Instructions for Mail Order

Once you've finished studying the course material:

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

Mail the completed forms with your payment to:

ATrain Education, Inc

5171 Ridgewood Rd

Willits, CA 95490

*Check or money order payable to ATrain Education, Inc (or enter your credit card information on the registration form).

When we receive your order, we will grade your test, process your payment, and email a copy of your certificate to the email address you provide.

You will be able to download a certificate when you complete the course. If you would like a fancy copy of your certificate (suitable for framing), please add $8.50 to your payment.

Questions? Call 707 459-3475 (Pacific Time) or email (Sharon@ATrainCeu.com).

[Continue to next page to start course]

Suicide Prevention, 2 units (359)

Contact hours: 3
Author: Lauren Robertson, BA, MPT
Price: $29
Expiration: December 31, 2027

Course Objectives

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

1. Describe the scope of suicide in the United States.
2. List 3 warning signs for suicidal ideation and behaviors.
3. Describe 5 risk factors for suicidal ideation and behaviors.
4. Relate 4 job-associated concerns that can lead to chronic stress among nurses.
5. Describe the importance of screening, assessment, and safety planning for patients as risk for suicide.
6. Define imminent harm.
7. Relate 5 evidence-based approaches that have been shown to be successful in reducing suicidal ideation and behaviors.
8. List 4 commonly accepted ethical principles.

Course Overview

This course covers suicide prevention including warning signs, protective factors, and individual, community, and societal risk factors. It describes how chronic and toxic stress and secondary traumatic stress affect healthcare personnel, potentially increasing suicide risk. The course also discusses “pathways to care” for healthcare providers at risk for suicide that addresses screening, assessing, safety planning, referrals, and follow-up. Evidence-informed approaches and best practices to reduce suicide rates are covered, as well as the ethical legal considerations of caring for patients and nurses who are suicidal.

The course fulfills the requirement for training in suicide prevention for healthcare providers in Connecticut, Kentucky, and Nevada as well as nationally.

Target Audience

Nurses, nurse practitioners, advanced practice nurses, nursing students, and other healthcare providers who are required to complete a course on suicide prevention.

1. Suicide in the United States

Definitions

- **Suicide**: death caused by self-directed injurious behavior with intent to die.
- **Suicide attempt**: when someone harms themselves with any intent to end their life, but they do not die because of their actions.
- **Suicidal ideation**: thinking about, considering, or planning suicide.

Source: CDC, 2022, May 24.

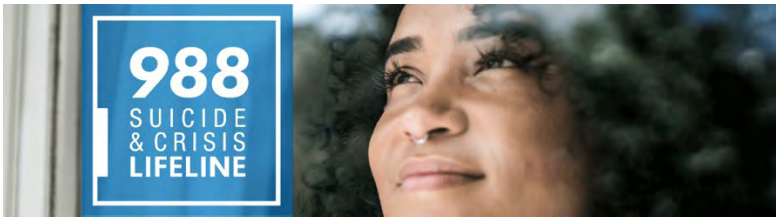
1.1 Suicide Among the General Population

In the United States, suicide affects people of all ages, genders, and ethnic groups, regardless of socioeconomic status. Among children, teenagers, and young adults, suicide is the **second** leading cause of death, while among middle-aged adults, suicide is the **fifth** leading cause of death (NCHS, 2024, October 2).

In 2021, more than 49,000 Americans died from suicide, making it the eleventh leading cause of death overall. Remarkably, in the same year there were twice as many suicides in the U.S. as homicides (NCHS, 2024, July 23). Suicide attempts are much more frequent than completed suicides, with an estimated 1.3 million suicide attempts among U.S. adults each year (Moscardini et al., 2020).

The *National Strategy for Suicide Prevention*—updated in 2024—has expanded prevention efforts with the goal of improving our understanding of suicide prevention practices within healthcare systems and communities. Because of these national efforts, organizations and businesses that had not previously viewed suicide prevention as part of their mission have become engaged in efforts to reduce suicide (HHS, 2024).

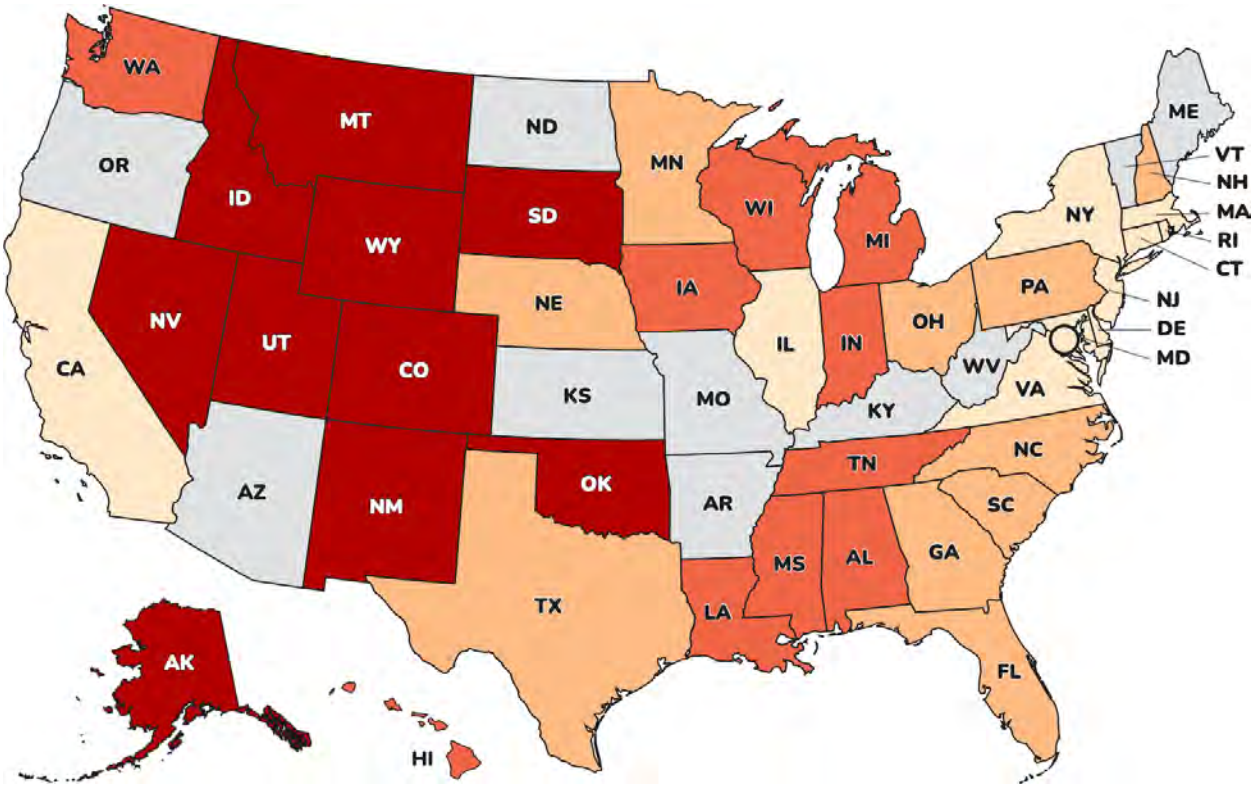
In 2019, the *President's Roadmap to Empower Veterans and End a National Tragedy of Suicide* (PREVENTS) was launched and in July of 2022 the Federal Communications Commission designated 988 as the national number for mental health crises (HHS, 2024).



Source: SAMHSA, 2025. Public domain.

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

Suicide Rates in the United States (by state; per 100,000; 2023)



[1] The number of deaths per 100,000 total population.

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

1.2 Suicide Among Nurses

For nurses and other healthcare providers, a web of biological, psychological, social, environmental, and situational concerns can influence suicidal ideation and behaviors. Between 2007 and 2018, the incidence of suicide among nurses nationally was significantly greater than among the general population; in contrast, the incidence among physicians was not statistically different from that of the general population (Davis et al., 2021).

The methods of suicide and substances identified during the toxicology examinations for nurses and physicians are similar, with some evidence of higher substance use compared with individuals in the general population who die by suicide. Nurses who died by suicide had the highest rate of antipsychotics, opiates, and amphetamines in the toxicology examination (Davis et al., 2021).

Unfortunately, minimal attention has been paid to preventing suicide among nurses compared to physicians, although there are similar considerations with burnout, depression, and suicide risk among both groups. Suicide among nurses in the U.S. is not systematically evaluated or reported at a local or national level through public or professional agencies (Davidson, Stuck, Zisook, Proudfoot, 2018a).

Key Points about Suicide

- Suicide is a preventable public health problem, not a weakness or failure.
- Everyone has a role to play in prevention.
- Prevention involves changing risk factors and improving protective factors.
- Suicide does not affect all communities equally or in the same way.
- People experiencing suicidal thinking and behaviors deserve dignity, respect, and the right to make decisions about their care.

1.3 Suicide Information for Connecticut, Kentucky, and Nevada Licensees

Connecticut Licensees

In Connecticut, suicide is the 11th leading cause of death (the 2nd leading cause of death for people aged 10-35). While the rate of suicide is comparatively low when compared to other states (45th in the nation in 2018), one suicide death is too many. Additionally, though Connecticut's rates have remained lower than most other states, Connecticut has not been immune to the national trend of increasing suicide deaths. The suicide rate has pushed upward in the state since 2007, consistent with a corresponding national rise (CSAB, 2025).

In recent years, suffocation/hanging was the most common method of suicide death in Connecticut (36%). However, methods of suicide death vary by sex. Among men, firearms (34%), hanging (29%), and drug overdoses (10%) were the most common. Among women, hanging (37%), drug overdoses (32%), and firearms (11%) were the most common (CSAB, 2025)

Connecticut's suicide prevention initiatives are implemented through the Connecticut Suicide Advisory Board. In 2023, more than 2,300 Connecticut residents were in emergency departments for self-direct violence. Nearly 1,200 were admitted to the hospital for additional care and an additional 347 died by suicide (CDPH, 2024).

Kentucky Licensees

Suicide is the 11th leading cause of death in Kentucky (the 2nd leading cause of death for ages 10–34). Unfortunately, most communities in Kentucky (three-quarters) do not have enough mental health providers to serve residents (AFSP, 2021).

During the COVID pandemic, there was a documented increase in Kentucky in suicidal ideation in inpatient, outpatient, and emergency departments. Although nearly all demographic groups were negatively affected, certain subgroups were more highly affected in comparison to others. Specifically, males 14-17 years of age, Black and Hispanic residents, and those residing in rural areas had increased rates of documented suicidal ideation (Salt et al, 2022).

According to the *Kentucky Youth Risk Behavior Survey*, 15% of Kentucky high school students reported having seriously considered suicide within a 12-month period. In addition, 17.4% of Kentucky middle school students reported that they had seriously considered killing themselves at some point in their lives (KY DOE, 2025).

There are a host of characteristics that place Kentucky residents at increased risk for suicidal ideation and behaviors. Specifically, Kentucky is a predominantly rural state, highly affected by poverty. Substance use is a long-standing problem that has reached epidemic proportions. In 2020, Kentucky had the second highest drug overdose mortality in the country (AFSP, 2021).

Nevada Licensees

Suicide is the 9th leading cause of death in Nevada. In 2022, Nevada had the 11th highest rate of suicide deaths in the nation per 100K residents (NNPH, 2024). Each year, Nevada's suicide rate is consistently higher than at least 80% of the nation. One factor that contributes to these high rates of suicide is the use of firearms. Nevada is second only to Wyoming in the number of suicide deaths involving firearms.

Demographic groups with the highest rates of suicide include individuals ages 65+, males, American Indians, LGBTQ, and military veterans. Many risk factors contribute to risk of suicide, including trauma, mental illness, financial or legal problems, substance use, isolation, a history of violence, other suicide incidence within a community, and easy access to lethal means (NNPH, 2024).

2. Recognizing 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.

Attempts to predict and prevent suicide are limited due to its statistical rarity—suicide is exceedingly rare in comparison to associated risk factors. The vast majority of people who attempt suicide show some warning signs, which can be acute and urgent or simply cause for concern.

Widely accepted *general* suicide warning signs include feeling hopeless, anxious, agitated, or trapped. In addition, rage, anger, aggression, and withdrawing from family and friends can increase risk. Other general warning signs include sleeplessness, mood swings, reckless behavior, and alcohol or drug use (especially increased use).

Three widely accepted *direct* warning signs that are particularly indicative of increased risk are (DVA/DOD, 2019):

1. Communicating suicidal thought verbally or in writing.
2. Seeking access to lethal means such as firearms or medications.
3. Demonstrating preparatory behaviors such as putting affairs in order.

Warning signs can be evaluated by asking a patient or co-worker to describe thoughts, feelings, and behaviors they have experienced prior to the most recent onset of suicidal ideation. If a person reports they are experiencing any common warning signs, directly ask them if they are experiencing thoughts of suicide. Recognizing warning signs provides an opportunity for early assessment and intervention (DVA/DOD, 2019).

3. Protective and Risk Factors

A **protective factor** is anything that makes it *less likely* for a person to develop a disorder. A **risk factor** is anything that makes it *more likely* for a person to develop a disorder or predisposes a person to high risk for self-injurious behaviors.

3.1 Protective Factors

Protective factors—both personal and social—can buffer a person against the risk of suicide (Stone, 2017). The availability of appropriate support services—safety nets—can strengthen a person's protective factors, whereas a lack of resources may increase a person's risks.

Protective personal factors include:

- A sense of identity and belonging
- Good self-esteem, and an optimistic view of life
- Moral objections to suicide
- Problem-solving and coping skills, e.g., the ability to resolve conflicts, and good impulse control
- Involvement with cultural, spiritual, or religious practices
- Self-care, e.g., understanding the importance of health and wellness, seeking help when needed, engaging in constructive and enjoyable leisure activities

Protective social factors include:

- Strong interpersonal bonds and friendships
- Good community support
- A safe and stable home environment
- Strong intimate relationships

Being responsible to others, employment, and child-rearing responsibilities can also be protective social factors.

3.2 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 and 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.

Predicting suicide risk is a key challenge in suicide prevention, with risk misclassification having serious consequences—both "false negatives" who go on to self-harm without being identified and "false positives"—who are monitored, screened, or treated unnecessarily (McKernan et al., 2018). Increased risk is associated with a number of factors, many of which are present in a large number of people, making it difficult to identify who may be at risk for suicidal behaviors.

The strongest **individual** risk factors for suicidal ideation and behaviors include:

- History of mental disorders, especially clinical depression
- History of alcohol and substance abuse
- One or more previous suicide attempts
- Unwillingness to seek help

Additional risk factors for an **individual** include:

More directly related to a person's family history

- A family history of suicide
- A family history of child maltreatment
- High conflict or violent relationships

Other individual risk factors

- Isolation or feelings of isolation
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Losses, such as of close relationships
- Illness and disability

At the **community** level:

Conditions that increase risk

- Lack of access to mental health services
- Suicide clusters in the community
- Community violence

Additional community risk factors

- The stress of acculturation
- Historical trauma
- Discrimination

At the **societal** level, risk factors include:

- Easy access to lethal means
- Certain cultural and religious beliefs
- An unwillingness to seek help because of stigma.

Stigma can be a particularly powerful societal risk factor because it can include labeling, stereotyping, separation, loss of status, and discrimination. When stigma occurs in the context of mental illness, it can have even more harmful than the mental illness itself and can be a risk factor for suicide (Roškar et al, 2022).

Interventions to Reduce Risk	
Intervention	**Goal or Outcome**
Economic supports	Household financial security Stable housing
Improve access and delivery of healthcare	Mental health coverage in health insurance policies Providers available in underserved areas
Provide protective environments	Reduce access to lethal means Reduce excessive alcohol use
Promote connectedness	Peer norm programs Engagement in community activities
Promote coping and problem-solving skills	Social-emotional learning Parenting skill and family relationship programs
Direct support for people at risk	Gatekeeper training and crisis intervention Treatment to prevent re-attempts

Source: Stone et al., 2017.

3.2.1 Mental Health

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.

Post-mortem forensic reviews suggest that most suicide decedents have identifiable mental illness, though only about one-half had received a mental health diagnosis in the year prior to their death. The under-recognition of mental conditions seriously limits the potential to identify and appropriately treat individuals at risk for suicide (DVA/DOD, 2019).

In people with a mental illness, the odds for suicide related to severe depression, schizophrenia, and bipolar disorder are approximately 3 to 10 times greater than that of the general population, with a higher increased risk in males than females. Despite this, mental illness is a poor predictor of suicidal ideation and behaviors since suicide does not occur in 95% to 97% of all cases (Fosse et al., 2017).

3.2.2 Access to Lethal Means

Access to lethal means is a risk factor for suicide. Lethal means are objects, substances or actions that might be used in a suicide attempt. This includes items such as firearms, poisons, alcohol or drugs, and actions such as jumping from a bridge or building (DSPO, 2020). Reducing access to lethal means includes:

- Restricting access to firearms.
- Promoting safe storage of firearms and other lethal products.
- Reducing access to potentially toxic medications.

Household gun ownership is a significant positive predictor of both homicides and suicides. In 2019, 50% of the more than 47,000 suicides in the U.S. involved firearms (Kivisto, 2022). Firearms are deadly and individuals who attempt suicide using firearms are more likely to die in their attempts than those who use less lethal methods (HHS, 2012, latest available).

Among nurses and physicians, poisoning is the most common lethal means used in suicide. Both nurses and physicians were more likely to have antidepressants, benzodiazepines, and barbiturates identified in the results of the toxicology examination. The higher presence of barbiturates at death is notable because of their infrequent clinical use (Davis et al., 2021).

Reducing access to lethal means used in suicide attempts and suicide is now considered a key component in a comprehensive suicide prevention strategy and has been shown to be effective in reducing suicide death rates (DVA/DOD, 2019).

3.2.3 Increased Risk Related to Medical and Physical Issues

Physical illness is a commonly overlooked risk factor for suicide. It can cause significant stress, feeling like a burden to family, potential loss of employment, excessive medical bills, 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).

Certain medical conditions are associated with an increased risk for suicidal ideation and behaviors. This can include chronic pain, cognitive changes that make it difficult to make decisions and solve problems, and the challenges related to long-term conditions and illnesses.

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.

Trauma is also a risk factor for suicide. Although some people who experience trauma move on with few symptoms, many—especially those who experience repeated or multiple traumas—suffer a variety of negative physical and psychological effects. Trauma exposure has been linked to later substance abuse, mental illness, increased risk of suicide, obesity, heart disease, and early death.

3.2.4 Substance Misuse

Suicide is a leading cause of death among people with substance use disorders. Compared to the general population, individuals treated for alcohol misuse or dependence are at about 10 times greater risk for suicide; people who inject drugs are at about 14 times greater risk for suicide (CSAT, 2017).

Depression—a common co-occurring diagnosis among people with substance use disorders—can confer additional risk. 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 (CSAT, 2017).

Substance Use Disorders

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

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

The most common substance use disorders in the U.S. include:

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

Even when someone with a substance use disorder is in treatment, the prevalence of suicidal ideation and suicide attempts remains high; there is a significant prevalence of suicide among those who have at one time been in treatment for a substance use disorder. Suicidal thoughts and behaviors are also a significant indicator of other co-occurring disorders (CSAT, 2017). The number of substances used seems to be more predictive of suicide than the types of substances used.

3.2.5 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).

3.2.6 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 networks, 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).

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).

3.3 Documenting Risk

Documenting risk involves gathering information, noting warning signs, and initiating appropriate screening and referrals. Good documentation promotes safety, coordinates care, and establishes a solid medical and legal record. Documentation provides a written summary of any steps taken, along with a statement of conclusions that shows the rationale for the plan. The plan should make good sense relative to the seriousness of risk (CSAT, 2017).

Good documentation also supports a team approach, as it requires follow up on referrals and coordination with other providers. Effective suicide prevention is comprehensive: it requires a combination of efforts that work together to address various aspects of the problem (CSAT, 2017).

4. The Impact of Stress

There are many factors to consider when addressing suicide risk for nurses and other health professionals. The nursing profession can be stressful, and nurses are exposed to human suffering on a daily basis. This can lead to chronic stress and secondary traumatic stress, potentially increasing the risk of suicidal ideation and behaviors.

Prior to a completed suicide, nurses have reported more job-related concerns than non-nurses. This includes problems related to disciplinary action, diversion, inability to work due to chronic pain, and physical and mental illness (James et al., 2023).

The impact of ongoing stress can increase the risk of suicidal ideation and behaviors. Despite the known risks related to stress, suicide among nurses is more common than generally acknowledged. It is often shrouded in silence, at least in part due to stigma related to mental health and its treatment (Davidson, Mendis et al., 2018a).

4.1 Chronic and Secondary Stress

Chronic toxic stress occurs when an individual is exposed to prolonged or repeated traumatic events, such as violence, abuse, or neglect. Over time, this can lead to changes in the brain and body that can increase the risk of mental health problems such as depression, anxiety, post-traumatic stress disorder, and burnout. *Secondary traumatic stress* occurs when an individual is exposed to the trauma of others. Both can have a significant impact on an individual's ability to cope.

In today's complex healthcare environment, nurses have a great deal of responsibility and accountability. They deliver care that is highly regulated, and they are under constant pressure to provide the required care within strict time limits. While burnout is common and painful in its own right, it also leads to suboptimal performance and patient safety issues, and is intimately associated with depression, a known precursor to suicide (Davidson, Mendis et al., 2018b).

Many nurses point to ethics-related stress, perceive limited respect for their work, and express increased dissatisfaction with their work situations. Stress can accumulate over time, related to inadequate equipment, insufficient labor resources, blame, potentially inappropriate treatments, violence, medical errors, and moral distress (Davidson, Mendis et al., 2018b).

During the COVID pandemic, high workloads and unprecedented levels of burnout stressed the U.S. nursing workforce, particularly younger, less experienced RNs. These factors have already resulted in high levels of turnover with the potential for further declines. This is exacerbated by disruptions to prelicensure nursing education and comparable declines among nursing support staff (Martin et al., 2023).

4.2 Stress Related to Workplace Violence

Nurses and other healthcare workers can be exposed to violence, harassment, abuse, or intimidation in the workplace. Exposure to violence is associated with increased risk of depression, post-traumatic stress disorder, anxiety, suicide attempts, and suicide (CDC, 2022).

Nurses are the frontline workers who spend more time with patients than other healthcare providers, increasing the potential for violent encounters. Factors that can increase the risk of violence in healthcare settings include workplace stress, novice nurses, shift jobs, and understaffing (Kafle et al., 2022).

These situations can lead to delayed care for patients, who may interpret delays as negligence on the part of an individual nurse. Patients assign certain roles to nurses and violence can occur when a nurse does not perform according to the wishes or expectations of a patient. Nurses may also be the recipient of abuse from visitors, coworkers, supervisors, or administrators (Kafle et al., 2022).

Workplace violence can be physical or psychological, and can include racial abuse, bullying, and verbal abuse. It can be directly related to increased job stress, decreased job satisfaction, absenteeism, burnout, disordered sleep, fatigue, post-traumatic stress disorder, fear, and suicide (Kafle et al., 2022).

Violence against frontline healthcare workers increased dramatically during the COVID pandemic. The attacks have increased occupational stress and the physical and mental health risks of individual healthcare workers. The violence has spilled over to social media and the private sphere and created new forms of hate crimes and harassment. Physical aggression, primarily known from war and conflict settings, now occurs in ordinary workplace settings (Kuhlmann et al., 2023).

Women account for the vast majority of the healthcare workforce. Gender-based and sexual violence is widespread and most often affects women. Unfortunately, there is a severe lack of data, research, and knowledge and a scarcity of political will and policymaking that address this issue (Kuhlmann et al., 2023).

5. Screening, Assessment, and Referrals

> 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

Asking a patient, friend, or co-worker about suicide requires a thoughtful, caring, and non-judgmental approach. The goal is to identify a person who has thoughts of self-harm but has not yet formulated a plan or acted on those thoughts.

Nurses and other direct-care providers are in a key position to prevent suicide. However, to enable them to act, they need to feel confident assessing suicidal risk. Given that the majority of people with suicidal ideation or behaviors have seen a health professional in the month before their death, it is highly likely that nurses and other direct-care providers will have to provide care for someone who is potentially suicidal (Davison et al., 2017).

Education is vital. In an important survey, nurses reported feeling unconfident and ill-prepared to discuss suicide or suicidal ideation. As a result, people were rarely identified as being at-risk. Knowing how to identify an at-risk person—and understanding the level of risk—is the first step in preventing suicide (Davison et al., 2017).

Because risk occurs on a continuum, screening, assessment, management, and referrals are different for each situation. Identifying at-risk individuals, accessing services, and relying on evidence-based care remain key challenges (Stone et al., 2017).

Identifying and caring for someone thought to be at risk for suicide involves five key steps:

1. Screening
2. Assessment
3. Safety Planning
4. Referrals
5. Follow-up

To be most effective, a pathway to care should be standardized across an organization, ensuring that anyone at risk of suicide receives the same level of care and support. It must also ensure that privacy is respected, and an individual’s risk of suicide is not disclosed to others without their consent.

5.1 Screening

Asking a person about suicide starts with open-ended questions that invite the patient or co-worker to provide more information. If warning signs are noted, or there is a concern about suicide, screening should be initiated—whether or not you can pinpoint the reason for concern (CSAT, 2017).

Any actions taken by the screener should make good sense in light of the seriousness of suicide risk. Judgments about the degree of seriousness should be made in consultation with a supervisor or a treatment team, not by a healthcare provider acting alone (CSAT, 2017). A critical part of any screen is understanding when a referral is needed; if the initial screen indicates increased risk, be prepared to make an immediate referral.

Screening is a key element of the *Zero Suicide* framework, which encourages healthcare organizations to (Corr, 2022):

- Identify individuals with suicide risk using a comprehensive screening and assessment tool.
- Use evidence-based, standardized screening and assessment tools to screen all patients at every visit.
- Have protocols in place for those who screen positive.

A simple screening questionnaire can identify high-risk individuals who otherwise may not be identified. In fact, a brief screening tool can more effective and reliable than leaving the identification up to a clinician's personal judgment or by asking about suicidal thoughts using vague or softened language.

The *Ask Suicide-Screening Questions* (ASQ), approved by the Joint Commission for all ages, is one such tool. It is brief, validated, and takes about 20 seconds to administer; it contains four screening questions (NIMH, 2021).

ASQ Screening Tool

Ask the patient:

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts about killing yourself?
4. Have you ever tried to kill yourself?
5. Are you having thoughts of killing yourself right now?
6. For more detailed information about the ASQ Screening Tool, please go here.

In a *National Institute of Mental Health* study, a "yes" response to one or more of the four questions on the ASQ questionnaire identified 97% of youth at risk for suicide. A multisite research study has demonstrated that the ASQ is also a valid screening tool for adult medical patients (NIMH, 2021).

Additional validated screening tools include the ED Safe Secondary Screener, the Patient Health Questionnaire-9 (PHQ-9), the Patient Safety Screener, and the TASR Adolescent Screener. The Columbia-Suicide Severity Rating Scale can be used for both screening and more in-depth assessment of patients who screen positive for suicidal ideation using another tool (JC, 2019).

Unfortunately, many screening tools do not accurately predict risk of suicide. These tools tend to yield an unacceptably high false-positive prediction rate—many of those determined to be “at risk” never experience clinically significant suicidal thoughts or behavior. This is coupled with an unacceptably low degree of accuracy when identifying true cases—a substantial portion of those individuals who die by suicide were not identified by the screening tools (DVA/DoD, 2019).

5.2 Assessment

> 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.
>
> National Action Alliance for Suicide Prevention

If a client screens positive for increased risk, the standard of care established by the Joint Commission requires a suicide risk assessment. To determine the proper course of treatment, either conduct a more comprehensive assessment or refer your client for secondary screening and assessment (JC, 2019).

Assessing suicide risk should evaluate suicidal thoughts, intent, and behaviors. Warning signs are an important consideration, as well as the presence of risk and protective factors that may increase or decrease the patient’s risk of suicide (DVA/DoD, 2019).

Patients determined to be at a high level of risk should be evaluated by a behavioral health specialist, which can include treatment of co-occurring mental health conditions. Psychiatric hospitalization may be needed if related risk factors—such as acute psychosis—are responsive to inpatient treatment. Outpatient management should include frequent contact, regular re-assessment of risk, and a well-designed safety plan (DVA/DOD, 2019).

In extreme circumstances, if a client or co-worker is judged to meet the criteria as a “danger to self”, a legal process can be initiated whereby a person can be held against their wishes in a locked facility for up to 72 hours. During this time, a more in-depth medical assessment will be completed, and medication management and other safety strategies will be initiated.

5.3 Safety Plans

The *Suicide Prevention Resource Center* and the Joint Commission, among others, recommend safety planning as a standard of care for individuals identified as at-risk for suicide-related behaviors. Safety planning is a brief intervention to help individuals survive suicidal crises by having them develop a set of steps to reduce the likelihood of engaging in suicidal behavior (Moscardini et al., 2020).

Safety planning produces a written plan that restricts access to lethal means. It encourages problem-solving and coping strategies, enhances social support, and identifies a network of emergency contacts. Safety plans should include specific warning signs as well as coping strategies that have been effective in the past (DVA/DOD, 2019).

Safety Planning Intervention has gained widespread acceptance in the suicide prevention community and has been incorporated into numerous treatment guidelines and interventions. The plan is collaboratively built by a clinician and a patient and encourages individuals to engage in six sequential steps when feeling suicidal (Harmer et al., 2024):

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

5.4 Referrals

> Every person can become a suicide prevention gatekeeper. Gatekeepers learn to recognize situational and behavioral clues of someone in a suicidal crisis, how to talk with someone about suicidal thoughts, and how to persuade that person to get help.
>
> KSPG, 2021

Any provider with an ethical duty to assess client safety can initiate the referral process. If clients are referred for hospitalization and agree to be hospitalized, 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.

A confidential referral to appropriate mental health resources should be completed for anyone identified as being at high risk for suicide. Anyone making a referral must assure that the co-worker or patient has all the necessary information to make an informed decision about seeking help.

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

Recognition and referral training can be a valuable training tool even for healthcare providers who already have mental health training. It provides additional education, support, access to resources, and opportunities to practice assessment skills. Despite the comorbidity of mental health disorders and suicide, the vast majority of mental health professionals do not typically receive routine training in suicide assessment, treatment, or risk management.

5.5 Follow-Up and Continuity of Care

Because a variety of healthcare providers, friends, and family members may be associated with the care of a person at risk for suicide, follow-up and 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.

Nevertheless, follow-up is critically important after the initial intervention. This includes regular check-ins, follow-up assessments, and monitoring for any changes in the person's risk for suicide.

Follow-up is often interrupted when patients who are or have been at risk for suicide 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).

A common misconception is that suicide risk is an acute problem that, once dealt with, ends. Unfortunately, individuals who are suicidal commonly experience a return of suicide risk following any number of setbacks, including relapse to substance use, a distressing life event, increased depression, or any number of other situations. Sometimes suicidal behavior even occurs in the context of substantial improvement in mood and energy. Monitoring for signs of a return of suicidal thoughts or behavior is essential (CSAT, 2017).

It is a mistake to think that once a referral has been made, the issue is settled. It is essential to follow up with other providers to determine that appointments are kept. Follow-up emphasizes the importance of watching for a return of suicidal thoughts and behaviors, following up with referrals, and continually coordinating with providers who are addressing the patient's suicidal thoughts and behaviors (CSAT, 2017).

Additional follow-up should include:

- Keeping family members engaged.
- Confirming that the client and family have emergency contacts.
- Removing access to lethal means.
- Completing a treatment termination summary when this stage of care is reached.

CSAT, 2017

Following Up with Margo

Background

Margo is a 27-year-old woman who presented in your office for treatment following a suicide attempt. She had slit her wrists 2 weeks before and was recently discharged from the hospital psych ward.

Screening and Assessment

When Margo is asked if she ever tried to harm herself in the past—how many times and in what ways—she replied: "The first time I thought about suicide, 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. Two weeks ago, I was upset when my boyfriend broke up with me and I slit my wrists in a warm bathtub."

Discussion

When assessing a person for suicidal ideation and behaviors, start by asking broad questions and get more specific as the interview proceeds. Avoid yes/no questions, which can communicate an expectation in favor of either a yes or no response.

At this point in your assessment, it may be unclear whether Margo has a clear intention of taking her life or if she requires higher levels of protection than someone with less inclination toward dying.

The key point about Margo is that her attempts have accelerated and become more sophisticated. Keep in mind that the more times a person attempts suicide, the more likely they are to complete the event. In Margo's case, this should increase your concerns about future risk. Understanding the level of risk will guide your decision about safety, which is the first priority.

What Actions Should You Take?

Margo has just been released from protective custody. What do you think is the most effective care she should receive?

a. A follow-up phone call every month from her doctor.

b. Monitoring, outreach, therapy, and case management.

c. Threatening her with protective custody if she is unable to handle the stresses in her life.

d. Encouraging her to move back home with her parents so they can closely monitor her behavior.

Correct answer: b

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 Margo, who has survived a suicide attempt, effective clinical care and follow-up should focus on community and family support, therapy, and lethal means restriction.

6. Imminent Harm and Lethal Means

6.1 Suicidal Ideation and Risk of Imminent Harm

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, 2024):

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

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, 2025).

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, 2025).

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.

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 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:

- Complete removal of a lethal method.
- Reducing carbon monoxide content emissions from vehicles.
- Interfering with physical access.
- Reducing the appeal of a more lethal method.
- 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. Systems of Care and Best Practices

A **system of care** is a coordinated and integrated delivery system that provides mental health services across multiple sectors and levels of care. The goal of a system of care is to provide comprehensive, accessible, and coordinated care to individuals and families affected by mental health conditions, including suicide. Systems of care must be evidence-based, using best practices developed by suicide prevention specialists and researchers.

7.1 Evidence-informed Care

Evidence-informed care is the use of research and data to inform the development and implementation of mental health policies and programs. This includes the use of evidence-based practices, which are interventions and strategies that have been proven to be effective through rigorous research.

The *National Suicide Prevention Programs* (NSPP), initiated in the 1990s, encourages a holistic approach to combating suicide by improving public education and community engagement. The programs are designed to identify vulnerable groups, reduce stigma, improve the assessment and care of people with suicidal behavior, and improve surveillance and research (Lewitzka et al., 2019).

7.2 Best Practices

Best practice involves identification and assessment of an individual's suicide risk followed by access to appropriate mental health services and treatments, such as crisis intervention, counseling, and medication management. Follow-up, continuity of care, and ongoing monitoring are crucial.

A number of evidence-based best practices have been shown to be successful in reducing suicidal ideation and behaviors. This includes resilience training, stress reduction, psychosocial interventions, and education. Addressing depression and PTSD, encouraging health-promoting behaviors, and the development of programs and crisis lines have also had a positive impact.

7.2.1 Resilience Training

Resilience refers to an individual's ability to deal with challenging circumstances. It can mitigate the negative impact of distressing events and reduce the rate of posttraumatic stress disorders and burnout (Doo and Choi, 2022). Low resilience, defined as the inability to cope with daily stressors and overcome challenges, is a critical determinant of burnout (Nestor et al., 2023).

Healthcare providers who are resilient and experience traumatic events do not experience as many negative psychological symptoms as do people with less resilience. However, there is a belief or expectation—in some cases true, in others not—that nurses, as well as other healthcare personnel have a higher level of resilience than the general population. Nurses can erroneously feel that if they do not deal well with traumatic events, they lack resilience, and it is their fault (Doo and Choi, 2022).

Organizational support is a critical factor in improving resilience among nurses and other healthcare providers. However, during public health emergencies such as the COVID pandemic, many healthcare workers experienced an "unsafe environment and fear of abandonment" within their organizations, which has been related to psychological stress and depression (Doo and Choi, 2022).

7.2.2 Stress Reduction

Strategies to reduce the impact of stressors and increase support for nurses and other healthcare providers are needed at the organizational level. A systems level approach to hardwire coping strategies is important throughout nurses' careers. A new focus on how to process personal and professional grief is needed. Resources are needed for nurses and other healthcare providers traumatized by life (rape, childhood trauma) as well as work-related experiences (James et al., 2023).

The COVID-19 pandemic magnified the ongoing issue of healthcare provider burnout and has led to a marked increase in stress levels. During the height of the pandemic, healthcare providers were inundated with increasingly ill patients while simultaneously having to manage the fear of contracting the infection themselves. They also had to grapple with the risk of carrying the infection to their families—all of which contributes to their increased burden of stress (Nestor et al., 2023).

Hospitals, medical centers, and other institutions have struggled to cope with the toll that the COVID-19 pandemic is taking on healthcare providers. Many hospitals are pro-actively supporting provider wellness by offering coaching, behavioral, and wellness programs.

Health-promoting behaviors—including physical activity, spiritual growth, health responsibility, good nutrition, relaxation, reducing tension, and stress management—have been shown to decrease suicidal ideation. Those who engage in physical activity or participate in sports are at lower risk for suicidal ideation than those who do not. Individuals who feel they have a purpose in life report lower suicidal ideation than those who did not. In terms of social relationships, there is a significant body of literature identifying social support and healthy interpersonal relationships as a protective factor for suicidal ideation (DeBeer et al., 2016).

Did You Know. . .

Studies indicate that Transcendental Meditation has been shown to be effective in the healthcare setting for reducing psychological distress and promoting well-being. In a study involving healthcare providers in Florida, 65 participants practiced TM at home for 20 minutes 2 times per day. The practice rapidly and dramatically reduced symptoms of burnout, insomnia, and psychological distress, while also improving overall well-being (Nestor et al., 2023).

7.2.3 Psychological and Psychosocial Interventions

Many types of psychological and psychosocial interventions—such as psychotherapy and peer support—can be beneficial for individuals who are experiencing suicidal ideation or behaviors. These interventions help people learn new ways of dealing with stressful experiences, recognize patterns of thinking, and identify alternative actions when thoughts of suicide arise.

Psychotherapy usually takes place in a one-on-one or group format and can vary in duration from several weeks to ongoing therapy. Treatment promotes collaborative and integrated care, which can engage and motivate patients, increase retention in therapy, and decrease suicide risk (Stone et al., 2017).

Peer support is an intervention that has the potential to address suicide risk. Peers providing emotional support and sharing their experience of recovery increases connectedness and reduces hopelessness among support recipients, two key factors for preventing suicidal ideation. Peer support may also reduce suicide risk by decreasing stigma, increasing orientation to personal growth and recovery, and encouraging active care engagement (Bowersox et al., 2021).

The U.S. *National Suicide Prevention Strategy* and other guidelines have included recommendations that peer support be integrated into the care of individuals at high risk for suicide. Mutual peer support groups have a long tradition of providing support to individuals in recovery from mental health crises, and historically, these groups grew out of a desire for alternatives to psychiatric hospitalization (Bowersox et al., 2021).

Don't Clock Out

Don't Clock Out is an organization founded in 2022 that advocates for nurses living with mental illness and PTSD. It provides a digital crisis intervention platform to members of the nursing community who are considering suicide. It was founded following the suicide of Michael Odell, who left his shift and jumped to his death from a San Francisco Bay Area bridge. For more information about their Self Care Unit Podcast and Weekly Support Group, please click here.

7.2.4 Education Programs

Suicide prevention education programs aim to improve knowledge of suicide, specifically in relation to risk factors, protective factors, and warning signs. These programs seek to improve the way people respond to and provide support for vulnerable individuals. Multiple systematic reviews have found that education programs can make a positive contribution to suicide prevention, both for gatekeepers working across a range of settings and for specific vulnerable groups (Ferguson et al., 2018).

Education programs can contribute to favorable shifts in knowledge, attitudes, skills, and confidence, particularly in the short term. There is strong evidence to support the training of general practitioners to recognize and treat depression and anxiety as a suicide prevention strategy.

Less is known about the value of suicide-specific education programs for other health professionals, particularly the nursing profession (Ferguson et al., 2018). Suicide prevention work needs to be given greater focus both in education as well as in ongoing clinical work. Nurses need the right skills to meet suicidal patients, as it has been shown to reduce stigma in patients and make nurses pay more attention to and prioritize suicide prevention work to a greater extent (Wärdig et al., 2022).

7.2.5 Especially for Nurses

Suicide prevention programs should address both institutional and individual factors associated with nurse suicide. Transitions into retirement and job loss are vulnerable times warranting psychological support (James et al., 2023).

After a suicide, nurse colleagues must continue to deliver patient care as they grieve. A standard operating procedure for how to handle the suicide of a nurse colleague does not exist, compared with what is available for physicians (Davidson, Mendis et al., 2018a).

Without a predefined process, each unit manager is left to independently develop a grief recovery plan to support staff in processing their emotions. It is common that, no one, at any level, is comfortable talking about a suicide that has occurred (Davidson, Mendis et al., 2018a).

7.2.6 Healer Education Assessment and Referral

A program initially designed for physicians, residents, and medical students, the *Healer Education Assessment and Referral* (HEAR) program provides education, assessment, and referral services to individuals who may be at risk for suicide.

The **education component** of the HEAR program provides information and resources to individuals and their families, including warning signs of suicide, how to identify individuals at risk, and how to access appropriate resources for help.

The **assessment component** involves a thorough evaluation of the at-risk individual's mental and emotional state, as well as identification of risk factors for suicide. This can include a review of an individual's medical and mental health history, a psychological assessment, and a review of social and family support systems.

The **referral component** of the HEAR program involves connecting individuals and their families with appropriate resources for help, such as mental health professionals, support groups, and crisis hotlines. Healers may also provide ongoing support and follow-up care to ensure that individuals are receiving the help they need to stay safe and healthy.

The HEAR program has been piloted for nurses with promising results. The initial pilot program, conducted in 2016, yielded some surprising results. Participating nurses reported more stress and distress than previous results from physicians. Nurses reported higher rates of intense affective states than physicians (e.g., feelings of intense loneliness, hopelessness, desperation, and loss of control (Accardi et al., 2020).

7.2.7 Community Engagement

Community engagement encourages involvement in a range of social activities. The goal is to improve physical health, reduce stress, and decrease depressive symptoms. Involving community members from the beginning and respecting them as experts on their own experience is critically important. Becoming familiar with the community's history, risk and protective factors, cultural norms around language and communication, and beliefs about death are important for program organizers.

Besides educating the community about suicide warning signs and reducing stigma, community organizers and healthcare providers can work to increase:

- Knowledge of interventions (e.g., alerting emergency services)
- The intention to intervene
- Confidence to intervene (Worsteling and Keating, 2022)

Additional community-based interventions such as gatekeeper training, media campaigns, and support groups can reduce the risk of suicide. Collaboration, working with community partners, schools, hospitals, and law enforcement creates a coordinated response to suicide prevention. Data collection and monitoring of suicide rates and trends help organizations develop and implement suicide prevention strategies.

The *American Foundation for Suicide Prevention* offers an array of community programs for suicide education and prevention. The Nevada chapter, focuses on eliminating the loss of life from suicide by delivering innovative prevention programs, educating the public about risk factors and warning signs, raising funds for suicide research and programs, and reaching out to those individuals who have lost someone to suicide.

7.2.8 Pharmacologic Treatment

Pharmacologic treatment can be helpful in managing underlying mental disorders and address the danger of repeated or dangerous self-directed violence. If the individual is under the influence of alcohol, illicit substances, or other medications, the amount and type of medication must be carefully chosen and titrated.

All medications used by patients at risk for suicide should be reviewed. When prescribing drugs to people who are at risk for self-harm, consider the toxicity of prescribed drugs, limit the quantity dispensed or available, and identify another person who is willing to be responsible for securing access to medications (DVA/DOD, 2019).

Treatment of depression, bipolar disorder, and borderline personality disorder is essential. This can include selective serotonin uptake inhibitors, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, lithium, or antipsychotics (Harmer et al., 2024). Individuals who have psychiatric and substance use problems should receive psychosocial interventions along with medication.

Only two evidence-based medications have been shown to lower suicidal behaviors: lithium and clozapine. However, these medications do not reach therapeutic levels immediately. Anxiolytics, sedative/hypnotics, and short-acting antipsychotic medications may be used to directly address agitation, irritability, psychic anxiety, insomnia, and acute psychosis, until such time as a behavioral health assessment can be made.

8. Ethical and Legal Considerations

Suicide is a difficult subject, both ethically and legally. Challenges, conflicts, and dilemmas can arise that influence the care and treatment of patients. Addressing these problems requires both competence and knowledge about ethical and legal issues related to suicidal ideation and behaviors.

8.1 Ethical Considerations

Healthcare providers are facing more and more challenging and complicated ethical situations. From and ethical standpoint, when the welfare of the patient is compromised, healthcare providers must act in the patient's best interest.

To guide ethical practice, four ethical principles are commonly cited: (1) beneficence (do good), (2) nonmaleficence (do no harm), (3) autonomy (control by the individual), and (4) justice (fairness). However, these traditional bioethical principles can be confusing when applied to the ethics of suicide care. A healthcare providers' duty to do no harm can contradict a suicidal patient's autonomy regarding end-of-life decision-making, leading to ethical dilemmas for the provider (Montreuil et al., 2021).

Recent studies have examined the lived experiences and perceptions of various healthcare providers caring for suicidal patients. These studies highlight the various emotional and ethical challenges that accompany caring for this patient population. Two recurrent themes include: (1) a desire for additional training on suicide care and (2) concern about the lack of evidence-based clinical guidelines to assist in suicidal patient management (Montreuil et al., 2021).

Ethics-related stress is nothing new. Many nurses and other frontline workers have long perceived limited respect for their work and describe increased dissatisfaction with their work situations. According to the National Council of State Boards of Nursing, nearly 100,000 nurses say they are considering leaving the profession for other jobs.

Although the COVID-19 pandemic has exacerbated many of these trends, it is often not the root cause of the problem, nor are the issues isolated to the United States. In fact, the main drivers of nurses' intent to leave are frequently identified as more durable issues or problems, such as insufficient staffing levels, desire for higher pay, not feeling listened to or supported at work, and the emotional toll of the job (Martin et al., 2023).

Definitions

- **Morality**: personal values, character, or conduct of individuals within communities and societies.
- **Ethical principle**: a general guide, basic truth, or assumption that can be used with clinical judgment to determine a course of action.
- **Code of ethics**: describes the obligations, values, and ideals for a profession.

Montreuil et al., 2021

8.2 Ethical Issues During COVID

> COVID-19 has been a uniquely traumatic experience for the health workforce and their families, pushing them past their breaking point. We owe them a debt of gratitude and action. And if we fail to act, we will place our nation's health at risk.
>
> Former Surgeon General Vivek Murthy May 23, 2022

During the COVID pandemic, nurses and other healthcare providers were faced with uncertainty and trauma. This was related to caring for patients with COVID-19, inadvertently killing patients due to crisis workloads, contracting COVID-19, the risk of transmitting COVID to family members, and job loss. Political unrest and financial upsets also contributed to a feeling of uncertainty (James et al., 2023).

The COVID pandemic subjected people to serious restrictions of their liberties: quarantine and mask requirements, vaccine mandates, closed borders, curfews, and restrictions on free movement. Events and gatherings were banned, and visitors were denied access to healthcare facilities, even when spouses, family members, and friends were seriously sick or dying. Contact tracing required people to reveal personal information, and many people were prevented from attending school or going to work (Biller-Andorno and Spitale, 2022).

Ethical issues related to equity and fairness—especially access to scare resources such as healthcare services, equipment, medications, and vaccines—became complex issues at every level and in every country. Key considerations emerged related to maximizing utility, nondiscrimination, fairness, and protection of vulnerable groups (Biller-Andorno and Spitale, 2022).

The pandemic and its management put high demands on public trust. Particularly in the early phase, there was a lack of evidence related to infection rates, treatments, preventive measures, case fatality rates, or risk factors. The lack of high-quality evidence contrasted with the abundance of mis- and disinformation, especially on social media (Biller-Andorno and Spitale, 2022).

Healthcare professionals experienced situations that violated their moral codes and values. They were asked to make difficult ethical decisions that often ran counter to their training and their fundamental concern for the wellbeing of their patients. They often had to set aside patient care to perform other tasks related to the pandemic. They had to keep up to date with public health guidelines, such as when to place COVID-19 patients in isolation, when to sedate them, or admit them to intensive care. Some of these practices went against the moral principles underpinning ethical care. The severity and gravity of the pandemic led to ethical conflicts and chronic stress, emotional exhaustion, depersonalization, and a lack of personal fulfilment (Muñoz-Quiles et al., 2022).

Many healthcare professionals experienced frequent ethical conflicts accompanied by intense concern and distress. These ethical conflicts were related to a lack of resources and a sense of powerlessness. Frequent exposure to potentially harmful events often increased depression, anxiety, psychological distress, and poor sleep quality (Muñoz-Quiles et al., 2022).

Training in ethical conflicts and moral deliberation in teams is one of the key strategies needed to address day-to-day care and to handle future situations that are similar to the COVID-19 pandemic. Building moral resilience and developing the ability to maintain or restore personal integrity in the face of moral adversity is a valuable personal resource in response to moral and ethical conflicts (Muñoz-Quiles et al., 2022).

8.3 Legal Considerations

> What every single lawyer does is send for the records and goes through the records with a fine-toothed comb. Many cases fall into a category I call ignoring the obvious. Ignoring the obvious is often reflected in either inadequate suicide assessments or risky medication practices. And again, as you've heard over and over, no matter how good the care is, if it isn't written down it didn't happen.
>
> Susan Stefan, 2019

Nurses can be reprimanded or have their licenses revoked for not following the *Nurse Practice Act* in the state they are practicing. They can also be held legally liable for negligence, malpractice, or breach of patient confidentiality when providing patient care. Legal issues can arise related to failure to assess, insufficient monitoring, failure to communicate, and failure to follow protocols (Ernstmeyer and Christman, 2024).

Laws allowing full scope of practice for nurse practitioners and greater ease of practice for RNs have been associated with lower population-level rates of suicide and homicide. These findings suggest that laws favorable to full nursing practice have a protective relationship to population health, including injuries (Choi et al., 2020).

8.3.1 Reasonable and Prudent Care

Reasonable and prudent care means a nurse uses good judgment in providing nursing care according to accepted standards and that another nurse with similar education and experience in similar circumstances would provide. In the context of suicidal behaviors, reasonable and prudent involves:

- Systematically assessing and formulating risk.
- Protecting the patient from self-harm.
- Developing a treatment plan to reduce assessed risk.
- Implementing the treatment plan.
- Evaluating progress and revising or modifying treatment plan as needed.
- Recognizing the need for follow-up and continuity of care.

8.3.2 Professional Judgment

Standard of care is a legal concept that describes what is expected of a reasonable and prudent healthcare practitioner. It means a provider is reasonably competent and reasonably aware of suicide literature. It means a provider has done a systematic suicide assessment, getting all the information needed to protect a patient. Professional judgment can fall below the accepted standard of care when the nurse or clinician (Simpson, Berman, Stefan, 2015):

- Kept poor records.
- Has no documented reasoning.
- Did not “think on the record.”
- Has no reasonable explanations for the failure to intervene and protect the patient.
- Engaged in standard care (everyone does it) v. standard of care.

To avoid the risk of jeopardizing—or even losing a nursing license—it is essential that nurses (and nursing students) follow the scope and standards of practice set forth by their state’s *Nurse Practice Act* as well as their organization’s policies, procedures, and protocols (Ernstmeyer & Christman, 2024).

8.3.3 Patient Confidentiality

> For patients who screen positive for suicide ideation and deny or minimize suicide risk or decline treatment, obtain corroborating information by requesting the patient's permission to contact friends, family, or outpatient treatment providers. If the patient declines 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.
>
> Sentinel Event Alert, The Joint Commission,
> Issue 56, February 24, 2016

Patient confidentiality is a major legal consideration—especially in the event of a co-worker's suicide or suicide attempt. Every person has the right to have personal, identifiable medical information kept private. This right is protected by federal regulations under the *Health Insurance Portability and Accountability Act* (HIPAA). HIPAA regulations extend beyond medical records and apply to patient information shared with others (Ernstmeyer & Christman, 2024).

Posting to social media sites has the potential to put nurses and other healthcare providers in legal jeopardy. Information related to co-workers, patients, patient care, or a healthcare organization should never be posted on social media. Healthcare workers (and students) who violate this guideline can lose their jobs, may face legal action, or can be disciplined or expelled from their nursing program (Ernstmeyer & Christman, 2024).

9. Concluding Remarks

Suicide is considered to be a preventable public health problem, though prevention efforts are beset by seemingly unsurmountable individual, relationship, and societal issues. It is important to keep in mind that, although mass shootings are in the news on a daily basis, nearly twice as many suicides as homicides occur each year in the United States.

For nurses and other healthcare professionals, recognizing warning signs, risk, and protective factors and understanding the importance of screening and assessment can help suicidal patients and co-workers get the help they need to prevent self-harm. Yet nurses and other direct care providers consistently point to the need for training (and experience) to better help them identify people at risk for suicide.

The COVID pandemic laid bare weaknesses that have plagued our healthcare system for many years. Several thousand healthcare workers died from COVID and many more fell ill, highlighting the dangers faced by these workers. Co-worker deaths from COVID and from suicide, societal frustration, and an alarming shortage of needed equipment and supplies placed a tremendous burden on nurses and other direct care providers.

As we emerge from the global pandemic, remember that many of the troubling issues that healthcare providers faced during the pandemic are still with us. The job is still stressful. Institutional support for workers is still uneven and in some sectors of our healthcare system, completely lacking. There are still massive staffing shortages. And nurse suicides are still happening.

Suicide among nurses is more common than generally acknowledged and is often shrouded in silence, at least in part due to stigma related to mental health and its treatment. In the nursing profession, there is an alarming lack of research on the factors that cause a nurse to commit suicide.

Education and training, along with institutional support are urgently needed to improve identification of people at risk for suicidal ideation and behaviors. Programs such as the Healer Education, Assessment, and Referral program piloted for nurses at the University of California at San Diego is an innovative program that provides support and resources for those in need. This program, along with other suicide education and support programs can change the lives of people at risk for suicide.

[Continue to next page to view references]

10. References

Accardi R, Sanchez C, Zisook S, et al. (2020). Sustainability and Outcomes of a Suicide Prevention Program for Nurses. *Worldviews on Evidence-Based Nursing*, 2020; 17:1, 24–31. Retrieved January 16, 2025 from https://pubmed.ncbi.nlm.nih.gov/32017435/.

Akee R, Feir DL, Gorzig MM, Myers S. (2024). Native American “deaths of despair” and economic conditions. *Research in Social Stratification and Mobility*. Volume 89, 2024 Retrieved April 19, 2025 from https://www.sciencedirect.com/science/article/pii/S0276562423001245.

American Federation for Suicide Prevention (**AFSP**). (2021). Suicide Data: Kentucky. Retrieved January 17, 2025 from https://aws-fetch.s3.amazonaws.com/state-fact-sheets/2021/2021-state-fact-sheets-kentucky.pdf.

Balbuena LD, Baetz M, Sexton JA, et al. (2022). Identifying long-term and imminent suicide predictors in a general population and a clinical sample with machine learning. BMC Psychiatry 22:120. Retrieved April 22, 2025 from https://bmcpsychiatry.biomedcentral.com/track/pdf/10.1186/s12888-022-03702-y.pdf.

Biller-Andorno N and Spitale G. (2022). Addressing Volatile Ethical Issues of Covid-19 with the Core Five Enduring Values List for Health Care Professionals. *NEJM Catalyst*. Retrieved January 16, 2025 from https://catalyst.nejm.org/doi/full/10.1056/CAT.22.0108.

Bowersox NW, Jagusch J, Garlick J, Chen JI, and Pfeiffer PN. (2021). Peer-based interventions targeting suicide prevention: A scoping review. *Am J Community Psychol* 0:1–17. Retrieved January 16, 2025 from https://cectresourcelibrary.info/wp-content/uploads/2021/07/Bowersox-et-al_peer-based-interventions-targeting-suicide-1.pdf.

Center for Substance Abuse Treatment (**CSAT**). (2017). Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment. A Treatment Improvement Protocol (TIP) Series, No. 50. HHS Publication No. (SMA) 154381. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved January 16, 2025 from https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4381.pdf.

Centers for Disease Control and Prevention (**CDC**). (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved April 22, 2025 from https://www.cdc.gov/suicide/pdf/preventionresource.pdf.

Centers for Disease Control and Prevention (**CDC**). (2021, November 5). Suicide in the U.S. Declined During the Pandemic. Retrieved January 16, 2025 from https://www.cdc.gov/nchs/pressroom/podcasts/2021/20211105/20211105.htm.

Choi KR, Takada S, Saadi A, et al. (2020). The relationship of nursing practice laws to suicide and homicide rates: a longitudinal analysis of US states from 2012 to 2016. *BMC Health Serv Res 20*, 176 (2020). Retrieved January 16, 2025 from https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-020-5025-x.

Connecticut Department of Public Health (**CDPH**). (2024). Self-Directed Violence in Connecticut: a Fact Sheet—2023 Update. Retrieved January 17, 2025 from https://www.preventsuicidect.org/wp-content/uploads/2025/01/2023-Self-Directed-Violence-Fact-Sheet-Final-10.18.24.pdf.

Connecticut Suicide Advisory Board (**CSAB**). (2025). State of Connecticut Suicide Prevention Plan 2020-2025. Retrieved January 17, 2025 from https://www.preventsuicidect.org/wp-content/uploads/2021/05/Suicide-Prevention-Plan-2020-2025.pdf.

Corr A. (2022). A Proven Roadmap to Reduce Suicides Starts with Transformative Health Care. *Pew Trusts*. Retrieved January 16, 2025 from https://www.pewtrusts.org/en/research-and-analysis/articles/2022/09/06/a-proven-roadmap-to-reduce-suicides-starts-with-transformative-health-care.

Davidson JE, Stuck AR, Zisook S, Proudfoot J. (2018a). Testing a Strategy to Identify Incidence of Nurse Suicide in the United States. *The Journal of Nursing Administration*, 48(5), 259-265. Pubmed ID: 29672372. Retrieved January 16, 2025 from https://escholarship.org/uc/item/0km9q5sr.

Davidson J, Mendis J, Stuck AR, DeMichele G, and Zisook S. (2018b). Nurse Suicide: Breaking the Silence. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC. Retrieved January 16, 2025 from https://nam.edu/nurse-suicide-breaking-the-silence/.

Davis MA, Cher BAY, Friese CR, Bynum JPW. (2021). Association of US Nurse and Physician Occupation With Risk of Suicide. *JAMA Psychiatry*. 2021;78(6):651–658. Retrieved January 16, 2025 from https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2778209.

Davison J, Mackay B, McGivern MJ. (2017). The Potential of Simulation to Enhance Nursing Students' Preparation for Suicide Risk Assessment: A Review. *Open Journal of Nursing*, Vol.7 No.2, 2017. Retrieved January 16, 2025 from https://www.scirp.org/journal/paperinformation.aspx?paperid=73969.

Defense Suicide Prevention Office (**DSPO**). (2020). Lethal Means Safety for Military Service Members and Their Families. Retrieved January 16, 2025 from https://www.dspo.mil/Portals/113/Documents/DSPO%20Lethal%20Means%20Safety%20Guide%20for%20Military%20Service%20Members%20and%20Their%20Families_v34_FINAL.pdf?ver=AF6RRG7pGAIcAqjtQQDyVg%3D%3D.

DeBeer BB, Kittel JA, Cook A, et al. (2016). Predicting suicide risk in trauma exposed veterans: The role of health promoting behaviors. *PLoS ONE* 11(12): e0167464. Retrieved January 16, 2025 from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0167464.

Department of Veterans Affairs (DVA). (2024). Mental Health: Suicide Prevention. Retrieved April 22, 2025 from https://www.mentalhealth.va.gov/suicide_prevention/.

Department of Veterans Affairs/Department of Defense (**DVA/DoD**). (2019). VA/DOD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide. Version 2.0–2019. Retrieved January 16, 2025 from https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf.

Diehl E, Rieger S, Letzel S et al. (2021). The relationship between workload and burnout among nurses: The buffering role of personal, social and organisational resources. *PLoS One*. Retrieved April 21, 2023 from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0245798.

Doo E-Y and Choi S. (2022) Effect of Nurses' Work Experiences in a COVID-19 Unit on Depression: Mediation Effect of Resilience and Moderated Mediation Effect of Organizational Trust. *Front. Public Health* 10:897506. Retrieved January 16, 2025 from https://www.frontiersin.org/articles/10.3389/fpubh.2022.897506/full.

Erfani P, Chin ET, Lee CH, Uppal N, Peeler KR. (2021). Suicide rates of migrants in United States immigration detention (2010–2020). *AIMS Public Health*, Volume 8, Issue 3: 416-420. Retrieved April 19, 2025 from https://www.aimspress.com/article/doi/10.3934/publichealth.2021031#b5.

Ernstmeyer K & Christman E. (Eds.). (2024). Legal Considerations and Ethics. *Open RN Nursing Fundamentals* by Chippewa Valley Technical College. Retrieved January 16, 2025 from https://wtcs.pressbooks.pub/nursingfundamentals/chapter/1-6-legal-considerations-and-ethics/.

Ferguson M, Reis JA, Rabbetts L, Ashby H-J, Bayes M, McCracken T, Ross C, Procter NG. (2018.) The effectiveness of suicide prevention education programs for nurses. *Crisis*, 39, no. 2, pp. 96-109. Retrieved January 16, 2025 from https://unisa.alma.exlibrisgroup.com/view/delivery/61USOUTHAUS_INST/12250718260001831.

Fosse R, Ryberg W, Carlsson MK, Hammer J. (2017). Predictors of suicide in the patient population admitted to a locked-door psychiatric acute ward. *PLoS ONE* 12(3): e0173958. Retrieved January 16, 2025 from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0173958.

Harmer B, Lee S, Duong TVH, Saadabadi A. (2024). Suicidal Ideation. In: *StatPearls*. Treasure Island (FL): StatPearls Publishing; 2023 Feb–. Retrieved January 16, 2025 from https://pubmed.ncbi.nlm.nih.gov/33351435/.

Harmer B, Lee S, Duong TVH, Saadabadi A. (2022). Suicidal Ideation. In: StatPearls. Treasure Island (FL): *StatPearls* Publishing; 2022 Jan–. PMID: 33351435. Retrieved April 19, 2025 from https://pubmed.ncbi.nlm.nih.gov/33351435/.

Health and Human Services (**HHS**). (2021, January 19). The Surgeon General's Call to Action to Implement the National Strategy. Retrieved January 16, 2025 from https://www.hhs.gov/sites/default/files/sprc-call-to-action.pdf.

Health and Human Services (**HHS**). (2024). 2024 National Strategy for the Prevention of Suicide. Retrieved April 22, 2025 from https://www.hhs.gov/programs/prevention-and-wellness/mental-health-substance-use-disorder/national-strategy-suicide-prevention/index.html.

Horowitz LM, Boudreaux ED, Schoenbaum M, Pao M, Bridge JA. (2018). Universal Suicide Risk Screening in the Hospital Setting: Still a Pandora's Box? January 2018 Volume 44, Issue 1, Pages 1–3. Retrieved January 16, 2025 from https://www.jointcommissionjournal.com/article/S1553-7250(17)30544-5/fulltext#back-bib0035.

Ingram J, Lyford B, McAtamney A, et al. (2022). Preventing suicide in refugees and asylum seekers: a rapid literature review examining the role of suicide prevention training for health and support staff. *Int J Ment Health Syst* 16, 24. Retrieved April 19, 2025 from https://ijmhs.biomedcentral.com/articles/10.1186/s13033-022-00534-x.

James K E, Agarwal S, Armenion K L, Clapp C, Barnes A, Ye G Y, Zisook S, & Davidson J E. (2023). A deductive thematic analysis of nurses with job-related problems who completed suicide during the early COVID-19 pandemic: A preliminary report. *Worldviews on Evidence-Based Nursing*, 00, 1– 11. Retrieved January 16, 2025 from https://sigmapubs.onlinelibrary.wiley.com/doi/10.1111/wvn.12640.

Joint Commission, The (**JC**). (2019). National Patient Safety Goal for suicide prevention. Retrieved January 16, 2025 from https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf.

Kafle S, Paudel S, Thapaliya A, Acharya R. (2022). Workplace violence against nurses: a narrative review. *J Clin Transl Res*. 2022 Sep 13;8(5):421-424. Retrieved January 16, 2025 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9536186/.

Kentucky Department of Education (**KY DOE**). (2025). Suicide Prevention and Awareness. Retrieved January 17, 2025 from https://www.education.ky.gov/school/sdfs/Pages/Suicide-Prevention-and-Awareness.aspx.

Kentucky Suicide Prevention Group (**KSPG**). (2021). Suicide Prevention Resources. Retrieved January 17, 2025 from https://www.kentuckysuicideprevention.org/.

Kivisto AJ. (2022). Beyond Legislative Lethal Means Restriction Approaches to Suicide Prevention. *Journal of the American Academy of Psychiatry and the Law Online*, 50 (2) 170-176; Retrieved January 16, 2025 from http://jaapl.org/content/50/2/170.

Kuhlmann E, Brînzac MG, Czabanowska K, et al. (2023). Violence against healthcare workers is a political problem and a public health issue: a call to action. *European Journal of Public Health*, Volume 33, Issue 1, February 2023. Retrieved January 16, 2025 from https://academic.oup.com/eurpub/article/33/1/4/6889488.

Lewitzka U, Sauer C, Bauer M., et al. (2019). Are national suicide prevention programs effective? A comparison of 4 verum and 4 control countries over 30 years. *BMC Psychiatry* 19, 158. Retrieved January 16, 2025 from https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-019-2147-y.

Li M, Bergren S, Simon M, et al. (2022). Cultural attributes of suicidal ideation among older immigrants: a qualitative study. *BMC Geriatr* 22, 678. Retrieved April 19, 2025 from https://bmcgeriatr.biomedcentral.com/articles/10.1186/s12877-021-02628-6#Sec1.

Martin B, Kaminski-Ozturk N, O'Hara C, Smiley R. (2023). Examining the Impact of the COVID-19 Pandemic on Burnout and Stress Among U.S. Nurses. *J Nurs Regul*. 2023 Apr;14(1):4-12. Retrieved January 16, 2025 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10074070/.

McCann, Adam (2024). Best and Worst States for Health Care. WalletHub. Retrieved January 9, 2025 from https://wallethub.com/edu/states-with-best-health-care/23457.

McKernan LC, Clayton EW, Walsh CG. (2018). Protecting Life While Preserving Liberty: Ethical Recommendations for Suicide Prevention with Artificial Intelligence. *Frontiers in Psychiatry*. Volume 9, 2018. Retrieved January 16, 2025 from https://www.frontiersin.org/articles/10.3389/fpsyt.2018.00650/full.

Montreuil M, Séguin M, P Gros C, Racine E. (2021). Everyday ethics of suicide care: Survey of mental health care providers' perspectives and support needs. *PLoS One*. 2021 Apr 22;16(4):e0249048. Retrieved January 16, 2025 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8061990/.

Moscardini EH, Hill RM, Dodd CG, Do C, Kaplow JB, Tucker RP. (2020). Suicide Safety Planning: Clinician Training, Comfort, and Safety Plan Utilization. *Int J Environ Res Public Health*. 2020 Sep 4;17(18):6444. Retrieved January 16, 2025 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7559434/.

Muñoz-Quiles JM, Ruiz-Fernández MD, Hernández-Padilla JM, et al. (2022). Ethical conflicts among physicians and nurses during the COVID-19 pandemic: A qualitative study. *Journal of Evaluation in Clinical Practice*. Retrieved January 16, 2025 from https://onlinelibrary.wiley.com/doi/10.1111/jep.13742.

National Center for Health Statistics (**NCHS**). (2024, October 7). Suicide and Self-Harm Injury. Retrieved January 16, 2025 from https://www.cdc.gov/nchs/fastats/suicide.htm.

National Center for Health Statistics (**NCHS**). (2024, July 23). Suicide Mortality in the United States, 2000–2020. NCHS Data Brief No. 433. Retrieved January 16, 2025 from https://www.cdc.gov/nchs/products/databriefs/db433.htm.

National Institute of Mental Health (**NIMH**). (2021). Ask Suicide-Screening Questions (ASQ) Toolkit. Retrieved January 16, 2025 from https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials.

Nestor MS, Lawson A, Fischer D. (2023). Improving the mental health and well-being of healthcare providers using the transcendental meditation technique during the COVID-19 pandemic: A parallel population study. *PLoS One*. Retrieved January 16, 2025 from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0265046.

Northern Nevada Public Health (**NNPH**). (2024). Suicide Prevention. Retrieved January 16, 2025 from https://www.nnph.org/programs-and-services/cchs/chronic-disease-prevention/injury-prevention/suicide-prevention.php.

Ratkowska K and De Leo D. (2013). Suicide in Immigrants: An Overview. *Open Journal of Medical Psychology*, Vol. 2 No. 3, 2013, pp. 124-133. Retrieved April 19, 2025 from https://file.scirp.org/Html/7-2250046_34019.htm.

Roškar S, Kralj D, Andriessen K, Krysinska K, Vinko M and Podlesek A. (2022). Anticipated Self and Public Stigma in Suicide Prevention Professionals. *Front. Psychiatry* 13:931245. Retrieved January 16, 2025 from https://www.frontiersin.org/articles/10.3389/fpsyt.2022.931245/full.

Salt E, Wiggins AT, Cerel J, Hall CM, Ellis M, Cooper GL, Adkins BW, Rayens MK. (2023). Increased rates of suicide ideation and attempts in rural dwellers following the SARS-CoV-2 pandemic. *J Rural Health*. 2023 Jan;39(1):30-38. Retrieved January 16, 2025 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9349837/.

Simpson S, Berman L, Stefan S. (2015). Legal and Liability Issues in Suicide Care. *Zero Suicide in Health and Behavioral Health Care*. Retrieved January 16, 2025 from https://zerosuicide.edc.org/sites/default/files/Legal%20and%20Liability%20Issues%20in%20Suicide%20Care%205.27.16%20PPT%20Transcript.pdf.

Stone DM, Holland KM, Bartholow B, et al. (2017). Preventing suicide: A technical package of policies, programs, and practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved January 16, 2025 from https://stacks.cdc.gov/view/cdc/44275.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2025). 988 Suicide and Crisis Helpline: Best Practices. Retrieved April 22, 2025 from https://988lifeline.org/best-practices/.

Vidal-Alves MJ, Pina D, Puente-López E, Luna-Maldonado A, Luna Ruiz-Cabello A, Magalhães T, Pina-López Y, Ruiz-Hernández JA, Jarreta BM. (2021). Tough Love Lessons: Lateral Violence among Hospital Nurses. *Int J Environ Res Public Health*. 31;18(17):9183. Retrieved January 16, 2025 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8431196/.

Wärdig RE, Hultsjö S, Lind M, Klavebäck I. (2022). Nurses' Experiences of Suicide Prevention in Primary Health Care (PHC): A Qualitative Interview Study. *Issues in Mental Health Nursing*. Retrieved January 16, 2025 from https://www.diva-portal.org/smash/get/diva2:1690285/FULLTEXT01.pdf.

Washington State Department of Health (**WSDOH**). (2016). Washington State Suicide Prevention Plan. Retrieved January 16, 2025 from http://www.doh.wa.gov/Portals/1/Documents/Pubs/631-058-SuicidePrevPlan.pdf.

Worsteling A, Keating BW. (2022). Community and bystander interventions for the prevention of suicide: Protocol for a systematic review. *PLoS ONE* 17(6): e0270375. Retrieved January 16, 2025 from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0270375.

[Continue to next page to start quiz]

Quiz: Suicide Prevention (359)

Module 1

1. Suicide is a major public health concern. In the United States in 2021, there were more than twice as many suicides as homicides.

a. True
b. False

2. Between 2007 and 2018, the incidence of suicide among nurses nationally was significantly greater than among the general population.

a. True
b. False

3. The loss of a nurse colleague to suicide is more common than generally acknowledged and is often shrouded in silence.

a. True
b. False

Module 2

4. Warning signs of suicide:

a. Are present in the vast majority 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.

Module 3

5. Two strong individual risk factors for suicide are:

a. Local epidemics and access to medical care.
b. Previous suicide attempt and an unwillingness to seek help.
c. Cultural and religious beliefs and financial loss.
d. Willingness to seek help and female gender.

6. Among nurses and physicians, poisoning is the most common method of suicide.

a. True
b. False

7. Suicide is a leading cause of death among people with substance use disorders.

a. True
b. False

Module 4

8. Chronic toxic stress:

a. Is more common in doctors than in nurses.
b. Occurs when an individual is exposed to prolonged or repeated traumatic events.
c. Usually dissipates when the reason for the stress is removed.
d. Is not a problem in most healthcare occupations.

Module 5

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 client's mental state and provide immediate psychosocial counseling.

10. A suicide safety plan:

a. Produces a written plan that restricts access to means for completing suicide.
b. Encourages problem-solving and coping strategies.
c. Enhances social support and identifies a network of emergency contacts.
d. All of the above.

11. Anyone at high risk for suicide:

a. Should be given time off to rest and recuperate.
b. Should have a confidential referral to appropriate mental health resources completed.
c. Should be restrained and sent to a locked ward.
d. Should be arrested.

12. Following a suicide attempt, followup care involves:

a. Keeping family members engaged.
b. Confirming that the client and family have emergency contacts.
c. Removing access to lethal means.
d. All of the above.

Module 6

13. Imminent harm means a person is thought to be at immediate risk of self-harm or suicide.

a. True
b. False

14. Restricting access to lethal means can include:

a. Complete removal of a lethal method.
b. Reducing carbon monoxide content emissions from vehicles.
c. Limiting children's access to firearms in the home.
d. All of the above.

Module 7

15. Education programs about suicidal ideation and behaviors can contribute to favorable shifts in knowledge, attitudes, skills, and confidence, particularly in the short term.

a. True
b. False

16. The HEAR program, piloted for nurses in 2016, found that nurses:

a. Reported much less stress and distress than physicians.
b. Have much higher resilience that other healthcare providers.
c. Reported higher rates of intense loneliness, hopelessness, desperation, and loss of control than physicians.
d. Say they already know all they need to know about suicide.

17. The only two evidence-based medications that have been shown to lower suicidal behaviors are:

a. Antidepressants and antiepileptics.
b. Benzodiazepines and antianxiety medications.
c. Lithium and clozapine.
b. Antivirals and antidepressants.

Module 8

18*. Standard of care* is a legal concept that describes:

a. What is expected of a reasonable and prudent healthcare practitioner.
b. That a provider is reasonably competent and reasonably aware of suicide literature.
c. That a provider has done a systematic suicide assessment, getting all the information needed to protect a patient.
d. All of the above.

19. Reasonable and prudent care means a nurse uses good judgment in providing nursing care according to accepted standards and that another nurse with similar education and experience in similar circumstances would provide.

a. True
b. False

20. Posting to social media about the suicide death of a co-worker is acceptable as long as the information is anonymous.

a. True
b. False

[Continue to next page for answer sheet]

Answer Sheet: Suicide Prevention (359)

Name (Please print) _____

Date _____

Passing score is 80%

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

[Continue to next page for course evaluation]

Course Evaluation: Suicide Prevention (359)

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 United States. 1 2 3 4 5

2. List 3 warning signs for suicidal ideation and behaviors. 1 2 3 4 5

3. Describe 5 risk factors for suicidal ideation and behaviors. 1 2 3 4 5

4. Relate 4 job-related concerns that can lead to chronic stress among nurses. 1 2 3 4 5

5. Describe the importance of screening, assessment, and safety planning for patients as risk for suicide. 1 2 3 4 5

6. Define imminent harm. 1 2 3 4 5

7. Relate 5 evidence-based approaches that have been shown to be successful in reducing suicidal ideation and behaviors. 1 2 3 4 5

8. List four commonly accepted ethical principles. 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: Suicide Prevention (359)

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: _____