- Collective high confidence (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety

Action

- Can be managed in primary care
- Outpatient mental health treatment in some circumstances

Source: DVA, 2019.

Low acute risk patients are those with recent suicidal ideation who have no current suicidal intent, no current or specific suicidal plan, no recent preparatory behaviors, and high confidence that the patient and family can maintain safety. Individuals may have suicidal ideation, but it will be with little or no intent or specific current plan (DVA, 2019).

If a plan is present, the plan is usually general or vague, without any associated preparatory behaviors (e.g., "I'd shoot myself if things got bad enough, but I don't have a gun"). These patients are capable of engaging appropriate coping strategies and are willing and able to utilize a safety plan in a crisis (DVA, 2019).

Low acute risk patients can usually be managed in primary care. Outpatient mental health treatment may be indicated, particularly if suicidal ideation and co-occurring conditions exist (DVA, 2019).

4.3 Challenges to Overcome

A gap in all many guidelines is the lack of inclusion of patient-driven safety plans to identify supports, resources, and coping strategies. Another gap in most guidelines is the omission of outpatient intervention safety strategies such as restricting access to lethal means (Harmer et al., 2022).

Continuity of care is a critical part of management and is often lacking. Effective clinical care includes monitoring patients for a suicide attempt after an ED visit or hospitalization and providing outreach, mental health follow-up, therapy, and case management.

Case Example: Daniel Breaks His Sobriety

Background

Dan 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. Dan is participating in OT to regain strength, for treatment of his left upper extremity, and for assessment of his activities of daily living.

During the subjective evaluation, Dan 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.

Dan expresses tremendous guilt because another person was injured and remorse for drinking after being sober for more than 2 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.

Dan tells you that he feels depressed, hopeless, and angry and finds no pleasure in life. He is unable to work, 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 patients 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 Dan'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 Dan provides a positive answer to both *PHQ2* screening questions, you should:

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

Answer: 2

Discussion

Your role is to screen your patient and determine whether there is a need for immediate referral. You have been to an “in service” that helped you understand the resources available in your area. Because your hospital has mental health services directly available, you make an immediate referral to social services. You assign an aide to sit with Dan in a quiet room until a social worker arrives.

If it was determined that Dan was at immediate risk of harming himself, he could be held against his will. However, only police and mental health workers or providers with specialized training can detain him against his will. Police can hold Dan against his will until a crisis worker arrives and can transport him to a psych facility if needed. Because of Dan’s expressed anger towards 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.

5. Referral Resources

Community agencies, mental health organizations, senior services, veterans support groups, and peer support programs can provide critically needed services, including employment and vocational help, housing assistance, and social interactions that are not focused on illness. Cooperation, collaboration, and communication are critical components of patient referral and recovery.

5.1 Recognition and Referral Training

Recognition and referral training—also called gatekeeper training—helps people without specific psychosocial training identify and refer people who may be at risk of suicide. Specific audiences for gatekeeper training include high school teachers and students, first responders, faith community leaders, people who work with older adults, LGBT youth, men in the middle years, and those involved in the criminal justice system (SPRC, 2018).

Gatekeeper trainings vary widely in their length, and depth of content, and target audience. They also vary by modality, with some utilizing online platforms and others offering in-person trainings (Spafford, 2023). Gatekeeper training is only one part of a comprehensive approach to suicide prevention.

It is of limited value if safety protocols are lacking as well as ways to help people find local agencies, professionals, and mental health professionals who can de-escalate suicidal crises (SPRC, 2018).

Gatekeeper trainings is most effective when the training is adapted to meet the specific cultural needs of the community in which they are used. Culturally speaking, who are the people being trained? Some populations share multiple cultures, so it is important to be as specific as possible. Possible groups can include (but are not limited to) race, ethnicity, spirituality, deaf and hard of hearing, LGBTQ2S, gender identity, tribal identity, military/veteran, socioeconomic status, and educational level (SPRC, 2020).

For providers who already have mental health training, recognition and referral training can still be a valuable training tool. It provides additional education, support, access to resources, and opportunities to practice assessment skills. Despite the comorbidity of mental health disorders and suicide, most 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.

5.2 Crisis Lines

Crisis lines provide immediate access, often 24 hours a day, for 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.

5.2.1 988 Crisis Line

Crisis intervention programs provide support and referral services, typically by directing a person in crisis (or a friend or family member of someone at risk) to trained volunteers or professional staff via telephone hotline, online chat, text messaging, or in person. The *National Suicide Prevention Lifeline* is now known as the *988 Suicide & Crisis Lifeline*. It is active across the United States.

The *988 Suicide & Crisis Lifeline* is made up of an expansive network of over 200 local and state funded crisis centers located across the United States. The counselors at these local crisis centers answer calls and chats from people in distress every day. The Lifeline's crisis centers provide the specialized care of a local community with the support of a national network.

Source: SAMHSA, 2022.

In an evaluation of the effectiveness of the Suicide and Crisis Lifeline to prevent suicide, more than 1,000 suicidal individuals who called the hotline completed a standard risk assessment for suicide. Researchers found that over half of the initial sample had a plan for their suicide when they called. Significant decreases in psychological pain, hopelessness, and intent to die occurred during the phone call, with sustained decreases in psychological pain and hopelessness up to three weeks later. These results are promising and underscore the importance of continued care following the call (CDC, 2022).

A 2022 Harris poll assessed public perception of suicide prevention services, including crisis lines. More than half of the 2,054 respondents said they had at least heard of the National Suicide Prevention Hotline although many were not familiar with its recent 988 designation.

Respondents to the Harris poll reported at least one barrier to reaching out to crisis services (SPRC, 2022 September):

- Fear of out-of-pocket costs (26%)
- Fear of what my family would think (26%)
- Lack of confidence that services in my area can help (25%)
- Fear of police/law enforcement responding (24%)
- Lack of insurance to cover costs (24%)

5.2.2 Veterans Crisis Line

The *Veterans Crisis Line* provides specially trained and experienced responders to help veterans (and their loved ones) of all ages and circumstances. Since its launch in 2007, the *Veterans Crisis Line* has answered nearly 7.6 million calls and initiated 1.4 million referrals. An anonymous online chat service, added in 2009, has engaged in more than 910,000 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 360,000 texts (DVA, 2024).

Source: Department of Veterans Affairs, 2024.

The *Military Crisis Line* is a free, confidential resource for all service members, including members of the National Guard and Reserve, and Veterans, even if they're not enrolled in VA benefits or healthcare. It is available 24/7 and is free and confidential. Phone, chat, and text services are available for service members stationed outside the United States (DVA, 2024).

5.3 Online Tools and Mobile Applications

Technology has 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 supplement 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).

5.4 Continuity of Care

> Caring for suicidal persons will most likely require multiple levels of services in a team environment. Discharge 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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Continuity of care means there is coordination between different patient services and providers. This includes the smooth and effective transmission of information for the patient's treatment and management. Poor or lacking continuity of care is related to elevated risk of hospital readmission and attempted and completed suicide, while better continuity of care appears to be protective against suicidality (Arnon et al., 2024).

Key components of good continuity of care within a healthcare organization includes (Arnon et al., 2024):

- Designating a suicide coordinator.
- Monitoring admissions related to suicide attempts.
- Training staff.
- Establishing written protocols.
- Implementing an agreed upon plan.
- Structuring collaboration between providers.

Because a variety of healthcare providers, friends, and family members may be associated with the care of a person at risk for suicide, continuity of care can be easily lost. Maintaining continuity across facilities and providers can be helped by electronic medical records; however, not everyone has access to this information. A confounding factor is that mental health information has higher levels of consent for accessing records.

It is estimated that about 23% of suicides are partially attributed to continuity of care issues. This can include admission difficulties, patient refusal of services, limited services offered by a continuing care team, abrupt termination of services, lack of community follow-up, poor transition between services, and the loss of or change in case manager (Arnon et al., 2024).

Continuity of care is often interrupted when patients transition between care facilities or between other health systems or provider organizations. Patients have expressed frustration with seeing multiple providers, both within a treatment facility and across multiple locations (DVA/DOD, 2019).

Continuity of care is improved when providers directly contact other providers and schedule follow-up appointments. Transition support services (such as telephone or telehealth contact with behavioral health providers) can improve continuity of care and prevent delays in follow-up services (DVA/DOD, 2019).

Additional practices that improve continuity of care 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, latest available).

Unfortunately, many patients with high suicide risk are never referred for follow-up care and receive only limited mental health services. Many also fail to receive adequate treatment for underlying mental health or substance use disorders.

6. Imminent Harm and Lethal Means

Suicidal ideation—thinking about, considering, or planning suicide—and the risk for suicide are only loosely linked. Suicidal ideation is considered “active” when a person is experiencing current, specific, suicidal thoughts—when there is a conscious desire to inflict self-harm, and the individual has any level of desire for death to occur. The individual's expectation that their attempt could produce a fatal outcome is the key consideration (Harmer et al., 2022).

Imminent harm means a person is thought to be at **immediate** risk of self-harm or suicide. When trying to predict the risk of imminent harm or suicide, transitions in care have been shown to be particularly high-risk periods. These transitions include the initial diagnosis with a mental condition, initiation of psychotropic medication, discharge from the hospital, and having a recent life-changing event (Balbuena et al., 2022).

Imminent danger is linked to certain **behavioral warning signs**. A person in imminent danger requires immediate attention. Presence of one or more of these behaviors is a strong indication referral is acutely needed (DVA, 2023, November 6):

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

6.1 Imminent Harm

The 988 Suicide and Crisis Hotline has established policies for callers at imminent risk of suicide, which apply to in-person interactions as well. It begins with active listening and actively engaging the individual at risk in discussion of their thoughts of suicide. Active engagement, cooperation over coercion, and securing a person’s safety are critical, with the use of involuntary methods as a last resort (SAMHSA, 2022).

Active engagement means crisis counselors work to establish an effective connection with an individual seeking support from the Lifeline. Engagement creates a connection and makes it possible to collaborate with, and empower, the individual to secure their own safety, or the safety of the person for whom they are reaching out. The word “active” encourages conscious and intentional engagement in phone- or text-based crisis counseling (SAMHSA, 2022).

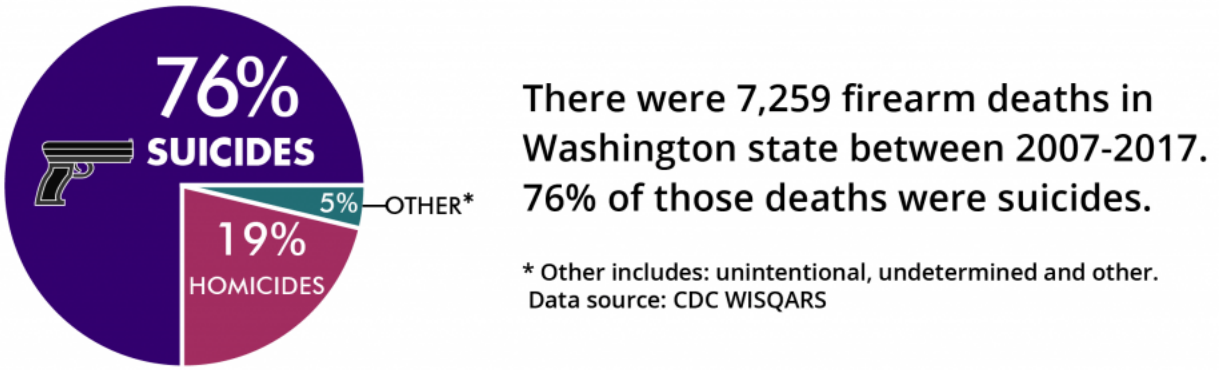
6.2 Discussing Lethal Means

Lethal means are the instruments or objects used to carry out a self-destructive act. The risk of imminent harm is strongly linked to the availability of lethal means. If a patient 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.

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 can be a significant predictor of both homicides and suicides.

Suicide Deaths in Washington by Firearm (2007-2017, latest available)



Source: University of Washington (UW), 2024.

When asking about lethal means, be direct and non-judgmental. 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.

6.3 Restricting Access to Lethal Means

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

Research has shown that the interval between deciding to act and attempting suicide can be as short as 5 or 10 minutes and people tend not to substitute a different method when a highly lethal method is unavailable or difficult to access. Reducing access to lethal means among people at risk and increasing the time interval between deciding to act and the suicide attempt can be lifesaving (CDC, 2022).

Implementation of means restriction is broad and can include:

1. Complete removal of a lethal method.
2. Reducing carbon monoxide content emissions from vehicles.
3. Interfering with physical access.
4. Reducing the appeal of a more lethal method.
5. Limiting children’s access to firearms in the home.

Safe storage of medications, firearms, and other household products can reduce the risk for suicide by separating a person at elevated risk from easy access to lethal means. 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.

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, latest available).

6.4 Counseling on Access to Lethal Means

Counseling on Access to Lethal Means (CALM) is a free, self-paced, online course for healthcare and social service providers. It is designed for those who have training and experience in mental health counseling but is also appropriate for other healthcare providers. CALM emphasizes that restricting access to lethal means should be part of a comprehensive prevention strategy because many suicidal people are ambivalent about wanting to die, and many suicide attempts are made impulsively, during a short-term crisis (Zero Suicide, 2018).

7. Community-Based Healthcare Providers

> 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

Medical providers such as pharmacists, dental professionals, rehab therapists, and others providing care in outpatient and private clinics play an important role in suicide prevention. However, many healthcare professionals acknowledge the lack of confidence, skills, knowledge, and competence in all facets of suicide awareness and prevention in their professional training and in practice. To improve this situation, suicide prevention skills must be taught in entry-level programs, so they will filter into the practice of all providers (Larivière et al., 2021).

Healthcare providers face challenges asking about suicidal feelings, partly related to the perceived reluctance of their patients to disclose suicidal ideation and because many providers believe that suicide is difficult to predict and prevent. Lack of time is also universally acknowledged as a barrier (Elzinga et al., 2020).

A large European study looked at some of the difficulties faced by healthcare providers related to assessing suicidal ideation and behaviors. Providers reported feeling stuck with patients, feeling professionally isolated, and being “lost in a referral maze”. They expressed the need to have mental health staff based in their practices, such as is done in the Netherlands’ healthcare system (Elzinga et al., 2020).

Practitioners expressed the need to improve access to—and collaboration with—mental health services. The lack of such collaboration is a common barrier to suicide prevention. In the United Kingdom, for example, studies have found that mental health practitioners tend to minimize a healthcare provider’s assessment of a patient’s suicidal state (Elzinga et al., 2020).

7.1 Pharmacists

In the United States, there are more than 68,000 community pharmacies, many of which are open 24 hours per day. This means pharmacists are a frequent healthcare touchpoint for many community members and are well-positioned as gatekeepers for suicide prevention. Community pharmacy staff have reported encountering patients either in crisis or who died by suicide and have expressed a need for training in suicide prevention skills (Stover et al., 2023).

Community pharmacists annually interact with patients with mental health issues an average of 31 times more often than a patient’s primary care provider. Despite this, little is known about pharmacists’ attitudes towards suicide prevention. Very little is also known about an individual client’s willingness to reveal suicidal thoughts to their pharmacist. Stigma, fear, embarrassment, and a preference for self-reliance can prevent a suicidal patient from seeking help (Kamal and Jacob, 2023).

Pharmacists are in a unique position to provide information about suicide to their clients despite barriers such as workload, time constraints, staff negative attitudes, and stigma towards mental illnesses. At a minimum, being able to talk about suicide and complete a simple screen for suicidal ideation and behaviors can alert them to take further action. Connecting a person to help—whether to their physician, a family member, or the suicide hotline is critical.

Widespread training of practicing pharmacists, pharmacy techs, and students can be useful. In the U.S., Washington is one of the few states that requires pharmacists to complete continuing education related to suicide prevention. In addition to building knowledge, these training programs can decrease stigmatization against people with mental health conditions (Witry and Clayden, 2020).

Pharmacy students may be exposed to people with suicidal ideation in their roles as trainees and technicians. They may experience high levels of stress and may have personal and peer experiences related to suicide. It can be beneficial to begin training student pharmacists in assessing suicide risk and referring people with suicidal ideation to resources (Witry and Clayden, 2020).

In a 2018 review that evaluated a variety of approaches for educating students and engaging community pharmacists in suicide prevention, the authors recommended that suicide prevention training for pharmacy professionals address the following areas: identifying warning signs for suicide, communicating with individuals to assess risk of suicide, referring individuals to appropriate resources, and counseling about which medications may increase risk of suicidal ideation (Stover et al., 2023).

However, only two of the reviewed five trainings for student pharmacists included information on medication counseling and the role of medication in suicidal ideation and behavior. Notably, trainings lacked medication-specific information, such as mentioning the medications labeled for increasing patients' risk of suicidal ideation or behavior, even though more than 143 agents carry this label. This information should be included in future trainings (Stover et al., 2023).

Case: Francoise Gets Help from Her Pharmacist

Background

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.

One day, 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. She also smells of alcohol, which can increase the risk of death—intended or unintended—from a 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 askes Francoise: Over the last 2 weeks, how often have you been bothered by either of these 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 of self-harm.

The pharmacist decides to ask some follow up 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:

1. Over the last 2 weeks, have you had thoughts of killing yourself?
2. 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. Francoise 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' husband arrives quickly and agrees to take his wife to the ER. The pharmacist follows up the local emergency department and learns that Francoise has arrived at the hospital and is being evaluated.

Discussion

Relapsing bipolar disorder can place a person at increased risk for suicide. Because Francoise stopped taking lithium and succeeded in getting 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, a nonjudgmental attitude. They kept Francois in a safe environment under one-to-one observation until someone arrived to take her to the hospital. The system set up by the pharmacy to flag high-risk mediations along with a screening protocol provided help to a person in acute crisis.

7.2 Dental Professionals

Since August of 2020, dental hygienists and dentists in Washington state have been required to take a continuing education course on suicide screening and referral. Because dental professionals spend a great deal of time with their patients, often see their them on a regular basis, and are familiar with their medical history, they are in a good position to screen and refer patients 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.

Clinicians working within dentistry are familiar with screening for a variety of health conditions. Dental professionals also undertake routine screening for conditions such as oral cancer, non-accidental injuries, and dental disease on a daily basis (Kelly and Kilgariff, 2023). It is important for dental clinics to have policies and procedures in place that describe screening tools, employee training, and referral resources.

Patients with mental health issues may have a greater risk of oral disease because of side effects of medication, lack of self-care, and higher treatment needs because of difficulties in accessing care. Dental team members are in an ideal position to recognize signs of oral health-related mental health concerns. Also, head and neck cancer survivors are twice as likely to die by suicide than survivors of other cancers. It is important the dental team understand the effect such conditions have on patients' mental wellbeing, and the increased risk of such patient groups (Kelly and Kilgariff, 2023).

Studies of patients' attitudes toward screening for medical conditions in a dental setting indicate that most patients express a favorable attitude toward chairside screening. They understand 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).

A simple screening tool such as the Patient Health Questionnaire 2 or another short, validated 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, including mental health and social services.

7.3 Rehabilitation Therapists and Allied Health Professionals

Suicide prevention has traditionally been the domain of mental health professionals operating within the biomedical model. Consequently, strategies to prevent suicide have been largely implemented within the setting of mental healthcare and have largely centered around the suicide risk assessment process (McGrath et al., 2023).

Although rehab therapists can act as gatekeepers in identification and referral of patients into other parts of the healthcare system (Lundin and Bergenheim, 2020), research has repeatedly found that rehab therapists experience difficulty supporting people with poor mental health. They commonly attribute their lack of confidence to a lack of training in mental health. Because of this, the ability to identify and address mental health issues is not seen as a priority within the profession (McGrath et al., 2022).

As with pharmacists and dental professionals. rehabilitation therapists are in a unique position to screen for suicidal ideation and behaviors. They routinely interact with, and care for, care for patients with musculoskeletal, neurological, and respiratory conditions. The association between suicide and poor physical health means they may encounter clients with suicidal thoughts and behaviors. Specifically, chronic pain has been identified as a risk factor for depression and suicidal ideation.

8. 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.

Firearms should be kept unloaded in a gun safe or lock box. In a case-control study of firearm-related events in 37 counties in Missouri, Oregon, and Washington, and five trauma centers in Washington and Missouri, researchers found that firearms being stored unloaded, separate from ammunition, and in a locked place (or secured with a safety device) was protective of suicide attempts among adolescents (CDC, 2022).

Medicines should be kept in a locked cabinet or other secure location away from people who may be at risk or who have made prior attempts (CDC, 2022). 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.

Campaigns such as *Safer Homes, Suicide Aware* focus on simple steps to prevent suicide attempts and deaths before a crisis occurs. These types of public health programs help educate family members, community healthcare providers, and mental health providers about potential hazards in the home.

Source: Safer Homes Coalition (Nd).

Case Example: Julio Is Facing a Divorce

Background

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 Javier, the dental hygienist for a teeth cleaning. Keisha, the office manager has asked Julio to fill out a short questionnaire while he is waiting for Javier.

After a short wait, Javier escorts Julio into his treatment room. Javier 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 Javier is prepping for the teeth cleaning, Julio thanks him for the excellent dental care he's received over the years and asks Javier to tell the dentist how much he appreciates everyone at the clinic. He tells Javier 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 case a referral is needed for one of their clients.

Javier excuses himself and asks the office assistant for the results of Julio's waiting room screen. Keisha lets Javier know that Julio marked "3" on both 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, Javier decides to discuss the results with Julio.

Javier: You mentioned that you feel depressed. On the waiting room questionnaire, you filled out in the waiting room you indicated that 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.

Javier: You sound very unhappy.

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

Javier: 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.

Javier: 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.

Javier: 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.

Javier: 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 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

Javier 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. Javier 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 talk to Julio. Javier reaches a social worker who agrees to meet with Julio. Javier stays with Julio in a private room until the social worker arrives.

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

9. Concluding Remarks

Suicide rates have increased recently in the United States, including an almost 20% increase in Washington State in recent years. As healthcare professionals working in outpatient clinics, community pharmacies, dental offices, social service offices, and other community settings, learning how and when to screen 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.

Routine screening can identify a person in crisis and provide the support needed to prevent self-harm. If a patient has been referred following a suicide attempt, screening is particularly important because someone who has attempted suicide remains at high risk following the attempt.

Washington law recommends that providers screen patients for suicidal ideation and behaviors. 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 in-depth assessment, and the need for referral.

Healthcare providers have an ethical duty to assess patient safety and understand the referral process. Be prepared with a plan, know how to activate resources, and make sure to follow up. Staying engaged will give patients the support they need 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, such as rehabilitation therapists, social workers, psychologists, dentist professionals, and community pharmacists 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 patient 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.

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Quiz: About Suicide Screening, Referral, and Imminent Harm in WA State, 3 units (325)

1. Suicide is a major public health concern. In the United States in 2020:

a. There were fewer suicides than homicides.

b. There were more than twice as many suicides as homicides.

c. Suicide was the leading cause of death among most age groups.

d. Suicide rates were highest in the northeast.

2. 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 more than 45,000 suicides.

d. Suicide rates were highest in the Northeast.

3. In Washington State, suicide rates:

a. Are much lower than the national average.

b. Are highest among Asian-American adults during their late 70s.

c. Are highest among American Indian / Alaska Native populations.

d. Are about the same as the national average.

4. In terms of gender differences and suicide:

a. Women are more likely to use deadlier methods than men, such as firearms or suffocation.

b. Men are more likely to die by suicide than women, but women are more likely to attempt suicide.

c. From 50 years of age, the suicide rates among women tend to progressively increase.

d. In women, signs of suicidal ideation include social withdrawal, anger, and reduced problem-solving capacity.

5. 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.

6. Two 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.

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

a. True

b. False

8. One of the most common mental health diagnoses among veterans returning from war is:

a. Schizophrenia

b. Posttraumatic stress disorder (PTSD)

c. Bipolar disorder

d. Hyperactivity

9. 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 patient's mental state and provide immediate psychosocial counseling.

10. Strong indicators of increased risk are

a. Mental illness and substance abuse.

b. Prior suicide attempts and deliberate self-harm.

c. Depression and hopelessness.

d. All of the above.

11. 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.

12. 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.

13. Recognition and referral (gatekeeper) training:

a. Is a school-based program that teaches students the basics of behavioral therapy.

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

c. Is a voluntary training program designed only for mental health professionals.

d. Required at risk youth and young adults to seek treatment at a hospital.

14. 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.

15. 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.

16. The results of your screen indicate that your patient 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.

17. 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.

18. 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 about suicide and give them a ride to the hospital.

d. Talk to clients about suicide and complete a quick screen.

19. A simple screening tool such as the Patient Health Questionnaire 2 or another short screening tool or a waiting room questionnaire can be quick and efficient way to screen for suicidal ideation in a dental clinic.

a. True
b. False

20. Because rehabilitation therapists care for clients with musculoskeletal, neurological, and respiratory conditions they may encounter clients with suicidal thoughts and behaviors.

a. True
b. False

21. Healthcare providers can encourage safe storage of medications that have the potential for abuse by:

a. Advising patients and family members to lock up prescription medications.

b. Limit the supply of in-home medications that have the potential for abuse.

c. Recommending the return unused medications.

d. All of the above.

[Continue to next page for answer sheet]

Answer Sheet: About Suicide Screening, Referral, and Imminent Harm in WA State, 3 units (325)

Name (Please print) _____

Date _____

Passing score is 80%

1. _____	12. _____
2. _____	13. _____
3. _____	14. _____
4. _____	15. _____
5. _____	16. _____
6. _____	17. _____
7. _____	18. _____
8. _____	19. _____
9. _____	20. _____
10. _____	21. _____
11. _____	

[Continue to next page for course evaluation]

Evaluation: About Suicide Screening, Referral, and Imminent Harm in Washington State, 3 units (325)

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

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

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

1. Describe the scope of suicide in the U.S. and Washington State	1 2 3 4 5
2. Relate 5 warning signs for suicide.	1 2 3 4 5
3. Describe 3 principles of effective suicide screening.	1 2 3 4 5
4. Discuss the importance of connecting patients to appropriate referral resources.	1 2 3 4 5
5. Describe recognition and referral training.	1 2 3 4 5
6. Understand how the risk of imminent harm is linked to lethal means	1 2 3 4 5
7. Describe 2 responsibilities of pharmacists, dental, and allied health professionals related to suicide screening and prevention.	1 2 3 4 5
8. Understand the 4 basic tenets of safe storage practices.	1 2 3 4 5
*The author(s) are knowledgeable about the subject matter.	1 2 3 4 5
*The author(s) cited evidence that supported the material presented.	1 2 3 4 5
*Did this course contain discriminatory or prejudicial language?	Yes No
*Was this course free of commercial bias and product promotion?	Yes No
*As a result of what you have learned, will 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 satisfaction with this learning activity?	1 2 3 4 5

*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 _____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. _____Social Media

_____Other _____

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:

[Continue to next page for registration and payment]

Registration and Payment: About Suicide Screening, Referral, and Imminent Harm in WA State, 3 units (325)

Please answer all the following questions (* required).

*Name: _____
*Email: _____
*Address: _____
*City and State: _____
*Zip: _____
*Country: _____
*Phone: _____
*Professional Credentials/Designations:

_____
*License Number and State: _____

Payment Options

You may pay by credit card, check, or money order.
Fill out this section only if you are paying by credit card.
3 contact hours: $29

Credit card information

*Name: _____
Address (if different from above):
*City and State: _____
*Zip: _____
*Card type: Visa Master Card American Express Discover
*Card number: _____
*CVS#: _____ *Expiration date: _____