Suicide Intervention and Prevention Training for Washington Healthcare Professionals (3 CH)

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COURSE OBJECTIVE: The purpose of this course is to prepare occupational therapists, physical therapists, and other healthcare professionals in Washington State to understand the complex nature of suicide, how to assess and determine risk for suicide, and appropriate treatment and management for at-risk individuals they may encounter both in and out of their practice settings.

LEARNING OBJECTIVES
Upon completion of this course you will be able to:

- Discuss the epidemiology and etiology of suicidal behavior.
- Summarize the risk factors for suicide.
- Describe the process of assessment and determination of risk for suicide.
- Outline the management of patients at risk for suicide.
- Identify treatment modalities that may be used for persons at risk for suicide.
- Discuss the public health approach for suicide prevention, including primary, secondary, and tertiary prevention strategies.

INTRODUCTION

Suicide, the taking of one’s own life, has been the subject of deliberation throughout history, and making a judgment about whether life is or is not worth living is a question that underlies philosophical thought. Suicide is always controversial, raising questions of rationality and morality. Depending on one’s philosophical point of view, it is either acceptable at any time, acceptable under certain circumstances, or never acceptable.
The will to live arises from instinctual self-preservation, and it takes a great deal of will power to overcome this natural instinct. Humans are motivated by the pursuit of pleasure and the avoidance of pain, and suicide is usually prompted by a desire to be rid of unbearable pain or distress, which can be ended by an impulsive act.

Healthcare providers play a critical role in the recognition, prevention, and treatment of suicidal behaviors, and the attitudes of these providers are paramount in how patients are treated. Historically, the stigma associated with suicide affects the attitudes of those who manage and treat these individuals.

Studies have shown that many people, including healthcare providers, believe people who are suicidal are weak, cowardly, attention seeking, crazy, and manipulative. The truth is that those who talk about suicide or express thoughts of wanting to die are at risk and do need attention, not judgment. If the behavior to elicit care is seen to be manipulative, then rejection may be the response of the potential caregiver (AFSP, 2013).

Talk of suicide must always be taken seriously, recognizing that people who are suicidal are in physical and/or psychological pain and may have a treatable mental disorder. The vast majority of people who talk of suicide do not really want to die. They simply are in pain and want it to stop. Suicide is an attempt to solve this problem of intense pain when problem-solving skills are impaired in some manner, in particular by depression.

Many healthcare providers express concern that they are ill-prepared to deal effectively with a patient who is suicidal. Having adequate knowledge and skill can avoid the feelings of inadequacy that may prevent the provider from effectively responding to the suicide clues a patient may be sending and from carrying out appropriate interventions. It can also lead to a better understanding of this choice that ends all choices.

**Epidemiology**

The World Health Organization reported in 2014 that globally over 800,000 people die by suicide every year—a rate of 1 death every 40 seconds—and there are more deaths from suicide than from war and homicide combined.

The latest figures (2013) indicate that:

- In 2013 someone in the United States died by suicide every 12.8 minutes. Suicide is the tenth leading cause of death for all Americans and second leading cause of death for people ages 10 to 24 years. After cancer and heart disease, suicide accounts for more years of life lost than any other cause of death.

- In 2013, 41,149 incidents of suicide were reported and 494,169 people were treated for injuries secondary to self-harm behaviors. Each day in our nation there is an average of 5,400 or more suicide attempts made by young people in grades 7 through 12. (These figures include only reported attempts and completions; it is not known how many incidents of attempted or completed suicide remain unreported.)
In the United States, suicide prevalence is 13.0 deaths per 100,000 persons. The highest rate (19.1 per 100,000 population) is among people 45 to 64 years old, and the second highest among those 85 and older. In 2013, adolescents and young adults 15 to 24 had a suicide rate of 10.9 per 100,000 population.

The ratio of suicide attempts to suicide death in older adults is estimated to be 4:1 and in youth, 25:1.

The suicide rate is close to four times higher among men than among women, and in 2013, those who died by suicide were 77.9% male and 22.1% female. Although men have a higher rate of dying by suicide, females attempt suicide three times more often. It is speculated that this is related to less lethal forms of suicide used by females.

By race and ethnicity, the highest rate was among whites and the second among Native Americans and Alaska Natives. Lower rates were found among Asians, Pacific Islanders, Blacks and Hispanics. White males accounted for 70% of all suicides in 2013.

In 2013, firearms were the most common method (51.4%) of death by suicide, followed by suffocation, including hangings, (24.5%) and poisoning (16.1%). Suicide by suffocation, most often by hanging, is the second leading cause of death in 10- to 14-year-olds, and suicide by firearms the third.

Washington State Suicide Statistics

According to the Washington State Department of Health, the state has higher rates of suicide than the national average, and the rate has been increasing since 2006. By gender, males in Washington account for the highest percentage of suicide deaths. Men ages 85 and older had the highest suicide rate, while men ages 45 to 64 had the highest number of suicides. Female suicide rates are highest in the 45 to 54 age group.

By ethnicity, Native Americans and Alaska Natives in Washington State have the highest rates of suicide, and Hispanics the lowest. However, whites make up the largest number of suicide deaths.

Although veterans make up only 8.5% of the general population, in the years 2010 to 2012, 23% of all deaths by suicide in the state were by members of the armed forces.

Regarding methods used to commit suicide, Washington follows the national trend. Firearms were the leading method of suicide for both males and females, accounting for 51% of suicide deaths, followed by suffocation (22%), poisoning (19%), falls (4%), cuts (2%), and drowning/fire/unspecified (2%).

The highest suicide rates by county in Washington State are in Asotin, Chelan, Clallam, Okanogan, Pacific, Pierce, Skamania, and Stevens counties. The rates in these counties are significantly higher than the rate for the entire state. King County had the lowest suicide rates during the period from 2008 to 2012, which were considerably lower than the rate for the state.
Those living in rural areas have a higher suicide rate, as do those living in poverty and with lower education attainment (Sabel, 2013).

<table>
<thead>
<tr>
<th>LEXICON OF SUICIDAL BEHAVIOR</th>
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<tr>
<td><strong>Altruistic suicide</strong></td>
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<td><strong>Assisted suicide</strong></td>
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<td><strong>Attempted suicide</strong></td>
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<td><strong>Blue suicide, copicide, death-by-cop, suicide-by-cop</strong></td>
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**Self-mutilation, parasuicide**
Deliberately hurting oneself without meaning to cause death, such as cutting, burning, or bruising oneself.

**Suicide**
Death caused by self-directed injurious behavior with intent to die as a result of the behavior.

**Suicide attack**
A violent terrorist act in which the attacker intends to kill others or cause destruction expecting to die in the process, such as suicide bombers.

**Suicidal ideation**
Thinking about committing suicide.

**Suicide pact**
An agreement between two or more individuals to commit suicide at the same time and/or place.

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**ETIOLOGY**

The exact cause of suicide is unknown, but we do know that it is not uncommon to have thoughts of suicide. In most cases, these thoughts do not lead to a suicidal crisis situation in which the person attempts or completes suicide. What exactly causes one person to reject suicide and another to carry it out is still unanswered.

In recent decades many studies have been conducted in an attempt to understand the nature of suicide and to stimulate further research in ways that can help reduce or prevent its occurrence. It has been found that suicide is most often caused by a collection of risk factors and underlying vulnerabilities. There are a number of theories arising from this research that attempt to explain the suicidal state and action, and most all of them include biological factors, psychosociocultural factors, and response to adverse life events.

**Biologic Factors**

**GENETIC PREDISPOSITION**

Statistically, suicidal behavior seems to run in families. Family, twin, and adoption studies have established a genetic basis of suicidal behavior. The inheritance of suicidal behavior appears to be linked to two main components: the predisposition to psychiatric disorders and the predisposition to impulsiveness-aggressiveness traits. However, the presence of genetic risk factors does not mean that suicide is inevitable, since the inheritance of suicidal behavior is related to the interaction of multiple genes and influences of the environment (Kumar, 2014).
Identical twins have been found to have stronger similarity for suicide than fraternal twins, even when raised separately. In studies of people who were adopted and died by suicide, suicide was found to be more common among their biological parents than their adoptive parents. Studies also show that depression and other psychopathology also runs in families, but the heritability of suicide appears to exist independently from inherited depression (AFSP, 2015b). It is not clear whether the genetic component is primarily responsible for the underlying psychiatric disorder or for the suicide itself. Additionally, having an unrelated spouse who has a psychiatric disorder or who commits suicide increases the risk of suicide, showing the importance of environmental effects within the family structure (Schreiber & Culpepper, 2015).

People born into families that have a history of mental illness or suicidal thoughts have been found to be at high risk for development of suicidal ideation or mental illnesses themselves. Genetics may influence personality factors that may increase the risk, especially when depressed.

**STRUCTURAL CHANGES IN THE BRAIN**

Researchers have found abnormalities in a specific part of the brain of persons with major depressive disorder that are associated with suicidal behavior. Using diffusion tensor imaging (DTI), focusing on areas of the brain previously shown to be associated with suicide, they found structural differences in the white matter of the dorsomedial prefrontal cortex of persons who attempted suicide compared to other groups. This region of the brain has been linked to negative self-awareness, which often precedes suicide (Olvet et al., 2014).

Other studies have shown brain immunologic cell changes in the prefrontal white matter of the brain, which could indicate a mechanism whereby an acute stressor activates a reactive process in the brain and creates a suicidal state in a person at risk (Schneider et al., 2014).

**NEUROBIOLOGIC**

*Serotonin System*

A lowered level of 5-hydroxy indole acetic acid (5-HIAA) has been found in the cerebrospinal fluid of suicide attempters who had used violent methods. This is significant, as this acid is a breakdown product of serotonin, one of the neurotransmitters associated with mood and behavior disturbances.

Postmortem studies show a reduction in serotonin transporter bindings in certain regions of the brain of those who died by suicide compared with those who died from other causes. It is postulated that the association between suicidal behavior and the serotonin system is complex and may be related to aggressive impulsivity rather than to any specific psychiatric disorder (Goldney, 2013).
Hypothalamic-Pituitary-Adrenal Axis

Hyperactivity of the hypothalamic-pituitary-adrenal (HPA) axis has long been associated with patients who have major depressive disorder. To determine if the body is producing too much cortisol, dexamethasone is given, which should normally suppress the cortisol level. Using the dexamethasone suppression test (DST) to assess the function of the HPA axis has demonstrated that for individuals with major depression, those who were nonsuppressors had a fourfold higher risk of suicide compared to the suppressors. Patients with depression who committed suicide also have fewer noradrenalin neurons in the locus ceruleus of the brainstem as well as other receptor binding abnormalities (Goldney, 2013; Draud, 2015).

Neuropsychological Deficits

Executive function deficits and impairment in inhibition have been found more frequently among depressed patients with suicidal behavior compared with depressed patients without suicidal behavior. Executive function deficits include problems analyzing, planning, organizing, scheduling, and completing tasks. These deficits are believed to be linked to the dorsolateral prefrontal and orbitofrontal regions of the brain. Further research is needed to determine if cognitive inhibition deficit precedes suicidal behavior (Richard-Devantov et al., 2012).

PSYCHOPATHOLOGY

The exact etiology of mental illness remains unknown, but it has been shown through research that there is a significant biologic component.

Through the use of psychological autopsy (collecting all available information on the deceased using structured interviews of family, relatives, friends, and attending healthcare personnel), it has been shown that more than 90% of people who commit suicide have at least one and often more than one treatable mental disorder, such as:

- Depression
- Anxiety disorder
- Bipolar disorder
- Schizophrenia
- Personality disorder
- Conduct disorder
- Substance abuse disorder
- Posttraumatic stress disorder (PTSD)

Two of every 3 people who commit suicide are depressed when they act, and the use of alcohol plays a significant role in 1 in 3 completed suicides (AFSP, 2015b; Britton et al, 2015).
Major depression leads to a 20 times greater risk for suicide over the general population, and research has shown that certain symptoms of depression raise the risk of suicide:

- Intense anxiety
- Panic attacks
- Desperation
- Hopelessness
- Feeling that one is a burden
- Loss of interest or pleasure
- Delusional thinking

(AFSP, 2015b)

PTSD has been found to be a risk factor for suicidal ideation among veterans returning from Iraq and Afghanistan. One study found that those veterans with PTSD were 3 times more likely to report hopelessness or suicidal ideation than those without PTSD (Hudenko et al., 2014).

**Psycho-Sociocultural Factors**

Psycho-sociocultural factors refer to a person’s ability to consciously or unconsciously interact with the social and cultural environment. They involve past experiences; the environment in which a person lives; the relationships with and support from others; the cultural norms; and the cognitive abilities, intellect, personality, and other psychological factors that make someone respond to their environment in their own unique way.

**DEVELOPMENTAL FACTORS**

Early experiences in key relationships play an important role in present functioning. Studies have shown that the paths leading to suicide have roots in early life. Children need to be treated with decency and respect. They have rights, and when these rights are violated, children are damaged. They carry the wounds from this damage into adulthood.

The most destructive force for development of suicidality is early rejection by a parent or main caregiver. This rejection can occur through emotional, physical, and/or sexual abuse. This is very traumatic, as the child’s life depends on the parent or caregiver. Children in these relationships tend to accept the blame for what is happening to them. When the child and his/her body are cared for abusively, the child begins to develop an estrangement between the self and the body. Dissociation mentally and physically becomes a defense mechanism. The ability to dissociate physically from the body makes it easier to carry out an aggressive act against it.

Children from these situations develop a very high tolerance for physical trauma and physical pain and a very low tolerance for mental pain—a characteristic of those who become suicidal (Glendon Association, 2009; Geoffrey et al., 2014).
SOCIAL FACTORS

Social networks offer opportunities for emotional release and a feeling of belonging and connectedness. Isolation leads to feelings of alienation and depression, and alienation is one of the strongest motivators for suicide. The perceptions that one is a burden and that one does not belong can result in a desire for death (Goldney, 2013).

Isolation, withdrawal, friendlessness, unpopularity, feeling humiliated before peers, being labeled different, or being in trouble at school, home, or with the law are all social factors that can influence the decision to commit suicide.

BULLYING AND SUICIDE

Bullying along with other factors increases the risk for suicide among youth. Bullying is defined as the intentional infliction of injury or discomfort on another person through words, physical contact, or in other ways, including the use of the Internet (cyberbullying). Over time and repeated attacks, this leads to depression and anxiety, lowers self-esteem, and produces a mentality of helplessness, which contributes to suicidal thoughts and behavior. At-risk youth who are bullied, especially those who are already depressed, may view suicide as a rational solution to their problems.

The CDC (2014) reports that youth who frequently bully others and youth who report being frequently bullied are at increased risk for suicide-related behavior. Young people who report both bullying others and being bullied have the highest risk for suicide-related behavior of any groups involved in bullying.

Bullying is not confined to young people. Adult bullying exists as well. Adults mostly use verbal as opposed to physical bullying, and the goal is to gain power over another person and be dominant. Domestic violence is such an example, which often involves both verbal and physical bullying.

CULTURAL FACTORS

Cultural factors are the values, beliefs, and practices that are shared by a group of people and passed down from generation to generation. They include language, customs, religious beliefs, and social institutions. Cultural groups can be supportive, creating feelings of belonging and serving as a safety net when members need support while experiencing problems or stressors. Being a member of a tightly united group can serve as a suicide deterrent.

The “down side” of group membership may be that it requires stressful obligations and high levels of commitment, leading a member of the group to adapt to the norms rather than think for oneself. Some groups can be repressive and oppressive, which may contribute to suicidal thoughts and feelings. Some groups may even demand a person sacrifice him or herself for the greater good.
Social norms dictate whether or not suicide is stigmatized. Many societies and religions, such as Christianity, ban suicide, considering it taboo behavior or a sin. Others allow suicide. For example, some Islamic groups permit suicide as a means of martyrdom in war. The Hindu code of conduct makes suicide by fasting acceptable for incurable disease or as a response to great adversity. Judaism views suicide as acceptable only if one is being forced to commit an egregious sin such as murder (MPAC, 2014).

Adolescents generally have a high suicide attempt rate, and those who are involved in certain subcultures have an even higher risk. For instance, there is an increased incidence of self-harm activities (such as cutting) in the “Goth,” “emo,” and “punk” populations. Adolescents involved in repeated self-injury are up to 8 times more likely to attempt suicide (Soreff, 2015).

**Adverse Life Events**

In combination with other factors that contribute to an act of suicide, adverse or negative life events increase the risk. Such events may involve:

- The loss of a loved one through death, divorce, separation, or breakup of a relationship
- The loss of a house, money, or employment
- Separation from children
- Serious or terminal physical illness or serious injuries resulting from an accident
- Chronic physical pain
- Intense emotional pain, hopelessness, and helplessness
- History of being victimized, such as by domestic violence, rape, or assault
- A loved one being victimized
- Physical, verbal, or sexual abuse or unresolved abuse from the past
- Feeling trapped in a perceived negative situation and that nothing can get better
- Being incarcerated or having serious legal problems
- Perceived humiliation or failure
- Combat exposure
- Psychiatric hospitalization or recent discharge from a psychiatric hospital
- Exposure to another person’s suicide or to graphic or sensationalized accounts of suicide
- Poverty and low income along with few economic options or opportunities

(AFSP, 2015c; Soreff, 2015)
Suicide Among Age Groups

CHILDREN

Suicide occurs among children—some as young as 6 years. Suicide by children is difficult to comprehend, and very few scientific studies have been done that attempt to understand this phenomenon. Many young children who attempt or commit suicide have some type of mental disorder, most commonly depression, and they are often the victims of sexual or physical abuse.

One study involving 8- to 11-year-old boys and girls found that suicide attempts in children are different from those of adolescents. While their suicidal intentions were low to moderate, the methods they chose were highly lethal (Stordeur et al., 2015). The most common methods of suicide in children are hanging, jumping from heights, railway suicides, and firearms (CDC, 2015b).

ADOLESCENTS

The journal *Pediatrics in Review* reports that depression is underrecognized and undertreated in adolescents, and nearly 75% of adolescents with depression do not receive treatment. These youth have the potential to experience negative outcomes in all areas of life, including physical health, and some affected adolescents commit suicide (Maslow et al., 2015).

Teens commit suicide for a combination of complex reasons, including mental disorders. Other factors may include:

- Bullying, cyberbullying, and peer pressure
- Sexual orientation issues
- Being a victim of domestic and/or sexual abuse
- Drug and alcohol use
- Parental divorce
- Parental emotional neglect
- Pressures at school to excel and choose a career path
- Imitative behavior following sensationalized media coverage of a suicide (Arnarsson et al., 2015; Gould, 2003; Isohookana et al., 2013)

ADULTS

The CDC (2013) reports that suicide of adults aged 35 to 64 years has been found to be associated with:

- Economic challenges
• Loss of employment
• Intimate partner conflict or violence
• Caregiving responsibilities and stress (the “sandwich” generation)
• Substance abuse
• Health problems, both physical and mental, including depression

Suffocation, predominantly by hanging, is used by all age groups, but recently has become more common among the middle-aged, especially when the stressors involve external rather than psychological problems. The reason for this is unknown (Hempstead & Phillips, 2015).

OLDER ADULTS

The older adult is involved in a review of one’s past life, enjoying successes, dealing with regrets and disappointments, and considering the prospects for a satisfying future. Studies have been done that examine the adjustments older people must make during this period of their lives—facing the inevitability of death and finding meaning despite the common loss of roles, status, finances, health, and/or social support. Conflict in these areas can lead to significant levels of anxiety and depression, which increase the risk for suicide.

Adverse life events that are associated with the development of mental health problems in the older adult include:

• Loss of a spouse or significant other
• Moving from home, especially into a nursing home
• Retirement
• Poor health
• Loss of independence
  (Lyons et al., 2015)

The suicide rate for older adults is highest for those who are divorced or widowed (SAVE, 2015).

EUTHANASIA AND RATIONAL SUICIDE

The term euthanasia means “good death.” It is an umbrella term for taking measures to end the life of someone with unbearable suffering associated with terminal illness. When a physician provides the means to commit suicide but does not administer it, it is known as passive voluntary euthanasia (PVE) in the form of physician-assisted suicide (PAS). When a second party fulfills a dying person’s request to be put to death, it is referred to as active voluntary euthanasia (AVE).

The question “Is suicide ever rational?” has been the subject of much debate. Most of the literature defining the term includes three characteristics: 1) the person has made a realistic
assessment of his/her situation, 2) the person’s decision-making capacity is unimpaired by psychological illness or severe emotional distress, and 3) the motivation would be understandable to the majority of people in the community or social group.

Recently, more and more older adults are expressing the wish to end their lives as they see fit. The term rational suicide is usually applied to an adult with the ability to make a free choice and with sound decision-making skills. These individuals have what they consider an unrelenting, hopeless physical condition (terminal illness) and feel that their life is already complete. They express the wish to control the time, place, and manner in which they die.

Often older adults have poor social support systems and worry about being a burden to others. Some express the fear of spending a long period in a hospital or a nursing home. Other reasons given for wanting to die include:

- Loss of autonomy
- Loss of ability to engage in activities
- Loss of dignity
- Loss of bodily functions
- Inadequate pain control
- Financial implications of receiving treatment

In some countries, physician-assisted suicide is legal but active voluntary euthanasia is not, and in other countries both are legal. In the United States active voluntary euthanasia is illegal, but as of 2015, physician-assisted suicide is legal in Vermont, Washington, Oregon, Montana, and California. It remains an issue under legal debate.

Source: Brauser, 2015; Barone, 2014.

WASHINGTON STATE DEATH WITH DIGNITY ACT

In 2008 Washington passed the Washington Death with Dignity Act, Initiative 1000. This act allows terminally ill adults who wish to end their life to request lethal doses of medication from medical and osteopathic physicians. These ill individuals must be Washington residents who have an estimated six months or less to live.

During 2014, prescriptions were written by 109 different physicians and dispensed by 57 different pharmacies to a total of 176 persons. Of these 176 persons, 126 died after ingesting the medication, 17 died without having ingested it, and the ingestion status of the remaining 27 people who died is not known. For the six remaining individuals, no documentation of death was received by the state health department.

The majority of the individuals were senior citizens, and the number one underlying condition was cancer.

Source: WA DOH, 2015.
CASE

Jacob
Avery, a registered nurse, was working the nightshift in the emergency department when an ambulance arrived with a young male patient who was discovered sitting inside his car with the engine running in a closed garage. When his mother found him, he was still breathing and had a heartbeat. She called 911. On arrival, the patient was conscious but disoriented and was receiving high-dose oxygen via a facemask.

The young man’s name was Jacob, and he was 17 years old. His mother informed the staff that Jacob “has not been himself lately.” She went on to describe him as withdrawn and quiet, having problems sleeping, and without an appetite. He was no longer attending school functions because he felt “too tired.” He was also having problems with his girlfriend, expressing fear that she wanted to break up with him.

As Avery was drawing a blood sample, Jacob opened his eyes, pulled off the facemask, looked around, whispered, “Oh, no, I’m still here,” and began to cry.

(continues below)

ASSESSMENT AND DETERMINATION OF RISK

Suicide screening and assessment of risk for suicide are important in any suicide prevention plan; however, it is very difficult to predict who will actually die from suicide.

Suicide Screening

Suicide prevention screening refers to a procedure in which a standardized instrument or tool is used to identify individuals who may be at risk for suicide. It can be done independently or as part of a more comprehensive health or behavioral health screening. Such screening may be done orally by a person asking questions, with pencil and paper, or using a computer. Suicide screening can be applied either universally or selectively.

A universal screening program can be applied to everyone in a specific population regardless of whether or not they are thought to be at a higher risk than the average person. Universal screening may be done, for example, for every patient who visits a primary care office, or perhaps every student in a specific high school.

Selective screening programs are often used to screen members of a group of people that research has shown to be at higher than average risk for suicide. Screening is done whether or not any members are displaying any warning signs of elevated risk. In a primary care setting, this might involve targeting only those patients being treated for depression or a substance abuse disorder.

Currently there is limited evidence that screening instruments may be able to identify adults at increased risk for suicide. Evidence is even more limited in older adults and adolescents.
Because data is inconclusive about the benefits of screening the general primary care population for suicide risk, the U.S. Preventive Services Task Force (2014) does not support routine screening of adolescents, adults, and older adults in primary care.

Suicide screening may be of benefit when risk factors or warning signs exist. The following **risk factors for suicide** should be considered in identifying those who would benefit from screening:

- Recent history of a suicide attempt
- Diagnosis of a serious, disfiguring, or stigmatized disorder (such as HIV/AIDS)
- Drug abuse or alcohol abuse problems
- Family history of suicide or violence
- History of psychotic symptoms (hallucinations, illusions, or ideations)
- Talking about suicide (thoughts or plans)
- Symptoms of depression (expressions of hopelessness, helplessness, and worthlessness)
- Significant change in mood from cheerless to cheerful, possibly indicating the person has made a decision to commit suicide

**Suicide Assessment**

Suicide assessment, as opposed to screening, refers to a more comprehensive evaluation done by a clinician to confirm a suspected suicide risk, to estimate imminent danger, and to decide on a course of treatment. The assessment and management of a patient who is suicidal requires establishing rapport, assessing suicidal intent, inquiring about means of suicide, and determining management options. Suicide assessment may involve structured questionnaires and/or open-ended conversation with patient and/or friends and family.

**ESTABLISHING RAPPORT**

The initial contact with a person who is suicidal may occur in many different settings—home, telephone, inpatient unit, outpatient clinic, practitioner’s office, rehabilitation unit, long-term care facility, or hospital emergency department. Being skilled at establishing rapport quickly is essential for all clinicians. It is imperative that the person be given privacy, be shown courtesy and respect, and be made aware that the clinician wants to try and understand what has happened or is happening to him or her.

Most vulnerable people see healthcare workers as sympathetic listeners who understand their ambivalence about living and dying and welcome an opportunity to discuss their concerns. Some potential suicide patients, however, may be antagonistic toward others, including healthcare workers. This may be due to perceived rejections by significant persons in their lives.

Primary care providers may be in a unique position to manage those at risk for suicide due to their frequency of interaction with such patients. A review of 40 studies found that over 75% of
patients who committed suicide had contact with primary care providers within the year of their death, compared with one third who had contact with mental health services (McDowel et al., 2011).

Establishing rapport quickly involves active listening skills such as:

- Restating
- Summarizing
- Offering brief positive prompts
- Putting feelings into words
- Avoiding “why” questions, which tend to make people defensive
- Avoiding questions requiring only “yes” or “no” answers, which limit information that can be obtained
- Asking “who,” “what,” “where,” “when” and “how” questions
- Identifying emotions
- Validating problems, issues, and feelings

The individual who is suicidal should be encouraged and given the opportunity to express thoughts and feelings and allowed to discharge pent-up and repressed emotions. This can best be achieved by asking open-ended questions such as: “What are your feelings about living and dying?” Such questions allow an expression of the ambivalent feelings most often experienced by persons who are suicidal. Direct questions such as “Do you really want to kill yourself?” do not allow such an expression (IASP, 2015).

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<tr>
<th>Person’s Statement</th>
<th>Appropriate Responses</th>
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<tr>
<td>Everyone will be better off without me.</td>
<td>• Who would be better off?&lt;br&gt;• What would be better for those people?&lt;br&gt;• Where are you planning to go?</td>
</tr>
<tr>
<td>I just can’t bear it anymore.</td>
<td>• What is so hard to bear?&lt;br&gt;• What would make your life better?&lt;br&gt;• When did you begin to feel this way?</td>
</tr>
<tr>
<td>I just want to go to sleep and not deal with it again.</td>
<td>• What do you mean by “sleep”?&lt;br&gt;• What is it you don’t want to deal with anymore?</td>
</tr>
<tr>
<td>I want it to be over.</td>
<td>• What is it you want to be over?&lt;br&gt;• How can you make it be over?</td>
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I won’t be a problem much longer. | • How are you a problem?
• What is going to change in your life so you won’t be a problem any longer?
• When will you no longer be a problem?

Things will never work out. | • What can you do to change that?
• What, then, do you propose to do?

It is all so meaningless. | • What would make life more meaningful?
• What are some aspects of your life that make it worth living?
• What is happening in your life that makes it so meaningless?

Source: Adapted from Videbeck, 2011.

ASSESSING SUICIDAL INTENT

Some clinicians and caregivers are concerned about bringing up the subject of suicide with patients in the mistaken belief that it will give the person the idea and the permission to commit suicide. This is definitely not the case. By asking about suicidal thoughts or intent, the person is given an opportunity to openly talk about what concerns them to a person who is conveying respect and caring.

Once an individual is suspected of thinking about committing suicide, specific and direct questions should be asked, such as:

- Have you ever felt that life is not worth living?
- Have you been thinking about death recently?
- Did you ever think about suicide?
- Have you ever attempted suicide?
- Do you have a plan for suicide?
- What is your plan for suicide?

Assessment Tools

There are many tools available to assist healthcare providers in assessing suicidal intent. The most current favored assessment tool is the Columbia-Suicide Severity Rating Scale (C-SSRS). In 2012, the U.S. Food and Drug Administration (FDA) conferred “gold standard” status on this scale, which is used extensively in primary care, clinical practice, surveillance, research, and institutional settings worldwide. It is part of a national and international public health initiative involving assessment of suicidal ideation and behavior. It is exceptionally useful in initial screening, and no mental health training is required to administer it (Columbia University Medical Center, 2015; Giddens et al., 2014).
The C-SSRS consists of two sections: suicidal ideation and suicidal behavior. The scale provides definitions and standardized questions for each category.

For suicidal ideation, it defines types of ideation of increasing severity. It questions whether the person has a wish to die, through actual thoughts of suicide, and through thoughts with plan and intent. This is followed by questions regarding the intensity of the ideation.

The suicidal behavior section assesses for four suicidal behaviors: 1) an actual attempt, 2) an interrupted attempt, 3) an aborted attempt, and 4) preparatory behavior (Columbia University Medical Center, 2015).

Other effective assessment tools include:

- Harkavy-Asnis Suicide Survey
- InterSePT Scale for Suicidal Thinking
- Suicidal-Behaviors Questionnaire, Revised
- Beck Scale for Suicidal Ideation, Revised
- Beck Hopelessness Scale (BHS)
- Sheehan-Suicidality Tracing Scale
- Beck Suicide Intent Scale (SIS)
- Reasons For Living Inventory (RFL)
- Nurses Global Assessment of Suicide Risk (NGASR)
- Suicide Ideation Questionnaire (for children ages 13 to 18)
- Depression Hopelessness Suicide Screening Form (for prison inmates)

**Interview Techniques**

Although assessment tools are helpful, the best approach in determining risk for suicide is through an integration of a history with a structured interview. The structured interview is designed to increase the likelihood that the patient’s stated intent is accurate, reflected intent is comprehensive and valid, and the amount of withheld intent is minimized or absent.

One such interview-based approach is the **Chronological Assessment of Suicide Events (CASE)**. This structured interview technique allows the healthcare provider to get a detailed account of suicidal thoughts, any preparations and attempts, and current psychiatric symptoms that may require treatment (Peterson, 2014; TISA, 2015). It is an easily learned interviewing strategy that is designed for use by frontline clinicians in both the mental health and primary care settings.
The CASE approach is a flexible interviewing strategy for sensitively uncovering suicidal ideation, planning, behaviors, and intent by gathering important information in four time frames:

1. Exploring the **present** problem from beginning to end (past 48 hours)
2. Exploring **recent** suicidal events and determining extent and lethality of suicidal planning (previous 2 months)
3. Gathering **past** history of suicidal ideation or behaviors (back in time prior to 2 months ago)
4. Determining the **immediate and future** suicidal ideations (during the interview itself)

(Lotito & Cook, 2015)

### CASE

**Grace**

Alex is an occupational therapist who has received a referral from a primary care physician for a patient named Grace who has trigeminal neuralgia. Trigeminal neuralgia is a neuropathic pain syndrome that affects the fifth cranial nerve (trigeminal), one of the most widely distributed nerves in the head. The syndrome is characterized by severe unilateral paroxysmal facial pain and often is described by patients as the world’s worst pain.

Alex is familiar with this syndrome and is aware that it has been labeled the “Suicide Disease” because, even though the disease isn’t fatal, many afflicted with it take their own lives due to the intolerable and unbearable pain.

When Grace arrives for her first appointment, Alex reviews the disease process with her, describes what types of therapy he can offer, and discusses what the aims of occupational therapy management are in terms of adapting her activities of daily living in response to her pain and to improve her quality of life. After performing Grace’s initial occupational therapy evaluation, Alex asks Grace to be involved in setting some realistic and meaningful short- and long-term goals for her treatment.

Throughout the course of Grace’s treatment, Alex engages her in conversation at each session, in part looking and listening for suicide warning signs. He is ready to intervene if there is any suspicion that she is experiencing suicidal ideation. At one session, Alex begins to notice that Grace has become more withdrawn and talks about how she doesn’t think she can continue to deal with the pain much longer. She appears sad and listless.

At this point, Alex provides Grace with a quality of life questionnaire and, after scoring it, determines that Grace would benefit from a referral through her primary care physician for psychiatric intervention.
ASSESSING LETHALITY

Suicidal deaths are more likely to occur when persons use highly damaging, fast-acting and irreversible methods, such as hanging, jumping from heights, or shooting, and to do so when rescue is fruitless.

The evaluation of a suicide plan is extremely important in order to determine the degree of suicidal risk. When assessing lethality of a plan, it is important to learn all the details about the plan, the method chosen, and availability of means. People with definite plans for a time, place, and means are at high risk for suicide. Someone who is considering suicide without making a plan is at a lower risk.

**Higher-risk methods** include:

- Firearms
- Jumping off a high place
- Suffocation by hanging
- Carbon monoxide poisoning
- Staging a car crash

**Lower-risk methods** increase the probability of intervention and include:

- Cutting one’s wrists
- Ingesting pills

When the means are available, such as possession of a firearm, the risk is even higher (Goldney, 2013).

MANAGEMENT OF THE PATIENT AT RISK FOR SUICIDE

Following suicide assessment, the clinician bases the decision for management upon the level of risk the patient has for committing suicide. Safety is the most important matter to consider in the initial management of a patient who is suicidal.

**Determining the Level of Risk**

Patients who have had recent suicidal ideation or thoughts but no specific plans or intent to commit suicide, who are able to control the impulse to act, and who have no history of suicidal behaviors are considered **low risk** and should have outpatient follow-up recommended.

Most people who are suicidal do not necessarily want to die; they just don’t want to continue living in an intolerable situation or state of mind. This ambivalence is one of the most important tools for working with suicidal persons. Almost everyone who is suicidal is ambivalent about...
dying, leaning toward suicide at one moment in time, and then leaning toward living the next. The healthcare provider can use this ambivalence to help focus the person on the reasons why he or she should live.

Often patients who have been given an opportunity to express their feelings to a concerned healthcare provider may convey a more positive outlook and further contact may not be required if the patient has a strong social support system. Follow-up should always be offered if there are inadequate social supports available.

A patient who has current suicidal ideation or thoughts, has a plan but with no intent to act, is able to control the impulse, and has no recent suicidal behavior is at moderate risk. The patient and family should be educated on risk and treatment options. A safety plan should be established and access to lethal means should be limited. Referral should be made for outpatient psychiatric evaluation and treatment.

Patients with persistent thoughts of suicide; those with a plan and/or intent to commit suicide; and those presenting with significant agitation, impulsivity, psychosis, or a recent suicide attempt are considered high risk. In this situation, clinicians should ensure that the patient is under constant observation and monitoring while arrangements are made for immediate transfer with escort to emergency care for psychiatric evaluation and possibly hospitalization (IASP, 2015; Goldney, 2013; U.S. DVA, 2015).

After a patient has been stabilized and there is improvement in suicidal ideation, risk for suicide still remains. Those who attempt suicide have a risk of death during the following year that is 100 times greater than that of the rest of the population (Norris & Clark, 2012).

**Outpatient Management**

It is important that the patient’s social support system be enlisted to assist with outpatient management. The patient should have frequent contact with his or her primary care provider and access to mental health and behavioral specialists as well as community programs that provide crisis counseling.

For some patients with specific mental disorders, such as personality disorder, parasuicidal or self-mutilation behaviors may become more common and chronic. The provider should take each threat seriously, as these behaviors can become lethal (Norris & Clark, 2012).

Appropriate psychopharmacotherapy, psychotherapy, or sociotherapy should be initiated for the patient who is being managed on an outpatient basis, and any medications prescribed for the patient should be given in limited amounts (e.g., 3- to 5-day supply with no refill). The intensity of outpatient treatment should vary in accordance with risk indicators and might mean more frequent appointments, telephone contacts, and concurrent individual and group treatment.
CASE

Jacob (continued)
The emergency department (ED) nurse, Avery, quietly spoke to Jacob, asking him if he knew where he was. When he didn’t reply, she told him he was in the hospital being treated for carbon monoxide poisoning. He said, “Then I didn’t die?” She replied, “No, you didn’t.”

Avery waited a second or two and then asked Jacob how he was feeling. He said he was feeling very sad and disappointed. Using active listening skills, Avery encouraged him to talk. He expressed feelings of sadness, anger, and frustration, and said, “Nothing is going right in my life. I just want to get out of it!”

Assuming a possible suicide attempt, Avery asked Jacob, “When did you first think of harming yourself?” He replied, “Yesterday. My girlfriend told me she wanted to break up and date someone else.” Avery said, “That must have been very hard for you.” He agreed that it was.

Avery asked him if he had ever had suicidal thoughts before, and he said that he “does every so often now.” She then asked him what he meant by “every so often now,” and he replied that he’s been thinking this way for the past few months, ever since the beginning of the school year.

Because Jacob had used a high-risk method to attempt to kill himself, Avery considered him to be at high risk for self-harm. She helped him undress and put on a hospital gown. Then she called in an ER Tech to stay with Jacob while she went to report his condition and discuss treatment with the ED team. Another team member went through Jacob’s belongings to remove any objects he might use to try to harm himself again.

A psychiatric evaluation was ordered for Jacob, following which it was determined that he had signs and symptoms consistent with the diagnosis of major depression. Jacob and his mother were informed that the safest place for Jacob at the time would be in the hospital, where he could begin treatment. He was admitted voluntarily to the hospital’s acute psychiatric unit.

(continues below)

Inpatient Management

Admission to a psychiatric hospital or unit generally is necessary for those at high risk for suicide in order to keep them safe. The greatest majority of such admissions are voluntary, which means the person freely agrees to be admitted for treatment. Anytime someone attempts suicide and refuses treatment, however, the person most likely will be involuntarily committed for treatment.

Should hospitalization be necessary, it is important that the patient, family, and friends know that the aim is to protect and not to punish the patient. The hospital stay should be structured to meet the patient’s individual needs, and follow-up appointments should always be scheduled.
INVOLUNTARY COMMITMENT
Involuntary commitment means placing a person in a psychiatric hospital or unit without their consent. The laws governing involuntary hospitalization vary from state to state, but in general, they confine involuntary commitment to persons who are mentally ill and/or under the influence of drugs or alcohol and are deemed to be in imminent danger of harming themselves or others. In the United States, the maximum initial time for involuntary commitment is usually 3 to 5 days.

If the person is not discharged on or before the 3- to 5-day limit because more treatment is necessary, a court order may be sought to extend the involuntary commitment.

According to Washington State Law, Title 71, Chapter 71.05 RCW, an individual can be involuntarily committed if found to be mentally ill and either presents a likelihood of serious harm or is gravely disabled. A petition is a legal request filed by a designated mental health professional for not more than 72 hours (not counting weekends and holidays). Following the 72-hour hold, the court can order the person to be committed for an additional 14-day involuntary intensive treatment or 90 additional days of a less restrictive alternative outside the confines of the hospital.


INPATIENT TREATMENT PLANNING
On admission to an acute psychiatric unit, a nurse meets with the patient to complete a nursing assessment and to orient the patient to the unit. During this interview, the presenting problem is identified and a nursing diagnosis is made. The most important concern on admission is patient safety. This may be written as:

- Risk for suicide, or risk for self-directed violence related to (likely cause), as manifested by (specific behaviors)

The initial care plan typically includes:

- Prevention of self-harm, suicide attempts, or escalation of either
- Monitoring of patient 24 hours a day

The intervention includes implementation of suicide precautions that include continuous observation by designated clinical staff, documentation of observation every 15 minutes, and the use of restraints if necessary according to protocol.

Within 24 hours, the patient is evaluated by the admitting psychiatrist and a multidisciplinary team that often includes a medical practitioner (physician, physician’s assistant, or nurse practitioner), an RN, a social worker, and an occupational therapist. Following evaluation, the team meets with the patient to discuss the treatment plan. The plan should identify short- and
long-term goals, steps to achieve them, and the professionals responsible for helping to achieve them. During hospitalization, some form of psychotherapy will also be provided.

The treatment plan **outcome criteria** for a patient with suicidal intent might include:

- Prevention of self-harm or suicide attempts
- Reduction of level of injury from self-harming behavior
- Improved quality of life
- Improved social or occupational functioning
- Improved mental and physical health conditions

Discharge planning is begun at the time of admission and revised throughout the stay. A written **discharge plan** is developed along with the patient, family member, or other authorized representative and the treatment team. It includes:

- A risk management plan (which can be modified) to address specific identified risk factors
- A suicide safety plan with self-management strategies
- Information on accessing services in crisis
  (Rooney, 2015; Rull & Harding, 2014)

### SELF-MANAGEMENT SUICIDE SAFETY PLAN

A good suicide safety plan should be a written document that includes the following:

- Recognition of what triggers a crisis
- A list of personal warning signs of possible crisis (e.g., thoughts of suicide, increased urge to drink)
- Effective internal coping strategies (ways to respond to warning signs to reduce distress such as using deliberate breathing techniques, exercising, and going for a walk)
- Social supports and social settings that can reduce emotional distress (e.g., using a social setting as a distraction or obtaining personal social support (family or friends), going to a movie, sitting in a public area, or interacting with people)
- If self-management and/or social supports do not reduce distress, a list of professionals or resources that can be contacted (i.e., primary mental health provider, mental health clinic, emergency department, and the National Suicide Prevention Hotline at 800-273-TALK [8255])
- Steps to remove access to lethal means (e.g., remove weapons, lock up pills)

CASE

Jacob (continued)

Robert, the psychiatric nurse who received Jacob’s admission orders, greeted Jacob on his admission and helped him get settled and oriented to the unit. Jacob’s belongings were checked in, and his belt and shoelaces were removed. He then spent the next hour interviewing Jacob about the events surrounding his suicide attempt. Following the interview, Robert’s nursing diagnosis was:

- Risk for suicide related to depression and adverse life events as manifested by his attempted suicide by carbon monoxide poisoning

The initial treatment plan involved establishing suicide precautions and assigning a psychiatric technician for 24-hour monitoring. Robert, as RN, was to monitor and record Jacob’s mood, behavior, and pertinent verbatim statements every 15 minutes.

In the morning, Robert presented Jacob’s history to the team that included the psychiatrist, Dr. Ramos; the social worker, Marion; and the occupational therapist, Nancy. Following their discussion, Robert and Jacob met with Dr. Ramos, who continued the assessment of Jacob’s depression and possible need for medication. Jacob was also seen by the social worker for evaluation and input into the treatment plan.

With Jacob’s collaboration, the treatment team wrote the following treatment plan:

TREATMENT PLAN

Problem
Depression as manifested by sadness, frustration, anger, low energy, withdrawal, sleep and eating disturbances, and suicidal ideation with suicide attempt.

Long-Term Goal
Symptoms of depression will be significantly reduced, with absence of suicidal ideation by discharge.

Short-Term Goals
1. Jacob will not self-harm and will report an absence of suicidal ideation by the end of one week.
2. Jacob will sleep 6 to 8 hours each night by the end of two weeks.
3. Jacob will consume three meals each day plus snacks by the end of one week.
4. Jacob will begin psychotherapy to learn to identify negative and maladaptive thoughts and how to replace them with more positive and adaptive thinking.
5. Jacob will begin to learn new coping skills, including problem solving and emotional regulation.
6. Jacob will actively take part in the unit milieu.
7. Jacob will actively take part in occupational and/or creative art therapies.

Interventions
1. Individual therapy will be provided by the social worker or clinical psychologist to help Jacob learn and implement coping skills and to help him identify, process, and resolve his feelings and concerns.
2. Family therapy will be provided by the social worker to develop a post-discharge crisis plan, to provide psycho-education about depression and suicide, and to increase Jacob’s parents’ ability to support and encourage him to use new coping skills.
3. Occupational therapy will help Jacob identify those aspects of his activities of daily living that are in need of change and will make recommendations to the treatment team regarding discharge planning.
4. The psychiatrist and the RN will provide medication management.

Evaluation
Ongoing evaluation of Jacob’s mental status and effectiveness of the treatment plan is conducted and the treatment plan modified as needed.

TREATMENT MODALITIES FOR PATIENTS AT RISK FOR SUICIDE

Patients who are suicidal warrant some form of emotional support or psychotherapy with a focus on learning more adaptive ways of coping in the future. They may also warrant medications for treatment of specific mental disorders such as major depression.

Cognitive Behavioral Therapy (CBT)

CBT is designed to counteract errors of cognition and involves both cognitive and behavioral techniques. Suicidal patients frequently believe they are failures in all aspects of their lives. During CBT they are asked to step outside themselves and view themselves as others would. By doing so, they are able to see their areas of competence, and their original assumption can be seen to be false.

The behavioral aspect is based on scheduling activities that can actually be mastered by the patient and that provide alternatives to suicidal behavior. The successful completion of each activity provides immediate confirmation that the patient is competent (Goldney, 2013).
Two such activities that may be done are “thought records” and “pleasant activity scheduling.” Thought records test the validity of a person’s negative thoughts by looking at objective evidence for and against the thought side by side with the goal of changing beliefs on a logical level.

Pleasant activity scheduling involves planning an activity for each day of the week that is pleasant and something the person would not normally do. This activity produces higher levels of positive emotions, making thinking less negative, narrow, rigid, and self-focused.

**Dialectical Behavior Therapy (DBT)**

DBT is a type of psychotherapy shown to reduce the suicide rate specifically among persons with borderline personality disorder. DBT is an intensive therapy that involves cognitive, behavioral, and supportive techniques. Through individual psychotherapy and group therapy, the person learns to recognize when feelings or actions are disruptive or unhealthy, to learn new skills to better deal with negative situations, and to improve motivation for appropriate behavior (Goldney, 2013).

**Interpersonal Therapy (IPT)**

IPT aims to elicit, clarify, and place into perspective feelings that have arisen from interaction with others in the social environment. It is an effective treatment for depression as a way to reduce suicide rates. The focus is on current problems, anxieties, and frustrations. Loss and threatened loss are addressed, along with the angry feelings that the person may be experiencing regarding a loss. IPT has been effective in preventing relapse of depression (Goldney, 2013).

**Problem-Solving Therapy**

Problem-solving therapy is based on the idea that symptoms are related to everyday problems that if solved would lessen the symptoms. Problems are dissected into their components, and the patient and therapist generate potential solutions. The solution is practiced through role-playing, and the patient is encouraged to use the new problem-solving techniques in his or her everyday life and personal relationships (Goldney, 2013; Pierce, 2012).

**Milieu Therapy**

Milieu therapy refers to the setting of an inpatient psychiatric unit whereby nursing staff and other patients interact in a play-based environment that enhances the effectiveness of both high- and low-structure therapy approaches. Its goal is to ensure that all aspects of a patient’s hospital experience are considered therapeutic. Within this setting, the patient is expected to learn new coping, interaction, and relationship skills that can be generalized to other areas of life. The key features of milieu therapy include:

- Containment for safety and security
• Validation to affirm the patient’s individuality
• Structured interaction with others and daily community meetings
• Open communication with support, attention, praise, and reassurance in order to improve self-esteem and increase confidence
  (Psychiatric Nursing, 2013)

Group Therapy

Group therapy is often integrated into a comprehensive treatment plan. It is a type of psychotherapy that involves one or more therapists working with a small group of people at the same time. The group leader explores the thoughts and feelings of members and creates an atmosphere of acceptance. Members become comfortable enough to discuss personal problems and express feelings such as guilt, shame, and anger. Members of the group act as a support system and a sounding board. The members help each other to find ways to improve difficult situations or challenges, and they hold each other accountable as they move along (APA, 2015).

Creative Arts Therapy

Creative art therapies include music, art, and dance/movement. Research has shown that music therapy decreases anxiety, depression, and loneliness in suicide-prone individuals (AMTA, 2015). Art therapy encourages emotional expression and improves self-esteem and conflict management (AATA, 2015). Dance/movement therapy is based on the premise that the body, mind, and spirit are interconnected, and movement can improve emotional, cognitive, physical, and social integration (ADTA, 2015).

Occupational Therapy

Occupational therapy provides education and addresses assertiveness, self-awareness, interpersonal and social skills, stress management, and role development. Interventions focus on enhancing skills the person already has, promoting wellness, and preventing relapse (AOTA, 2015).

Medications

In a long-term study of mood disorder patients, it was shown that treatment with antidepressants, atypical antipsychotics, and lithium reduced death by suicide as compared with those who did not receive these treatments (AFSP, 2015d). Medication is only prescribed if clinically indicated for a specific mental disorder such as major depression. It is also important to recognize the possibility of antidepressants precipitating suicidal behavior. If suicidal behavior is associated with a mental disorder for which there is good evidence that a medication is effective, then that medication should be offered (Goldney, 2013).
ANTIDEPRESSANTS AND SUICIDE

When antidepressants, namely selective serotonin reuptake inhibitors (SSRIs), are started or when doses are increased, some people may experience increased anxiety, agitation, restlessness, irritability, or anger, which can lead to suicidal thoughts or attempt. The FDA issued a warning for antidepressant medication use in young people under the age of 25, warning of the possibility of these side effects.

SSRIs include:

- Fluoxetine (Prozac)
- Paroxetine (Paxil)
- Sertraline (Zoloft)
- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Fluvoxamine (Luvox)

Source: Drugwatch, 2014.

SUICIDE PREVENTION STRATEGIES

A U.S. Surgeon General’s public service announcement in 2015 stated, “We all have a role to play in preventing suicide.” A public health approach to suicide prevention employs strategies that:

- Identify people at risk
- Increase help-seeking behavior
- Provide access to mental health services
- Establish crisis management and postvention procedures
- Restrict access to lethal means
- Enhance life skills
- Promote social networks and connectedness

(SPRC, 2015)

One commonly used and evidence-based framework for classifying suicide prevention strategies applied in public health is the primary, secondary, and tertiary model.

Primary Suicide Prevention Strategies

Primary suicide prevention strategies include activities that provide support, information, and education to the public in an attempt to reduce the number of suicides in the general population. It can be practiced in many places such as schools, homes, clinics, primary care, hospitals, work or industrial settings. Primary prevention also includes enhancing research to better understand
risk and protective factors related to suicide, their interaction, and their effects on suicide and suicidal behaviors (CDC, 2012).

GOALS OF PRIMARY PREVENTION

The goals of primary prevention include:

- Encouraging continued research, evaluation, and data collection
- Strengthening families and providing support to ensure that dysfunctional relationships do not develop
- Creating positive relationships to improve feelings of connectedness
- Promoting the role of education in schools, colleges, and universities to assist students in the development of self-esteem and self-confidence and to identify and support students at risk
- Strengthening local communities to provide positive attitudes, which can decrease feelings of vulnerability and social alienation
- Creating positive social behaviors and problem-solving skills
- Promoting help-seeking behaviors
- Increasing public awareness and access to information through community education campaigns, especially about mental illness and mental health issues
- Providing professional education and training to ensure basic competencies in suicide risk identification, counseling, and referral
- Reducing access to lethal means and methods of self-harm as a way to provide people in a temporary crisis situation with a chance for survival and recovery
- Educating the entertainment industry and the media in responsible reporting of suicides by following the American Foundation for Suicide Prevention’s “Recommendations for Reporting on Suicide” (See “Resources” at the end of this course.) (U.S. DHHS, 2012)

WASHINGTON STATE SUICIDE PREVENTION EFFORTS

The youth in Washington State complete suicide at a rate that makes it the second leading cause of death for persons between 10 and 24 years old. Each week on average, two young people kill themselves and 17 are hospitalized due to a suicide attempt.

Since 1995, Washington has instituted a plan to prevent suicide among its young people. The plan for suicide prevention for youth has five goals:

- Suicide is recognized as everyone’s business.
• Youth ask for and get help when they need it.
• People know what to look for and how to help.
• Care is available for those who seek it.
• Suicide is recognized as a preventable public health problem.

In 2012 a bill was passed that required certain health professions to complete training in suicide assessment, treatment, and management. A study accompanied this plan to determine its effectiveness, and in 2014 the state legislature expanded this requirement to more groups of licensed health professions. The legislature also requires that the Washington State Department of Health develop a lifespan suicide prevention plan by the end of 2015 (WA DOH, 2014).

Secondary Prevention Strategies and Crisis Care

Secondary suicide prevention strategies aim to decrease the likelihood of a suicide attempt in high-risk persons and require an awareness of warning signs that help people know what actions they can take to help someone at immediate risk for suicide. Secondary prevention strategies are specific measures used to care for individuals who are in a suicidal crisis and during the time that immediately follows. Crisis care is provided in hospitals, clinics, and on telephone hotlines.

<table>
<thead>
<tr>
<th>WARNING SIGNS</th>
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<tbody>
<tr>
<td>Very often family, friends, and coworkers say they had no idea that a person intended suicide. It is more likely, however, that the intention was just not recognized. Warning signs that a person is contemplating suicide include:</td>
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**Verbal Clues**

• Talk about death, having no reason to live, being a burden to others
• Talk about feeling trapped or in unbearable pain
• Comments about being hopeless, worthless, or helpless

**Behavioral Clues**

• Increased use of alcohol or drugs
• Searching for ways to kill oneself (Internet, reading material, verbal inquiries, etc.)
• Declining school or work performance
• Putting affairs in order, tying up loose ends, changing a will
• Giving away prized personal possessions
• Withdrawing from activities and isolating from family and friends
• Writing farewell notes
• Visiting or calling people to say good-bye
• Taking risks that could lead to death (e.g., driving fast or recklessly)
• Showing signs of depression (deep sadness, loss of interest, trouble sleeping or eating) that get worse
• Becoming irritable and/or aggressive

One very important warning sign occurs when depression is lifting. A sudden behavioral switch from being very sad to being very calm or appearing to be happy may signal that a decision has been made and the person now has the energy available to carry out a plan.

Source: AFSP, 2015e, Goldberg, 2014.

Immediate interventions include taking authoritative action, providing a safe environment, obtaining a history, making a diagnosis, planning interventions, initiating emergency measures, keeping accurate records, and facilitating a support system, as follows:

• If concerned about a person, speak up. If unsure whether someone is suicidal, ask.
• Respond quickly in a crisis. Evaluate immediate danger. If suicide seems imminent, call 911 immediately or take the person to a nearby hospital emergency department.
• Provide a safe environment. Remove all sharps, cords, or other objects that the person might use to harm him or herself. If possible, stay with the suicidal individual.

When the person has arrived at a hospital emergency department, crisis care continues.

• Healthcare providers obtain a history of the crisis event and intervene immediately. They gather laboratory specimens, examine patients for physical disorders, such as hypothyroidism, and evaluate clients for psychiatric disorders, such as major depression and bipolar disorders. They diagnose, plan, and institute specific care.
• Providers keep accurate records of all interventions and the response of persons who are suicidal. These records provide critical information if any legal action follows the event, such as a malpractice suit by a distressed family.
• Healthcare providers facilitate a support system for the person as soon as possible. Parents, friends, or other family members may be contacted to determine whether an adequate support system is available or if hospitalization is recommended.

CASE

Gregory
Michaela is an occupational therapist who works in the public schools with children who have emotional disturbances. One of the students, Gregory, who is 12 years old, has problems with depression, irritability, interpersonal skills, and learning skills. Michaela has developed a trusting relationship with Gregory and sees him twice a week to improve his ability to function at school and with his peers.
On Monday Gregory met with Michaela and seemed more withdrawn than usual. When Michaela asked him how he was feeling, he just shrugged his shoulders and said, "Okay, I guess." He then started to say something but stopped. He didn’t say anything more even though Michaela asked him several other questions attempting to assess his mood. This was not unusual behavior for Gregory, but Michaela had a feeling things were not quite right today. She felt he really wanted to talk to her about something but just wasn’t able to.

When he left the room that day, Michaela gave Gregory a piece of paper with her phone number written on it and told him he could call her if he wanted to talk. Gregory picked up his things, thanked her, and left.

Later that day, as Michaela was gathering her notes and files and getting ready to leave, she found an envelope that was addressed to her. She opened the envelope and discovered a handwritten note from Gregory that said he was happy to have her for a friend and he wanted to say good-bye.

Just then her telephone rang. It was Gregory, who was crying and saying he was trying to kill himself. He was scared and wanted someone to help him. Michaela asked him where he was, and he told her he was in his bedroom. She tried to keep him on the phone while she went into her files to get his home address, but he abruptly said good-bye and hung up the phone. Michaela immediately dialed 911 and gave her information to the dispatcher. She then hurried to the principal’s office, and the secretary contacted Gregory’s mother and father.

Later that evening, Michaela received a call at home from Gregory's mother, who said that when the police arrived, they found Gregory hanging from the towel rack in his bathroom, unconscious but still alive. She thanked Michaela for giving Gregory her phone number and for intervening. She told her she believed he would welcome a visit from her as soon as he was feeling better.

**Tertiary Prevention Strategies**

Tertiary prevention strategies are interventions following attempted suicide that aim to minimize the impact and reduce the likelihood of subsequent self-injury. Therapeutic treatments following suicidal behavior to prevent future attempts or to reduce the severity of injury, as well as referral for other supportive services, are examples of tertiary prevention.

Tertiary prevention strategies also include helping and providing care to individuals who had personal connections to the person who committed suicide. They are referred to as “suicide survivors” and may include family, friends, coworkers, healthcare professionals, therapists, teachers, and peers.

The intervention is often designed to identify those survivors who are at risk of suicide themselves, as well as to prevent posttraumatic stress disorder (PTSD), complicated grief, and depressive syndromes.

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DISCHARGE FOLLOWING A SUICIDE ATTEMPT

Following a suicide attempt and before the patient leaves the emergency department, it is important that both the patient and family:

- Have a thorough understanding of discharge arrangements, with written information about prescribed medications and treatment plans
- Be given a list of contacts to call, including outpatient providers, crisis lines, and peer-support center
- Be told what to look for that may indicate a return of suicidal feelings
- Have follow-up care established
- Be instructed in obtaining resources and supports in the community
- Be advised about reducing the hazards of another suicide attempt by removing lethal means
- Be given information on whom they can call with questions or concerns
- Be encouraged to get individual and family therapy
  (U.S. DHHS, 2006)

DEALING WITH THE AFTERMATH OF COMPLETED SUICIDE (POSTVENTION)

Tertiary prevention strategies include assessment of survivors who may need support dealing with their feelings and reactions following a loved one’s suicide. Survivors of suicide may experience any or all of the following emotions:

- Overwhelming guilt because they did not prevent the suicide
- Shame because suicide is a taboo behavior socially
- Profound grief, sadness, regret, distress, and anguish
- Anger at the person
- Feelings of betrayal or rejection by the person who committed suicide
- Fear because survivors may be held responsible
- Disorientation and disintegration due to the loss of a part of themselves
- Anxiety, feeling insecure
- Powerlessness, lack of control, helplessness
  (Bryan, 2013)

The goals of postvention are to help survivors grieve, understand why the person who committed suicide killed him- or herself, and decrease the assumption of inappropriate guilt for the death of the person. To achieve these goals, providers need to understand the intense emotions
experienced by these survivors of suicide, recognize the stages of bereavement, and facilitate healing and wholeness in survivors.

**Bereavement and Grief**

There are several theories regarding stages or phases of bereavement. Elizabeth Kübler Ross defined five overlapping stages of denial, anger, bargaining, depression, and acceptance. J. W. Worden refers to four tasks of mourning that include accepting the reality of the loss, experiencing the pain of loss, adjusting to a life without the loved one, and finally being able to put emotional energy into a new life (Yinstill Wellness, 2015).

Grieving has been defined as a spontaneous process of letting go of old dreams and expectations and acquiring new ones. The missing object for which the person grieves may be a person, valuable possessions, home, or even personal freedom. The process can be agonizing, especially when the loss is a loved one and when it is caused by suicide, the ultimate rejection.

“Complicated grief” is intense grief after the death of a loved one that lasts longer than what social norms expect and that causes functional impairment. The recommendation in such circumstances is psychotherapy directed at the loss and at restoring activities and effective functioning (Shear, 2015).

**Survivor’s Guilt**

Family members of people who commit suicide often feel guilty for not preventing the death. Healthcare providers also may feel guilty, believing that somehow, in some way, they could have prevented the death of a patient with whom they had established a relationship.

**Stigma**

Because suicide and mental illness is stigmatized, many people have difficulty or are unwilling to talk about it. Friends and acquaintances may not reach out to the survivors and this can leave them with a sense of isolation and abandonment. Some religions offer only limited rituals for those who have committed suicide. This, too, can lead to isolation and a feeling of alienation.

**Financial Issues**

Following a suicide the family may have financial issues to deal with. There may be debts owed because the family member was depressed and failed to pay bills, or there may be credit card debt due to spending sprees by a family member in a manic state of bipolar disorder. There may also be concerns about paying for a funeral.
Many people have life insurance policies. However, the date the policy was issued is an important factor. If there is a suicide clause in the policy it will state how much time must elapse between the date of issue and the date of the suicide. In most states the benefits will not be paid if the date of suicide is within one or two years from the date of issuance. In that event, premiums paid over the life of the policy may be returned to beneficiaries. For policies that have been in effect for longer than the one- or two-year time frame the insurance company will pay the proceeds (AFSP, 2015f).

## PROVIDING SUPPORT TO FAMILIES
Postvention interventions that may be beneficial in providing support for families following a suicide include:

- An opportunity to view the body with emotional support
- Support and assistance with official procedures and investigations
- Assistance with interpreting the postmortem report
- If appropriate, seeing a copy of a suicide note or message
- Assistance with notifying family and others of the death and its circumstances
- Written information regarding grief and coping strategies for grief
- Contact information for local bereavement and suicide bereavement support groups
- Written information on supporting children following a suicide
- Access to professional individual or group counseling, therapy, or psychotherapy if needed
- Guidance in responding to media inquiries and to questions posed in social environments
- Referral for financial evaluation and assistance
- Information about how suicide impacts family functioning and how other families have learned to cope
- Guidance in how to tell children about a suicide death of a family member
- Information on how to protect children from the risk of suicidal behavior
- Follow-up contact to offer support and assistance

Source: IABPG, 2015.

## CASE
**Alicia and Phillip**
Alicia and Phillip, ages 15 and 17, were aware that their father lost his job several months ago due to his company’s downsizing. He has been unsuccessful finding new employment, and they have been living on credit cards and handouts from family. They could see that their father was becoming more and more withdrawn, isolating himself and avoiding activities he usually
enjoyed. He no longer played golf with his buddies and had taken to drinking more alcohol. Their mother was concerned that he was becoming depressed and urged him to see a counselor. He told the family he was fine and would be okay once he found another job.

On Friday, as they arrived home from school, Alicia and Phillip saw an ambulance leaving their home. A police car stood in front of the house, and their mother met them at the door. She said something awful had happened. Their father had taken the handgun from his bedside table and shot himself in the head while she was out running errands.

Suddenly, their lives were turned upside down. Everything became surreal. Alicia and Phillip could not believe their father was dead. Only vaguely did they remember the people who came and went or the memorial service their mother arranged. Everything was a blur. They were in profound shock and denial.

The local newspaper headlined the news. Desiree, an occupational therapist, recognized the surname of Alicia, whom she had been working with at the high school for several years due to the girl’s learning disability. At the school the next day, Desiree consulted with the school psychologist and principal, and they developed a plan to contact Alicia’s family, offering support and care. They also referred the family to local resources, including an ongoing support group for suicide survivors provided by the local mental health agency.

Alicia and Phillip joined the survivor group and did well. Their mother sought individual counseling for assistance with her grieving process and the aftermath of her loss.

**POST-SUICIDE ISSUES FOR HEALTHCARE PROVIDERS AND INSTITUTIONS**

In addition to sadness for the loss and guilt for failing to prevent the death, healthcare providers may fear legal action in the form of a malpractice suit. To prepare for all these possibilities, individual healthcare providers need:

- A detailed plan of action in the event of a client suicide
- A support system made up of other members of their profession
- Accurate, detailed documentation of every aspect of patient care, including all assessment data and care
- Liability insurance to protect themselves from malpractice litigation

Likewise, healthcare institutions need to prepare for such events as suicides and establish action plans, which include:

- Formal review of each and every suicide event, addressing overlooked clues, faulty judgments, staff responsibilities, and protocols
- Plans for communicating with families after suicide
- Referral of survivors for individual counseling and group therapy
• Policy concerning staff attendance at memorial services
• Counseling for staff members, as needed
• Malpractice insurance for the institution and staff members
• Detailed written records for the client, including their assessment and treatment plan

CONCLUSION

Suicide—the deliberate ending of one’s own life—is an important public health concern around the world. Many complex factors contribute to a person’s decision to commit suicide, including biologic, psycho-sociocultural elements, and adverse life events. One important thing to consider is that most people are ambivalent about committing suicide. They are caught in a situation from which they see no way out but to end their lives. This ambivalence is important, as it is the starting point at which an effective intervention can occur.

It is imperative that healthcare professionals understand the ways in which they can assess and manage suicidal individuals and learn the skills necessary to effectively intervene and prevent a suicide from happening. These skills include:

• Recognizing who is at risk, especially those who may be at high risk in the near future
• Learning how to communicate openly with those suspected to be at risk
• Responding to the needs of persons who have attempted suicide and survived in order to prevent future suicidal behavior
• Working with survivors of a suicide loss to help protect them from consequences such as taking their own lives, PTSD, and depression
• Providing suicide prevention education to others

RESOURCES

American Foundation for Suicide Prevention
http://www.afsp.org

Columbia-Suicide Severity Rating Scale (C-SSRS)
http://www.cssrs.columbia.edu

National Suicide Prevention Lifeline
http://www.suicidepreventionlifeline.org
800-273-TALK (8255)
Recommendations for Reporting on Suicide
https://www.afsp.org/news-events/for-the-media/reporting-on-suicide

Suicide Prevention (National Institute of Mental Health)
http://www.nimh.nih.gov/health/topics/suicide-prevention/

Suicide Prevention Resource Center - Washington
http://www.sprc.org/states/washington

Veterans Crisis Line: 800-273-8255, press 1 (or text to 838255)

Washington Suicide Hotlines (suicide.org)

REFERENCES


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TEST

1. Which is a true statement regarding the prevalence of suicide in the United States?
   a. The highest rate of suicide is among adults aged 45 to 64 years.
   b. Suicide rates are higher among women than among men.
   c. The highest rate of suicide is among Native Americans.
   d. The lowest rate of suicide is among adult white males.

2. Which mental disorder leads to a 20 times greater risk for suicide over peers in the general population?
   a. Substance abuse
   b. Anxiety disorder
   c. Major depression
   d. Schizophrenia

3. Which is a social behavior that increases the risk for suicide among adolescents?
   a. Adverse childhood experiences
   b. Verbal bullying
   c. Religious beliefs
   d. Parental divorce

4. Suicide of adults aged 35 to 64 years is found to be associated more commonly with:
   a. Loss of independence.
   b. Inadequate pain control.
   c. Sexual orientation issues.
   d. Economic challenges.

5. The suicide rate for older adults is highest for those who are:
   a. Retired.
   b. Divorced or widowed.
   c. In poor health.
   d. Residing in a nursing home.
6. Which is a correct statement regarding the Washington State Death with Dignity Act?
   a. Only senior citizens meet Act eligibility requirements.
   b. The Act supersedes federal laws against active voluntary euthanasia.
   c. The Act applies only to persons who have an estimated 6 months or less to live.
   d. The Act applies to a resident of any one of the 50 states.

7. Evidence supports the benefits of suicide screening for:
   a. All adolescent patients in primary care.
   b. All patients regardless of risk factors.
   c. All older adult patients in primary care.
   d. All individuals with risk factors or warning signs for suicide.

8. The best approach for assessing suicidal intent is:
   a. Integrating a patient history with a structured interview.
   b. Taking a patient history and administering a depression screening tool.
   c. Using a suicide assessment scale while establishing patient rapport.
   d. Conducting an unstructured interview and psychiatric evaluation.

9. Which patient is at highest risk for suicide completion?
   a. A woman talking about suffocation by hanging
   b. A man with a suicidal plan who possesses a firearm
   c. An adolescent planning to take a handful of pills
   d. A young woman with a history of depression

10. A patient who has current suicidal thoughts, a plan without the intent to act, and no recent suicidal behavior is considered to be:
    a. Moderate risk.
    b. Low risk.
    c. No risk.
    d. High risk.

11. In Washington State, when is involuntary admission to a hospital setting appropriate for management of a patient at risk for suicide?
    a. When the patient has made a plan for suicide but has had no recent suicidal behavior
    b. Any time a patient makes a serious suicide attempt
    c. For any patient who attempts suicide using a high-risk method
    d. For the patient with a severe mental disorder who is suicidal
12. Which element is included in a self-management suicide safety plan?
   a. Implementing suicide precautions
   b. Monitoring the person around the clock
   c. Conducting psychotherapy for several weeks post-discharge
   d. Providing a list of personal warning signs of possible crisis

13. A form of psychotherapy that aims to elicit, clarify, and place into perspective feelings that have arisen from interaction with others in the social environment is called:
   a. Interpersonal therapy.
   b. Milieu therapy.
   c. Cognitive behavioral therapy.
   d. Problem-solving therapy.

14. A clinician in an inpatient facility conducts a teaching intervention for one resident structured as a play-based, interaction session including other residents. The clinician guides the session by combining both high- and low-structure forms of therapy. Which therapy modality is the clinician using?
   a. Dialectical Behavior Therapy
   b. Cognitive Behavioral Therapy
   c. Milieu Therapy
   d. Creative Arts Therapy

15. The clinician closely monitors an adolescent patient with major depression for suicidal thoughts or attempts when the patient is newly prescribed which drug?
   a. Amitriptyline (Elavil), a tricyclic antidepressant
   b. Bupropion (Wellbutrin), an atypical antidepressant
   c. Paroxetine (Paxil), a selective serotonin reuptake inhibitor (SSRI)
   d. Tranylcypromine (Parnate), a monoamine oxidase inhibitor (MAO)

16. An example of a primary intervention for suicide prevention is:
   a. Instituting crisis care.
   b. Screening large populations for suicide risk.
   c. Increasing public awareness and education.
   d. Conducting family therapy sessions.
17. A secondary intervention strategy for prevention of suicide is:
   a. Evaluating for imminent attempt or risk.
   b. Providing effective psychotherapy.
   c. Promoting help-seeking behavior.
   d. Referring for counseling services.

18. A goal of postvention for the survivors of a loved one’s suicide is to help them:
   a. Understand why the person killed him or herself.
   b. Gain an understanding of the theoretical basis for grief.
   c. Prevent them from grieving for the victim of suicide.
   d. Reconstitute their lives without missing their loved one.