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Contact Hours: **6**

Suicide Intervention and Prevention Training Risk Assessment, Treatment, and Management

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LEARNING OUTCOME AND OBJECTIVES: Upon completion of this continuing education course, you will demonstrate an understanding of the complex nature of suicide, how to assess and determine risk for suicide, and appropriate treatment and management for at-risk individuals. Specific learning objectives include:

- Discuss the epidemiology and etiology of suicidal behavior.
- Summarize the risk and protective factors for suicide.
- Describe the process of assessment and determination of risk for suicide.
- List the elements of appropriate documentation of suicide risk, actions, and plan of care.
- Outline the management and 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.
- Relate specific epidemiologic data, risk factors, protective factors, and interventions specific to the veteran population.

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 willpower 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 professionals 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 professionals, 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 suicidal behavior is seen to be manipulative to elicit care, 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 professionals express concern that they are ill prepared to deal effectively with a patient who is suicidal. By developing adequate knowledge and skills, these professionals can overcome feelings of inadequacy that may otherwise prevent them from effectively responding to the suicide clues a patient may be sending, thereby allowing them to carry out appropriate interventions. They can also develop a better understanding of this choice that ends all choices.

CHANGING TERMINOLOGY

Controversy has arisen regarding the use of the term *committed* when discussing suicide. It is said that this term refers back to a time in history when suicide was considered a crime. It carries with it the same connotation as that of “committing” rape, murder, or any other criminal act. Many organizations are attempting to educate both the mental health community and the public that a much less insensitive and accurate term might be used instead. This term is “death by suicide,” which will be used throughout this course.

Source: Caruso, 2015.

10 SUICIDE MYTHS AND MISUNDERSTANDINGS

Myths and misunderstandings abound concerning the subject of suicide. In order for a provider to be effective in intervening with a person who is suicidal, these myths and misunderstandings must be replaced with facts.



Myth #1: People who talk about suicide are seeking attention. Attempted suicides are often not seen as genuine efforts to end one's life but as a way to manipulate other people into paying attention to them.

Fact: Suicide should not be equated with seeking attention. In fact, the opposite is true. A person who attempts suicide is looking for an escape and cannot think of any other way than through death.

Myth #2: Suicide is an act of cowardice; it is the coward's way out.

Fact: Suicide is not caused by the absence of bravery. There are many causes, and more than courage is needed to overcome the issues involved. Suicide is a very difficult thing to consider and an even more difficult thing to accomplish.

Myth #3: People who attempt or die by suicide are selfish.

Fact: Suicide is seldom about others. Indeed, it is selfish to make someone else's suicide about you and demonstrates a lack of empathy and compassion for others.

Myth #4: All people who are suicidal have access to help if they want it, but those who die by suicide do not reach out for help.

Fact: The truth is, it is necessary to ask whether the individual was **able** to ask for help. Many seek support and help but do not find it. This is often due to negative stereotyping and the inability and unwillingness of people to talk about suicide. Financial barriers may include the lack of access, especially for those in rural areas who might not be able to easily travel to another community to seek help. Additionally, prejudices and biases among healthcare professionals can make the healthcare system unfriendly.

Myth #5: Only people who are crazy or have a mental disorder are suicidal.

Fact: Many people living with mental disorders are not affected by suicidal behavior, and not all people who die by suicide have a mental disorder.

Myth #6: Reaching out for help is the same as threatening suicide.

Fact: People who are suicidal are hurting, not threatening, and should be provided with the tools, support, and resources they need.

Myth #7: Suicide always occurs without any warning signs.

Fact: There are almost always warning signs, such as saying things like "everyone would be better off I weren't here anymore."



Myth #8: Once people decide to die by suicide, there is nothing you can do to prevent it.

Fact: Suicide is preventable. Most people who are suicidal are ambivalent about living or dying but simply want to stop hurting.

Myth #9: If you ask a person who is suicidal whether they are thinking about suicide or have chosen a method, it can be interpreted as encouragement or give them the idea.

Fact: It is important to talk about suicide with a person who is suicidal, as you will learn more about the person's intentions and thinking and can allow for diffusion of the tension that is underlying. Talking openly can give the person other options or time to rethink the decision.

Myth #10: When people who are suicidal start to feel better they are no longer suicidal.

Fact: A person who is suicidal sometimes begins to feel better because they have reached the decision to die by suicide and may have feelings of relief that their pain will soon be over.

Source: Caruso, n.d.; DoD, 2016; The Samaritans, 2016.

EPIDEMIOLOGY

Suicide Globally

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 that there are more deaths from suicide than from war and homicide combined. Suicide is considered a crime in some countries, and in others it is considered a public health issue.

Globally, suicide rates have increased 60% in the past 45 years, and 1.4% of deaths are suicides (WHO, 2016). Around the world, suicide is the 15th leading cause of death and the 2nd leading cause of death in 15- to 20-year-olds.

Risk factors differ among countries. In China and India, for example, mental disorders have less of a role than in the West (WHO, 2016; Insel, 2014). The country with the highest suicide rate in the world (four times higher than the global average) is Guyana, a rural country in the northeast of South America. Next are North Korea and South Korea. The country with the lowest suicide rate globally is Saudi Arabia (172nd). The United States ranks 47th (Habarta, 2015).



Suicide in the United States

Recent figures indicate that:

- Someone died by suicide every 12.3 minutes in 2014. Suicide is the 10th 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.
- 42,773 **incidents** of suicide were reported and 836,000 people were treated for injuries secondary to self-harm behaviors in 2014. 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.)
- Suicide **prevalence** is 13.0 deaths per 100,000 persons. The highest rate (19.5 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 ages 15 to 24 had a suicide rate of 11.6 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 2014, those who died by suicide were 77.42% male and 22.58% 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. Lower rates were found among Asians, Pacific Islanders, blacks, and Hispanics. White males accounted for 70% of all suicides in 2014.
- Firearms were the most common **method** (49.9%) of death by suicide in 2014, followed by suffocation, including hangings (26.7%), and poisoning, including overdosing (15.9%). 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.

(AAS, 2015; CDC, 2015a; CDC, 2015b; AFSP, 2015a; Jason Foundation, 2016)

Suicide among U.S. Veterans

The Veterans Health Administration states that suicide rates among veterans utilizing their services have basically remained constant over the past few years (Kemp, 2014).

Compared to the rest of the population, veterans are 2.3 times more likely to die from suicide. Tracking of military personnel suicides began in 1980, and the Afghanistan and Iraq wars have been associated with the highest suicide rates in the United States.



A recent study done by the Department of Veterans Affairs revealed:

- Compared to the U.S. population, both deployed and nondeployed veterans had a higher risk of suicide (deployed veterans 41% higher, nondeployed veterans 61% higher).
- Deployed veterans had a lower rate of suicide compared to nondeployed veterans, a difference of 16%, possibly due to the fact that service members with psychological issues are held back from deployment and suicide prevention efforts are focused on those who were deployed.
- Female veteran suicide rate was about one third (11.2 per 100,000) the rate of male veterans (33.4 per 100,000).
- Regardless of deployment status, the risk of suicide was higher among younger male, white, unmarried, enlisted, and Army/Marine veterans.
- The predictors of suicide were similar for both male and female veterans.
- The increased risk of suicide among female veterans compared to the general U.S. female population was higher than the increased risk among male veterans compared to the general U.S. male population.

(VA, 2015)

A study of veterans following discharge showed the rate of suicide was found to be greatest within three years after leaving the military. For males, suicides decreased by 6.1% on average per year, but among females it varied, with a rate of 9.1 per 100,000 in the first year, 6.1 in the second, 15.0 in the fourth year, and 9.9 in the seventh year. Early military separation (<4 years) and dishonorable discharge were suicide risk factors (VA, 2016a).

LEXICON OF SUICIDAL BEHAVIOR

Altruistic suicide

Suicide to benefit others, such as a soldier falling on a live grenade to save fellow soldiers

Assisted suicide

Death by suicide with the help of another person, sometimes a physician

Attempted suicide

A suicidal act that is not fatal, such as surviving after taking a nonfatal dose of medicine, cutting one's wrists, or crashing an automobile

Blue suicide, copicide, death-by-cop, suicide-by-cop

Acting in a threatening way so as to provoke a lethal response by a police officer

Cluster suicides

Suicides, often of young adults, that occur in the same city or town within a few months of each other following media coverage of a suicide



Completed suicide

A suicidal act that results in death

Copycat suicide

A suicide that resembles other highly publicized suicides

Euthanasia

From the Greek, meaning a “good death”; the intentional causing of a death to relieve pain or suffering, a mercy killing

Mass suicide

Suicide by a group of people, such as the 1978 cult suicide of 918 members of the People’s Temple in Jonestown, Guyana, and the 1997 Heaven’s Gate mass suicides in California

Murder-suicide

When a person kills another person(s) and then kills him/herself

Obligatory suicide

A suicide completed because the victim felt a personal duty to perform the act to honor the family, a cause, or a nation

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 dying by suicide

Suicide pact

An agreement between two or more individuals to die by suicide at the same time and/or place

ETIOLOGY AND RISK FACTORS

The exact cause of suicidal behavior is unknown, but it is known that thoughts of suicide are not uncommon. 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 biologic factors, psycho-sociocultural 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 such behavior. The inheritance of suicidal behavior appears to be linked to two main components: 1) the predisposition to psychiatric disorders and 2) 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 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.

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.

Additionally, having an unrelated spouse who has a psychiatric disorder or who dies by suicide increases the risk of suicide, showing the importance of environmental effects within the family structure (Schreiber & Culpepper, 2015).

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, 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 (Schnieder et al., 2014).

NEUROBIOLOGIC

Serotonin System

A lowered level of 5-hydroxyindoleacetic 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 normally suppresses 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 die by suicide also have fewer noradrenalin neurons in the locus coeruleus 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 die by 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 die by 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 three 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; Geoffroy 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 perception 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 die by 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, bullying 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 eight 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)

Factors Leading to Suicide According to Age

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 die by 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 die by suicide (Maslow et al., 2015).



Teens die by 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)

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)

ADULTS

The CDC (2013) reports that suicide among adults ages 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 die by 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 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.

Suicide Risk among Specific Populations

PERSONS WITH DEMENTIA

Little research has been done about suicidal ideation and behavior among patients with dementia. It has been assumed that the impairment of executive function precludes the attempt to die by suicide (Koyama et al., 2015).

Older adults account for 18% of all suicide deaths but make up only 12% of the U.S. population. This percentage may be even higher, as elder suicide may be underreported. The percentage may be closer to 40% after consideration of what are referred to as “silent suicides” that may involve overdoses, self-starvation, dehydration, and so-called accidents (Kiriakidis, 2015).

Studies done to date have been highly variable, and the estimates for suicidal ideation among this population vary anywhere from less than 1% to greater than 42%. One interpretation of all the studies may be that suicide is more common early in the course of dementia, which may be a



response to receiving the diagnosis of dementia or to the depression that often accompanies Alzheimer's disease. Other contributors may include disinhibition, impaired problem solving, and poor decision-making, as well as the adverse effects of behavioral and psychological symptoms on employment, general health status, and interpersonal relationships.

Studies currently do not provide adequate tools for determining the important contributors to the risk of suicide in this population or the risk at any stage of dementia. There is also little awareness of the role that pharmacologic agents play in the risk of suicide in patients with dementia (Alphs et al., 2016).

CAREGIVERS

As the population in the United States ages, more people require care provided by family members in managing all aspects of daily living. The risk to the health and well-being of caregivers is well documented. However, there is little research to discover the risk of suicide among this population. Two small studies suggest that family caregivers, especially those for a family member with dementia, may constitute a high-risk group for suicide. Sixty percent of caregivers in the study experienced signs of clinical depression (O'Dwyer et al., 2015).

Family caregivers with anxiety or depression are at a higher risk of suicide. Among family caregivers with anxiety or depression, being female, unmarried, and unemployed during caregiving, and having a low quality of life are associated with increased suicidal ideation. Family caregivers with anxiety who become unemployed during caregiving constitute a high-risk group (Park et al., 2013).

A recent pilot study found that 1 in 4 people who provide care for a family member with dementia had contemplated suicide more than once the previous year. Only half had ever told someone they were considering suicide in the future. The study also revealed that one third of those caregivers who contemplated suicide said it was likely they would attempt suicide in the future.

Caregivers who contemplated suicide had poorer mental health, lower effectiveness in obtaining community support services, and greater use of dysfunctional coping strategies. The study concluded with the recommendation that more research be done in this area and changes made in clinical practice in terms of supporting caregivers who are contemplating suicide (O'Dwyer et al., 2015).

MILITARY SERVICE PERSONNEL

The greatest problem with suicide in the military is among soldiers in the Army branch. One explanation given for this is that it is due to an increase in poor mental health among Army personnel related to military experiences, especially since the Afghanistan and Iraq wars. Hospitalizations among these soldiers have steadily been rising, doubling for depression alone. At the same time, active-duty soldiers have been hospitalized two and a half times more for alcohol abuse/dependence, five times more for drug abuse/dependence, and ten times more for PTSD (posttraumatic stress disorder).



It has been established that being in combat carries considerable risk to military personnel's psychological well-being, with higher depression and PTSD rates seen in those involved in combat when compared to those who have not. Evidence shows that the increase in military suicides is the result of an increase in mental health issues, driven in part, but not entirely, by combat and deployment involvement (Castro & Kintzle, 2014).

Pre-Enlistment Mental Health

Mental health issue rates have risen 65% among active-duty troops since 2000 (Kime, 2015). It has been found that nearly 85% of soldiers self-reported having had a mental disorder beginning prior to enlistment. The most common mental disorders reported by soldiers were panic disorder, attention deficit hyperactivity disorder (ADHD), and intermittent explosive disorder. An early onset of these disorders as well as substance use occurred more often in soldiers than civilians (NIMH, 2014; Naifeh et al., 2015).

Screening of military recruits is done in order to reject those applicants with a preexisting mental condition or previous suicide attempts. However, military psychiatrists note that screening out mentally ill recruits is not as simple as it sounds, as the military relies largely on the applicants themselves to disclose mental health history. It has been suggested that improved screening of recruits should occur, not to exclude them, but rather to provide treatment to those who acknowledge a history of mental illness (Naifeh et al., 2015).

In an all-Army study completed by the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS), soldiers reported the following suicidal ideation or behavior prior to enlistment:

- 13.9% considered suicide at some point in the past.
- 5.3% had made a suicide plan.
- 2.4% had attempted suicide.

(Naifeh et al., 2015)

The study found that prior to enlistment, patterns of suicidal ideation and behavior were lower than in a matched civilian group, but once in the Army, these became more common.

During Military Service

Following enlistment, 90.9% of Regular Army suicides were completed by enlisted soldiers. Currently and previously deployed enlisted soldiers in their first four years of service had higher rates. Soldiers attempting suicide appear to be mostly lower-ranking, enlisted, female, and previously deployed (NIMH, 2014). The Pentagon released a report stating that more than half of those who died by suicide were married and had access to a gun at home. However, suicide rates are the highest among soldiers who are divorced or



separated—24% higher than those who are single. Of suicide attempts, 54% involved drugs and 41% of these involved prescription medications (Kime, 2015; MSRC, 2016).

Approximately one third of postenlistment suicide attempts are tied to preenlistment mental disorders, accounting for 60% of first suicide attempts in the Army (NIMH, 2014; MSRC, 2016). Nearly two thirds of those who completed suicide had seen a doctor within the three months prior to taking their own lives, but less than half had a mental health diagnosis and less than a third gave any indication of planning to harm themselves (Kime, 2015).

A National Institutes of Mental Health study showed there was an increased risk in soldiers without at least a high school diploma or a GED certificate compared to soldiers with similar or higher degrees, and that demotions during enlistment increased the risk for suicide (MRSC, 2016).

Of particular concern is the fact that despite the military's attempt to remove barriers that are often associated with seeking care and to ensure soldiers that their careers will not be harmed by seeking care, the reality is that seeking care can impact career advancement. In addition, soldiers are encouraged to solve their own problems. In fact, they receive resilience training with the aim that they will not need to ask for help. This makes it easy to understand how a soldier may be diverted from getting the help needed (Castro & Kintzle, 2014). A Defense Department spokesperson stated, however, that service members are pursuing "help seeking behaviors" in greater numbers today, calling help lines at greater rates, and making more mental health appointments (Kime, 2015).

Military Veterans

The transition from the military to civilian life involves moving away from the military culture to a civilian culture, which produces changes in relationships, assumptions, work context, and personal and social identity. Because certain factors may create a susceptibility to negative outcomes with this transition, veterans are particularly vulnerable to self-harm acts (Castro & Kintzle, 2014).

When the veterans of modern-day wars return to civilian life, they are rejoining a community that has had little direct experience with the military. This can lead to a sense of alienation and feelings of not belonging (Zottarelli, 2015). In addition, a veteran's sense of accomplishment at having served in the military during wartime is often not understood or appreciated by civilians. This, too, can lead to feelings of alienation and feeling of not belonging (Castro & Kintzle, 2014).

The veteran of today is also in many cases dealing with unresolved mental and physical health issues. Many have been wounded in action, and many have received a diagnosis of PTSD. They often leave service without adequately addressing these issues, and when transitioning to civilian life, this can result in significant barriers to occupational and social functioning. These issues can also inhibit the veteran's ability to form meaningful



relationships, which can create within them a belief that they are a burden to their family and friends as well as the community as a whole.

For the older veteran, the move from middle life to later life can bring both physical and psychological deterioration, which may be related to war injuries (Castro & Kintzle, 2014).

Female Veterans

Female veterans ages 18 to 29 kill themselves at nearly 12 times the rate of female nonveterans. In every other age group, including women who were in the military as far back as the 1950s, the rates are between four and eight times higher. This indicates that causes extend well beyond the psychological effects of war. Two reasons given are that female veterans are at a higher risk for PTSD that stems from military sexual assault as well as physical injury.

Reintegration into family can often be difficult, as female veterans may not have a support system to deal with service-related issues. Women who are in dual-military marriages must adjust to changes in their partners as well as in themselves, and they often are the caregivers for injured veteran partners. Female veterans who are largely outside Veterans' Administration care in particular are at an "alarming risk" for suicide (Zottarelli, 2015).

Suicide Protective Factors

Although there are many risk factors for suicide, there are also factors that protect people from making an attempt or completing suicide. These protective factors are:

- Access to effective clinical care for mental, physical, and substance abuse disorders
 - Access to a variety of clinical interventions and support for seeking help
 - Support from family and community (connectedness)
 - Support resulting from ongoing medical and/or mental health relationships
 - Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
 - Religious and/or cultural beliefs that discourage suicide and support the instinct for self preservation
 - Restricted access to guns
- (CDC, 2015c)



Additional factors that protect youth from suicide attempt or completion include:

- Psychological or emotional well-being
- Good self-esteem
- Good academic standing
- Involvement in frequent physical activity or sports
- Feeling safe at school
- Having a caring adult available
- Reduced access to alcohol, firearms, and medications
(Malley, 2012)

SUICIDE SCREENING AND ASSESSMENT

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 prevention **screening** refers to a quick procedure in which a standardized instrument or tool is used to identify individuals who may be at risk for suicide and in need of assessment. It can be done independently or as part of a more comprehensive health or behavioral health screening. 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.

Suicide Screening

Generally, screening takes 10 to 20 minutes and can be done by any qualified health service personnel using a standardized screening instrument. 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, emergency department, 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. One argument for screening is that many patients who later die by suicide are seen in an emergency department or primary care setting in the weeks and months prior to a suicide attempt.

UNIVERSAL SCREENING

Data does not support universal screening. Screening has been shown to result in a very high false-positive rate. In one study, of nearly 42% of screened positives that received further assessment, 1.5% were true positives. Among adolescents, 51% screened positive, but only 5% were true positive. All patients with mental health complaints screened positive, but none were determined to be suicidal on further assessment (Schneider, 2015).

Universal screening raises concerns about legal issues if a patient is sent home with a positive screen, particularly if, sometime in the future, they attempt or complete suicide. Other important questions that have not as yet been answered are:

- Should all positives be cleared by psychiatry?
- Should all patients discharged receive referral to mental health resources?
- Should all who screen positive have one-to-one observation, at least until a full assessment by an ED physician has been completed?

Clinicians should be aware of the unintended consequences of high-risk suicide categorization, such as unwarranted detention for some patients as well as the stigma that arises after patients are labeled as dangerous to themselves (Schneider, 2015; Lotito & Cook, 2015).

The U.S. Preventive Services Task Force states that current evidence is lacking, is of poor quality, or is conflicting to assess the balance of benefits and harms of screening for suicide risk in adolescents, adults, and older adults in primary care (USPSTF, 2015).

JOINT COMMISSION RECOMMENDATIONS

Recent studies indicate that universal suicide risk screening in the ED is feasible and has led to an increase in risk detection (although not as yet found to be true when scaled). The Joint Commission has recommended that in acute and nonacute settings providers should:

- Review each patient's personal and family medical history for suicide risk factors
- Screen all patients for suicide ideation using a brief, standardized, evidence-based screening tool
- Review the questionnaire before the patient leaves the appointment or is discharged



- Take the following actions, using assessment results to inform the level of safety measures needed:
 - Keep patients in acute suicidal crisis in a safe healthcare environment under one-to-one observation, using suicidal precautions
 - For lower-risk patients, make personal and direct referrals to outpatient behavioral health and other providers for follow-up within one week of initial assessment
 - For all patients with suicidal ideation:
 - Give patient and family the phone number to the National Suicide Prevention Lifeline as well as to local crisis and peer support contacts
 - Conduct safety planning by working with the patient on identifying possible coping strategies and providing resources for reducing risks
 - Review the safety plan with the patient at each interaction until risks are no longer present
 - Restrict access to lethal means

Source: Boudreaux et al., 2016; TJC, 2016.

SELECTIVE SCREENING

Suicide screening is considered to be of benefit when risk factors or warning signs do 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 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 die by suicide



SCREENING TOOLS

The following are recommended evidence-based screening tools:

Patient Health Questionnaire-2 asks two questions about depression symptoms and can include an additional question about suicidal thoughts and feelings.

If a patient answers yes to any of the questions, the **Patient Health Questionnaire-9 (PHQ-9)** is administered. This asks nine questions about depression and suicidal ideation over the last two weeks, scored as: 1, not at all; 2 (several days); 3 (more than half the days), or 4 (nearly every day). For any items with a positive response, the patient is asked to rate the degree of difficulty it causes at work and in getting along with other people (TJC, 2016).

ED-SAFE Patient Safety Screener asks six questions:

1. Over the past 2 weeks have you felt down, depressed, or hopeless?
2. Have you felt little interest or pleasure in doing things?
3. Have you wished you were dead or wished you could go to sleep and not wake up?
4. Have you had thoughts of killing yourself?
5. In your lifetime have you ever attempted to kill yourself?
6. When did this happen?

Should the screening be positive, the **Patient Safety Secondary Screener: Deciding Whether to Consult Mental Health** is employed. This tool is designed to help guide decision making regarding whether the individual should have further evaluation by a mental health clinician (EMNet, 2016).

Ask Suicide-Screening Questions (ASQ) can be used with all patient populations, takes two minutes to administer, and asks four basic questions:

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? If yes, how?

Positive responses to one or more of these four questions have been found to identify 97% of the youth at risk for suicide (NIMH, 2016).

Mood and Feelings Questionnaire (MFQ) is a common depression screening tool designed for children ages 7 to 17 years. It uses 13 questions (33 in the long version, four of which specifically screen for suicide ideation). The tool is completed by both the child and the parent.



The child and parent answer with 0 for “not true,” 1 for “sometimes,” and 2 for “true”. Statements that screen specifically for suicide include:

- I/he/she thought that life wasn’t worth living.
- I/he/she thought about death or dying.
- I/he/she thought my/his/her family would be better off with me/him/her.
- I/he/she thought about killing myself/himself/herself.
(York et al., 2016)

Suicide Assessment

Suicide assessment is done to determine risk and is not a prediction. The goals of suicide risk assessment are:

- To identify factors that may increase or decrease a patient’s level of risk
- To estimate an overall level of suicide risk
- To develop a treatment plan that addresses the patient’s safety and modifiable contributors to suicide

Suicide risk assessment is a continuous process, best understood as a continuum rather than an isolated, one-time event.

Completing an accurate suicide risk assessment is a complex task. There are multiple factors influencing a person’s level of suicide intent and willingness to share such information. It is extremely important for healthcare professionals to use a systematic approach to conducting and documenting the possibility that a patient will die by suicide (Harris et al., 2015).

An evidence-based approach remains difficult mainly because suicidal behavior involves so many different factors. At this time, there is no tool or scale that is specific or sensitive enough to predict to any useful degree whether a person will die by suicide. It is, therefore, important that the assessment process involve both a standardized tool and a detailed clinical interview that is repeated over time (Harris et al., 2015; Lotito & Cook, 2015).

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 understand what has happened or is happening to him or her.



Most vulnerable people see healthcare workers as empathetic 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.

Basic Attending Skills

Basic attending and listening skills are valuable in establishing rapport and a therapeutic alliance in order to obtain information, set the foundation for the treatment plan, and assist in determining interventions. These skills range from nondirective listening behaviors to more active and complex ones.

Positive attending behaviors are nonverbal and include:

- **Eye contact.** Cultures vary in what is considered appropriate. Asian and Native Americans, for example, may view eye contact as aggressive. Most patients are comfortable with more eye contact when the interviewer is talking and less when they are talking.
- **Body language.** Usually leaning slightly toward the patient and maintaining a relaxed but attentive posture is effective. This may also include mirroring, which involves matching the patient's facial expression and body posture.
- **Vocal qualities.** These include tone and inflections of the interviewer's voice. Tonal quality may move toward "pacing," which is matching the patient's vocal qualities.
- **Verbal tracking.** This involves using words to demonstrate that the interviewer has an accurate following of what the patient is saying, such as restating or summarizing what the patient has said.

Negative attending behaviors include:

- Turning away from the patient
- Making infrequent eye contact
- Leaning back from the waist up
- Crossing the legs away from the patient
- Folding the arms across the chest

Listening Skills and Action Responses

Effective interviewing also requires nondirective and directive listening as well as directive action responses.



Nondirective listening responses:

- **Silence** is a skill requiring practice to be comfortable with. It is very nondirective, and if used appropriately, it can be very comforting for the patient.
- **Paraphrasing** or reflection is a verbal tracking skill that involves restating or rewording what the patient has said. There are three types of paraphrasing that can be utilized:
 - Simple paraphrasing gives direction but involves rephrasing the core meaning of what the patient has said.
 - Sensory-based paraphrasing involves the interviewer using the patient's sensory words in the paraphrase (visual, auditory, kinesthetic, etc.).
 - Metaphorical paraphrasing involves making an analogy or metaphor to summarize the patient's core message.
- **Intentionally directive paraphrasing** is solution-focused and attempts to lead the patient toward more positive interpretations of reality. It involves selecting positive parts of the patient's statement, and can also include adding to or "twisting" what has been said.
- **Summarization** is an informal summary of what the patient has said. It should be interactive, encouraging and supportive, and include positives or strengths that may help the patient cope.

Directive listening skills:

- **Validating feelings** involves acknowledgement and approval of the patient's emotional state. It can help patients accept their feelings as normal or natural and can enhance rapport.
- **Interpretive reflection of feeling**, also referred to as advanced empathy, seeks to uncover deeper, underlying feelings, which can bring about strong emotional insights or defensiveness.
- **Interpretation** can be a classic psychoanalytic technique that produces patient insight, or a solution-focused way to help patients view their problems from a new and different perspective, known as reframing.
- **Confrontation** involves pointing out discrepancies to help the patient see reality more clearly. It works best when excellent rapport has been established, and it can be either gentle or harsh.
(Sommers-Flanagan & Sommers-Flanagan, 2014)

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.

It is also important to avoid “why” questions, which tend to make people defensive. Asking “who,” “what,” “where,” “when,” and “how” questions allows for more detailed information to be obtained for consideration (IASP, 2015).

RESPONDING TO PERSONS WHO ARE SUICIDAL	
Person’s Statement	Appropriate Responses
Everyone will be better off without me.	<ul style="list-style-type: none"> • Who would be better off? • What would be better for those people? • Where are you planning to go?
I just can’t bear it anymore.	<ul style="list-style-type: none"> • What is so hard to bear? • What would make your life better? • When did you begin to feel this way?
I just want to go to sleep and not deal with it again.	<ul style="list-style-type: none"> • What do you mean by “sleep”? • What is it you don’t want to deal with anymore?
I want it to be over.	<ul style="list-style-type: none"> • What is it you want to be over? • How can you make it be over?
I won’t be a problem much longer.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • What can you do to change that? • What, then, do you propose to do?
It is all so meaningless.	<ul style="list-style-type: none"> • 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 die by suicide. This is definitely not the case. By being asked about suicidal thoughts or intent, the person is given an opportunity to openly talk about what concerns them to someone who is respectful and caring.



Once an individual is suspected of thinking about dying by 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 professionals in determining suicidal intent. These assessment tools are used to assess a person's intent to carry through. They are often used following positive results done with one of the screening tools mentioned above.

Columbia-Suicide Severity Rating Scale (C-SSRS) is currently the most favored assessment tool. In 2012, the U.S. Food and Drug Administration 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 (CUMC, 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 (CUMC, 2015).

Other effective assessment tools include:

Beck Depression Inventory-II (BDI-II) is designed to assess feelings and behaviors over the previous two weeks and can be used to track depressive symptom severity. It is validated for use in adolescents and adults in both an outpatient or inpatient setting and is one of the most widely used instruments for depression. The test directly assesses suicidal



ideation as well as pessimism, a more powerful indicator of suicidal behavior than suicidal ideation.

Beck Hopelessness Scale (BHS) takes five minutes to complete and is based on the known association between pessimism, hopelessness, and suicide. Hopelessness is an even stronger predictor of suicidal intent than the severity of depression. Scores obtained on the BHS have been more strongly connected to suicidal behavior, but it is recommended that it be used along with BDI-II when assessing suicide risk.

Beck Scale for Suicidal Ideation (SSI) measures active and passive suicidal desire as well as suicidal preparation. Positive responses are an indication that further detailed inquiry should be done.

Linehan's Reasons for Living Scale focuses on protective factors or the patient's reasons for not dying by suicide. It is reliable in helping to identify patients with suicidal ideation compared to those without, and it is recommended for use in monitoring chronic suicidality in high-risk patients over time. Use of this scale may assist the patient to identify strengths and reasons for living that may not otherwise be considered without prompting.

Firestone Assessment for Self-Destructive Thoughts is based on the observed association between the strong influence on negative thought processes and suicidal and self-destructive behaviors. This tool must be administered by a clinical psychologist and takes about 20 minutes to administer and score. It is designed to help clinicians determine the level at which a patient is experiencing the highest intensity of self-destructive thoughts. Predictive validity for suicide and the scores do not exist at this time; however, its potential for identifying specific maladaptive thinking related to suicidal ideation enhances the clinical interview when attempting to determine the overall risk for suicide. This is especially true when repeated over time (Lotito, & Cook, 2015).

Structured Interview

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.

A detailed clinical interview is a flexible, interpersonal process that is designed to initiate a therapeutic relationship, gather assessment information, and begin therapy. It is the entry point and is viewed as an assessment procedure (Sommers-Flanagan & Sommers-Flanagan, 2015).



The main components of a suicide assessment clinical interview include:

- Exploring suicide risk factors
- Assessing depression
- Direct questioning regarding suicidal ideation
- Determining the presence of a suicide plan
- Determining suicide intent by assessing the patient's reasons for living
- Judging the patient's self-control

The **Chronological Assessment of Suicide Events (CASE)** approach is a structured interviewing technique rather than a scale for assessing a person's risk for suicide. It allows the healthcare provider to get a detailed account of suicidal thoughts, any preparations and attempts, and current psychiatric symptoms that may require treatment. It is an easily learned interviewing strategy designed for use by frontline clinicians in both mental health and primary care settings and can be completed in 5 to 10 minutes. The CASE approach is not recommended for interviewing children (Lotito & Cook, 2015; Peterson, 2014; TISA, 2015).

This flexible interviewing strategy is used to sensitively uncover 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 (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 received a referral from a primary care physician for a patient named Grace, who has trigeminal neuralgia. Trigeminal neuralgia is characterized by severe unilateral paroxysmal facial pain and often described by patients as the "world's worst pain." Alex is familiar with this syndrome and its label as 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 the aims of occupational



therapy management in terms of adapting Grace's activities of daily living in response to her pain and improving her quality of life. After performing Grace's initial 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.

Barriers to Effective Suicide Assessment in the Emergency Department

At the present time there are no evidence-based practice guidelines for the identification, management, and disposition of patients arriving in an emergency department (ED) with acute risk for suicide. Although the ED is a common setting, suicide risk often goes undetected. The risk for suicide is especially increased within one week of discharge from an ED, implying there is a great need for continuous mental health care.

In a survey across the nation, ED directors have stated that preventive health services (e.g., suicide prevention measures) conflict with emergency medicine's "philosophy" of stabilizing acute illness and decompensated chronic health conditions. Challenges due to the fast-paced environment, the complex nature of suicide, and stigma present a number of barriers to be overcome. Four barriers to effective suicide prevention in the ED are:

1. **Overcrowding/financial issues.** Overcrowding of emergency departments due to many social and financial factors can limit the amount of time an ED provider can spend with a patient. Demand for services can exceed the capacity of a facility, and the requirement that EDs receiving federal funds for payment must provide services whether or not a person is able to pay can lead to a decrease in the number of facilities providing services. The pressures of overcrowding can prevent the integration of preventive services such as suicide risk assessment due to time constraints.
2. **Hospital size.** The size of the hospital matters. Nurses have been surveyed in both large and small hospitals to ascertain their attitudes toward patients who present with self-inflicted injuries. Those who worked in larger hospitals reported feeling less competent in assessing patients for risk of suicide and less empathy toward them than those working in smaller hospitals, which may be due to the large volume of patients seen by nurses in larger hospitals.



3. **Scarcity of mental health professionals.** The majority of EDs do not staff mental health professionals, and there is often inadequate access to psychiatric consultation. Providers working in EDs report having limited psychiatric training, in particular relating to assessment and management of suicidal risk. As a result of increasing demands on the providers, along with limited mental health resources, ED providers can either take a dismissive or overly cautious approach, both of which may be ineffective.
4. **Stigma and stereotypes.** Studies have repeatedly shown that ED providers have negative attitudes toward patients with psychiatric or suicide-related issues, and these attitudes most probably influence how the patient perceives care. One study that elicited experiences of patients who had received treatment in an ED after a suicide attempt found that over 50% felt their interactions with ED staff were punishing or stigmatizing.
(Petrik et al., 2015; SPRC, 2015a)

ASSESSING THE PLAN, LETHALITY, AND RISK

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 the 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 lower risk.

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

Methods of Suicide and Lethality

The desire for a painless method of suicide often leads individuals to choose a method that tends to be less lethal. This results in failed attempts. For every successful attempt, there are 33 unsuccessful ones, and for drug overdoses, the ratio is around 40 to 1.

Common methods chosen and their fatality rates are described in the following table:



SUICIDE METHODS AND FATALITY RATES	
Method	Description
Firearms	<ul style="list-style-type: none"> • Used in almost two thirds of fatal suicides in the United States (Kenneback & Bonin, 2016) • Often easily accessible; over one third of U.S. households have guns; 85% of firearms used in youth suicide come from the victim’s home (SAMSHA, 2014) • More lethal than other methods • Gunshot to the head 97% to 99% fatal; gunshot to the chest 97% fatal • Most other methods allow an opportunity to change one’s mind; death by firearm is immediate—once the trigger is pulled, there is no chance to abort the attempt
Asphyxiation / Suffocation	<ul style="list-style-type: none"> • Most common method is hanging, 89% fatal • Encasing the head in a plastic bag, 23% fatal; sometimes includes inhaling a gas such as helium or nitrogen • Drowning by driving or walking into a large body of water (63% fatal) or in as little as a slightly filled bathtub (21% fatal)
Jumping	<ul style="list-style-type: none"> • Jumping from a significant height such as a building, bridge, or cliff, 93% fatal • Jumping under a subway or underground train (67% fatal) or under a high-speed train (90% fatal)
Carbon monoxide poisoning	<ul style="list-style-type: none"> • Locking oneself in a closed garage with the engine running, often fatal even if one backs out of the attempt, 71% fatal
Staging an automobile crash	<ul style="list-style-type: none"> • 78% fatal
Chemical poisoning	<ul style="list-style-type: none"> • Cleaners, industrial fluids, cyanide, household products, etc., up to 54% fatal dependent on agent used
Exsanguination	<ul style="list-style-type: none"> • Slitting the wrists, 6% fatal • Slitting the throat or other major artery using a sharp implement such as a razor or knife, 51% fatal
Drug/alcohol poisoning	<ul style="list-style-type: none"> • Illegal drugs, 49% fatal • Prescription medications, 12% fatal • Nonprescription medication, 6% fatal • Alcohol in excessive amounts, unreliably fatal
Electric shock	<ul style="list-style-type: none"> • Jamming a utensil into a wall outlet, 65% fatal • Dunking an appliance in an occupied bathtub, 65% fatal
Sources: Hassamal et al., 2015; HSPH, 2016.	



Factors that influence the lethality of a chosen method include:

- **Intrinsic deadliness.** A gun is intrinsically more lethal than a bottle of pills.
- **Ease of use.** If a method requires technical knowledge, for example, it is less accessible than one that does not.
- **Accessibility.** A gun in the cabinet in the hall is a greater risk than a very high building 10 miles away.
- **Ability to abort.** More people start and stop mid-attempt than carry through. It is easier to interrupt a hanging or to call 911 after overdosing than if jumping off a bridge or using a gun.
- **Acceptability to the individual.** Must be a method that does not cause too much pain or suffering. For example, fire is readily accessible, but it is seldom ever used in the United States.

(Barber & Miller, 2014)

Level of Risk

Low risk. Patients who have had recent suicidal ideation or thoughts but no specific plans or intent to die by 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 do not 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 professional 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 professional 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.

Moderate risk. 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.

High risk. Patients with persistent thoughts of suicide; those with a plan and/or intent to die by 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; VA, 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).

Impulsiveness and Access to Means

The ease of access to methods of suicidal behavior is linked to a higher risk for suicide and believed to be linked to impulsiveness. Impulsiveness is the tendency to act before thinking through a plan and/or its consequences. Impulsiveness is associated with several mental disorders such as borderline personality disorder, conduct disorder, antisocial behavior, and substance/alcohol abuse (SAMHSA, 2014).

The actual suicide act occurs, as would any behavior, in a brief span of time, but the suicidal ideation and ambivalence that precedes it waxes and wanes. During a short-term crisis, suicide attempts can be made impulsively. Twenty-five percent of individuals aged 13 to 34 who attempted suicide and survived said that less than 5 minutes passed from the time they decided to kill themselves and the actual attempt to do so (SAMHSA, 2014).

Recent research has shown, however, that contrary to commonly held beliefs, impulsivity is not a strong predictor or cause of suicidal behavior. Impulsivity has only a small relationship with prior attempts, is a poor predictor of future attempts, and is unrelated to death by suicide (Klonsky & May, 2015; Anestis, 2015).

The evidence is heavily weighted to support the claim that suicide is rarely if ever an impulsive and unplanned behavior. It is essential to avoid thinking about suicide as a frantic, sudden escape from an acute crisis and instead think about it as a calculated pursuit of death that requires a willingness to persist through the pain, discomfort, and fear that comes along with suicidal behavior.

The new research now suggests that rather than impulsivity having a direct relationship to suicidal behavior, it has a distal relationship. Impulsivity facilitates a lifestyle in which painful and aggressive or provocative events are more apt to be experienced. Experiences associated with pain, injury, fear, and death can lead over time to a higher capacity for a suicide attempt (Klonsky & May, 2015; Anestis, 2015).



Differentiating between Nonsuicidal Self-Injury (NSSI) and Suicide Attempt (SA)

Healthcare professionals are increasingly confronted with another problem related to suicide attempts, called nonsuicidal self-injury. NSSI is defined as the “deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned” (such as piercing or tattooing) (APA, 2013).

Both NSSI and suicidal thoughts and actions are part of a group of behaviors resulting in physical damage to the body, and because these behaviors can look so similar, it can be very difficult to tell the difference between them (Whitlock et al., 2015). To predict suicide risk accurately and to make clinically sound decisions regarding treatment and hospitalization, it is imperative that providers understand the distinction between NSSI and SA. These differences include:

- **Expressed intent.** The expressed intent of NSSI is most often to feel better, but the expressed intent of suicide is to end feeling (living) altogether. NSSI behavior is classified as suicidal as opposed to nonsuicidal if any stated or inferred intent to die is given as a reason for the behavior.
- **The method used.** Methods for NSSI usually cause damage to the surface of the body only, such as cutting or burning. Suicide-related behaviors, however, are more lethal (e.g., firearms, hanging, self-poisoning). It has been found to be very rare for persons who practice NSSI and who are also suicidal to identify the same methods for each purpose.
- **Level of damage and lethality.** NSSI is very often accomplished by using methods designed to damage but not lethally injure the body enough to need treatment or to end life. Suicide attempts are always more lethal.
- **Frequency.** NSSI is often used regularly or off and on in order to deal with stress and other emotions. Suicide-related behaviors are much rarer.
- **Level of psychological pain.** In patients who practice NSSI, the level of psychological distress experienced is often quite a bit lower than that which gives impetus to suicidal thoughts and behavior. Also, NSSI tends to reduce stimulation in those who use it and is used as a means to avoid dying by suicide when the person is having suicidal ideations.
- **Presence of “black-and-white” thinking (cognitive constriction).** Cognitive constriction is seeing things as all or nothing, one way or the other, good or bad. There is no room for ambiguity, no room for gray. Persons who are suicidal often experience high cognitive constriction; however, it is less severe in those who use NSSI as a coping measure.
- **Aftermath.** The aftermath following NSSI or a suicide attempt is often extremely different. Unintentional death can occur with NSSI, but this is uncommon. The aftermath



of an NSSI incident is most often short-term improvement in functioning and the sense of well-being. The aftermath of a suicide attempt is exactly the opposite.

(Whitlock, 2015; Muehlenkamp, 2014)

Even though there are differences in the intentions between NSSI and SA, it is important to recognize that they share common risk factors. It is because of these risk factors that the presence of NSSI is, in and of itself, a risk factor for suicidal thoughts and behaviors (Whitlock, 2015).

NSSI is a strong predictor of future suicide attempts, even stronger than a history of patient SA. Although over half of individuals who report practicing NSSI report no suicidal thoughts and behaviors, NSSI is a strong risk factor for suicide and is associated with many psychological difficulties and disorders, including mood and anxiety disorders, borderline personality disorder, substance abuse, having difficulties with a negative affect (e.g., frustration or anxiety), hopelessness, self-criticism, poor body image, and low self-esteem (Lloyd-Richardson et al., 2015; Klonsky et al., 2014).

Although research suggests that NSSI may increase risk for a suicide attempt, little is known about the relationship between NSSI and suicidal ideation or attempts. At this time there is no evidence that NSSI causes suicidal thoughts and behavior; however, there is evidence that NSSI practice lowers the inhibition to engage in suicide behavior, as it provides practice in damaging the body, which can overcome the psychological and physical barriers to carrying out suicide behaviors (Whitlock, 2015; Muehlenkamp, 2014).

SIGNS OF NSSI

Physical warning signs that an individual may be practicing NSSI include:

- Frequent unexplained injuries such as burns or cuts
- Evidence of recent injury, such as scars or cluster of marks on the skin
- Injuries that are present on the opposite side of the body from the dominant hand
- Frequent bandaged wrists and/or arms
- Hidden wounds (under arms, between the toes, and occasionally insertions under the skin)
- Wearing clothing that is inappropriate for the season to cover up arms and legs
- Reluctance to take part in activities that require a change of clothing
- Minimization of wounds and attempts to distract the provider from investigating them
- Direct observation of self injurious behaviors such as self punching or scratching, needle sticking, head banging, eye pressing, finger or arm biting, pulling out hair, or picking at the skin

(Jenkins et al., 2014; Yearwood et al., 2012)



New NSSI practitioners are more likely to use exposed areas such as thighs and arms, and the extent and location of wounds may signal the stage of addiction to the behavior.

ASSESSMENT TOOLS AND METHODS

Currently, there is little guidance on how to proceed when a patient presents with self-injurious behavior with no suicidal intent. Providers often struggle with whether self-injurious behavior falls on the spectrum of suicidal behavior, and professionals have little information regarding how to assess NSSI, how to know when it is associated with suicide, and how to provide the correct level of care for these individuals.

One of the most useful tools to utilize during a clinical interview for assessing the suicide risk of those who practice NSSI is the Beck Hopelessness Scale (BHS) (see also above under “Assessing Suicidal Intent”). This scale is a brief, self-report measure shown to predict suicide in both inpatient and outpatient psychiatric patients and is one of the most widely used scales for hopelessness. It involves 20 true-false questions that assess positive and negative thoughts about the future over the course of the past week.

The BHS can be helpful in determining risk for suicide, as those who practice NSSI are known to be less pessimistic about the future than those who are suicidal. These individuals feel they have choices and can modify their pain. The practice of NSSI offers a sense of control over their situation, and this is in complete opposition to the experience of hopelessness expressed by persons with suicidal intent (Muehlenkamp, 2014).

There are several other tools available to assist with assessment of self-injury. These include:

Self-Report Measures

- **Functional Assessment of Self-Mutilation (FASM)** gathers information about NSSI history, methods, frequency, functions, and lethality.
- **Inventory of Statements about Self-injury (ISAS)** collects information about NSSI history, methods, frequency, and functions.
- **Nonsuicidal Self-injury Assessment Tool (NSSI-AT)** collects the patient’s NSSI history, methods, frequency, functions, addictive qualities, context of NSSI (e.g., social setting, routines), and NSSI treatment experiences.

Interviews

- **Self-Injurious Thoughts and Behaviors Interview (SITBI)** obtains the patient’s NSSI history, methods, frequency, functions, and lethality. Also assesses suicide thoughts and behaviors.
- **Suicide Attempt Self-Injury Interview (SASII)** obtains the NSSI history, methods, frequency, functions, and lethality. Also assesses suicide thoughts and behaviors. (Lloyd-Richardson et al., 2015)



Documentation

Good documentation is basic to clinical practice. Accurate, sufficiently detailed, and concise records of a patient's treatment allows for quality care and communication among providers (APA, 2016).

Since suicide risk assessment is not a one-time, isolated event, a standardized form is recommended to gather essential information on risk and protective factors as well as collateral information and to make it readily accessible to other clinicians. The use of such a form ensures that all important facets of the assessment are included and allows the clinician as accurately as possible to make a clinical judgment about level of risk and the treatment plan that coincides with this level (APA, 2016).

SUICIDE RISK ASSESSMENT DOCUMENTATION ELEMENTS

The following elements are considered essential in the accurate documentation of a suicide assessment:

- Events preceding the person's current suicidal ideation or behavior
- The frequency, duration, and intensity of suicidal thoughts
- Preparations made, such as giving away possessions, putting affairs in order, stockpiling pills
- The stated or inferred desire to die and the intent to act
- The reasons for wanting to die
- Past suicide attempts, including the outcome and aftermath
- Any protective factors that could reduce the risk of suicide
- The person's view of the risk factors for suicide
- The clinician's view of the person's risk factors
- The plan or methods considered and the means to carry out the plan
- Inquiries about firearms and other lethal means available to the person
- Efforts made to have lethal means removed from the patient's environment
- Consultations or collaboration sought from significant others, such as spouse or parents, as well as what they said
- Consultations with other providers (including phone, face-to-face, email)
- Categorization of level of risk (low, medium, high, imminent), including rationale



- Steps that were put in place, considering the combination of risk and protective factors unique to the patient
- Rationale for treatment decisions, including rationale for actions not taken
- Creation of a crisis plan
(MacDonald, 2015; Freedenthal, 2015)

Any information that does not fit on the standardized assessment form should be documented on separate sheets of paper that are individually signed, dated, and attached to the assessment form.

This record may become a legal document if the person goes on to attempt suicide or die by suicide. If notes are subpoenaed, they should never be edited (MacDonald, 2015; Freedenthal, 2015).

MANAGEMENT OF THE PATIENT AT RISK FOR SUICIDE

Following medical stabilization of a patient in the event of a suicide attempt or in patients identified as at risk for suicide, a safe environment should be the first consideration.

Patients with suicide ideation but with no plans or means in place, who also have good social support, may be treated as **outpatients**. With the consent of the adult patient, family or friends should be enlisted to ensure the patient's safety and adherence to follow-up. If the patient is considered safe to go home with later follow-up from behavioral health, the patient's contact information is obtained and passed on (Russ & Russ, 2016).

Inpatient admission should be offered for patients with a specific plan and means in place (Bolster et al., 2015).

Making a Referral

Initial contact providers can prevent suicides by connecting patients to appropriate behavioral health services. The Suicide Prevention Resource Center offers guidance to assist in identifying those needing referral (Dehay et al., 2013). (*See "Resources" at the end of this course.*)

- Because of the urgency, an **emergency assessment** (preferably within 7 days) should be requested.
- Patients who are initially assessed to be at moderate or high risk and who have symptoms of a psychiatric disorder should be referred to a **psychiatrist** for medication evaluation.
- Patients with alcohol or substance use/abuse issues should be referred for **alcohol/drug assessment** and treatment.
- Patients in any category of risk experiencing significant thoughts of suicide or death should be referred for **individual or family therapy**.



- All patients at risk should be provided information in writing about the **National Suicide Prevention Lifelines**. Counselors at these crisis centers are skilled in suicide crisis management and can provide information about local resources.

Close follow-up with a patient who has the potential for suicide is very important. Even a very simple follow-up contact (e.g., phone call) has been shown in studies to reduce the risk for additional suicide attempts and completed suicide. The provider should use each follow-up contact as an opportunity to assess for recurrent or increase in suicidal ideation or behavior.

For ED patients, if the number of days following discharge from the ED until the follow-up appointment exceeds the recommended seven days, the following should be considered, if available, while awaiting longer-term treatment:

- A transition clinic for short-term outpatient crisis management
- Partial hospitalization or day treatment program
- Crisis residential placement for 24-hour crisis stabilization (SPRC, 2013a)

EFFECTIVE COMMUNICATION FOR REFERRALS

Communication when making a referral is essential to the safe transition of care for a person at risk for suicide. The following is recommended for effective communication when making a referral:

- Do not rely on the patient to provide information. Give all patient information directly to the clinician being referred to.
- If there is a language barrier, identify clinicians who speak the language or have interpreter services, and include information in the referral about the patient's language assistance needs.
- Make certain the patient understands the reason for the referral, and provide clear explanations of the risk and benefits. Inquire about and address any concern or fears the patient may have about the referral.
- Follow up and confirm, and then document that the patient complied with the referral.
- If the patient fails to comply with referral, contact the patient and review perceived barriers.

Source: AHRQ, 2015.



Discharge Following a Suicide Attempt

Following a suicide attempt and before the patient leaves a treatment facility, 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 centers
- 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
(DHHS, 2006)

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 (e.g., personality disorder, nonsuicidal self-injury 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 ED 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.

(See also “Ethics and Involuntary Hospitalization” later in this course.)

Source: Caruso, n.d.

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 and 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)

Source: Stanley & Brown, 2012.



INSTITUTIONAL ACTION PLAN

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

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. Robert 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:

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)

Cognitive behavioral therapy 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 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, or self-focused.

Dialectical Behavior Therapy (DBT)

Dialectical behavior therapy 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, learns new skills to better deal with negative situations, and improves motivation for appropriate behavior (Goldney, 2013).

Interpersonal Therapy (IPT)

Interpersonal therapy 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 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 that 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, describing 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 (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, 2015b)

The Social-Ecological Model

The Centers for Disease Control and Prevention presents a model that involves a complex interaction between individual, relationship, community, and societal factors. Each level influences the other levels, which is more likely to sustain prevention efforts over time than any single intervention. The four levels address both protective and risk factors.

PROTECTIVE FACTORS

Societal

- Availability of physical and mental health care
- Restrictions on lethal means of suicide

Community

- Safe and supportive school and community environments
- Sources of continued care after psychiatric hospitalization



Relationship

- Connectedness to individuals, family, community, and social institutions
- Supportive relationships with healthcare providers

Individual

- Coping and problem-solving skills
- Reasons for living (e.g., children in the home)
- Moral objections to suicide

RISK FACTORS

Societal

- Availability of lethal means
- Unsafe media portrayals of suicide

Community

- Few available sources of supportive relationships
- Barriers to healthcare, such as prejudice and lack of access to providers or medications

Relationship

- High conflict or violent relationships
- Family history of suicide

Individual

- Substance abuse
- Previous suicide attempt
- Impulsivity/aggression
(CDC, 2015c; CDC, 2015d)

Veterans Health Administration (VHA) Prevention Framework

Within the Department of Veterans Affairs, the Veterans Health Administration's approach to suicide prevention is based on a public health framework that focuses on intervention within populations rather than a clinical approach that intervenes with individuals. This approach allows for consideration of the broader problem of suicide among all veterans, including those not currently being cared for by the VHA. This framework has three elements: 1) surveillance, 2) risk and protective factors, and 3) interventions.



SURVEILLANCE

The agency is involved in the systematic collection of data about suicide rates and identification of characteristics associated with higher or lower suicide risk. The VHA collects this data from the VHA facilities; however, the majority of veterans are not enrolled in the VHA healthcare system. No nationwide surveillance system exists for suicide among all veterans. Surveillance thus requires gathering information from other sources such as the Department of Defense (DoD) (Bagalman, 2016). The DoD Suicide Event Report standardizes suicide surveillance efforts across all the branches of the armed services (Air Force, Marine Corps, Army, and Navy) (T2, 2015).

RISK AND PROTECTIVE FACTORS

Risk and protective factors are gleaned from the data collected from surveillance and are then used to develop interventions that reduce risk factors and/or increase protective factors. Risk factors are used in identifying at-risk groups or individuals so that interventions can be developed and delivered to them. This research is supported by the Office of Research and Development, a center of excellence in suicide prevention, as well as the Mental Illness Research, Education, and Clinical Center within the VHA.

Veteran-specific research on risk and protective factors is required because the veteran population differs from the nonveteran population in ways that may be associated with suicide risk. Veterans who are enrolled in the VHA may also differ from nonenrolled veterans.

INTERVENTIONS

The development of intervention strategies addresses all veterans, at-risk subgroups, and high-risk individuals. VHA's suicide prevention interventions include:

- Easy access to care
- Screening and treatment
- Suicide prevention coordinators
- Suicide hotline
- Education and outreach
- Limiting access to lethal means

In order to facilitate access to care, the Veterans Access, Choice, and Accountability Act of 2014 requires the VHA to authorize reimbursement for non-VHA care under certain circumstances, and the Clay Hunt Suicide Prevention for American Act of 2015 included a one-year extension of the existing five-year post-discharge period of enhanced enrollment in VHA healthcare for certain veterans.



Each VA medical center has at least one suicide prevention coordinator who tracks patients identified as high risk for suicide. A safety plan is developed for them; it is a written document created by both patient and clinicians that identifies strategies for coping in a crisis.

The VHA has a gun safety program that includes free gun locks and the dissemination of gun safety information. VHA also is conducting research on blister packaging medication in an effort to reduce medication overdoses.

The VA established the Veteran's Crisis Line in 2007, and it has since answered over two million calls and initiated emergency service dispatch over 56,000 times. In 2009 the anonymous online chat service was added and has been involved in over 267,000 chats. In 2011, the VA Crisis A Line began a text-messaging service, which has since then responded to more than 48,000 texts. The VA is also coordinating with communities and partner groups across the country (VA, 2016b).

SUICIDE WARNING SIGNS IN THE MILITARY

Warning signs that a military service member may be contemplating suicide include:

- Calling old friends, particularly military friends, to say goodbye
- Cleaning a weapon that they may have as a souvenir
- Visits to graveyards
- Obsession with news coverage of the war or the military channel
- Wearing the military uniform or part of the uniform (e.g., boots) when such dress is not indicated
- Talking about how honorable it is to be a soldier
- Becoming overprotective of children
- Standing guard over the house, perhaps while everyone is asleep; staying up to "watch over" the house; obsessively locking doors and windows
- Stopping and/or holding medication
- Defensive speech, such as, "You wouldn't understand."
- Stopping making eye contact or speaking with others

Source: DSPO, 2016.

Primary/Secondary/Tertiary Model

One commonly used and evidence-based framework for classifying suicide prevention strategies applied in public health is the primary/secondary/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 facilities, hospitals, and 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).

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.) (DHHS, 2012)



Gatekeeper Training

The term *gatekeeper* in primary suicide prevention refers to people who have face-to-face contact with many individuals in the community as part of their normal routine. Gatekeepers are trained in the identification of persons at risk of suicide and refer them to supporting services or for treatment. Gatekeeping is the performance of the responsibilities of the gatekeeper.

Gatekeeper training programs focus on:

- Education about suicide and mental health
- Risk factors
- Risk assessment
- Communication skills
- Information about resources
- Referral process

There are many gatekeeper training programs that target various potential gatekeepers. Schools, for example, may target teachers and school staff and may also train students. Primary care and emergency department staff, law enforcement, adult members of the community, as well as veterans and their family members can be trained as gatekeepers. Examples of gatekeeper training programs are described in the table below.

GATEKEEPER TRAINING PROGRAMS	
Program	Target Population
QPR (Question, Persuade, Refer)	<ul style="list-style-type: none"> • Lay and professional gatekeepers • Law enforcement • Nurses
Applied Suicide Intervention Skills Training (ASIST)	<ul style="list-style-type: none"> • Caregivers • Clergy • Counselors • Community volunteers • Law enforcement
Army ACE (Ask, Care, and Escort)	<ul style="list-style-type: none"> • Soldiers • Junior leaders
Be a Link!	<ul style="list-style-type: none"> • Adult community members
Just Talk about It: Suicide Prevention Toolkit	<ul style="list-style-type: none"> • Middle/high school staff members • Students
At-Risk in the ED	<ul style="list-style-type: none"> • Emergency department staff



Connect Suicide Postvention Training	<ul style="list-style-type: none"> • Community members • Professional service providers
Campus Connect	<ul style="list-style-type: none"> • College and university staff • College and university students
Family of Heroes	<ul style="list-style-type: none"> • Family members of veterans
High School Gatekeeper Curriculum	<ul style="list-style-type: none"> • High school teachers and students
EndingSuicide.com	<ul style="list-style-type: none"> • Health professionals • School professionals
How Not to Keep a Secret (HNTKAS)	<ul style="list-style-type: none"> • Student peer leaders
Friend2Friend	<ul style="list-style-type: none"> • High school students
Sources: SPRC, 2016; SPRC, 2013b.	

To date, there is evidence that short-term outcomes—such as improvements in knowledge, individuals’ perceptions about suicide prevention, the reluctance to intervene, and self-efficacy—might be effective, but this is not conclusive. Further research is recommended to determine how the outcomes of gatekeeper training programs are related to both intervention behavior and changes in suicide rates among various populations (Burnette et al., 2015; SPRC 2016).

Reducing Access to Means

Restricting access to firearms, medications, and other lethal means should be a part of any comprehensive suicide prevention strategy. Reducing access to means is one of the prevention strategies with enough evidence of effectiveness to be considered evidence-based. If methods of self-harm are not available, the delay allows for a greater chance of being rescued (SAMHSA, 2014).

According to a recent study, many emergency department providers are skeptical about the effectiveness of means restriction, and most do not assess suicidal patients’ firearm access except when a patient has a firearm suicide plan. The study showed that less than half believed most or all suicides are preventable (Betz et al., 2013).

There are a number of ways to restrict access to lethal means, some of which are based on a public health approach. These include:

- Placing barriers on bridges, rooftops, or other high places
- Mandatory wait times when purchasing a firearm
- Selling over-the-counter medications with a high toxicity in small amounts and in individual blister packs
- Limiting the quantity of prescribed medications to ensure a lethal dose is not available



(Nelson et al., 2014)

The CALM Program

One protocol that is being used nationally is known as the CALM (Counseling on Access to Lethal Means) program, which teaches providers ways to reduce access to lethal means by patients at risk for suicide. This approach involves the following:

1. Speak with both the person and family or friends. If the person is an adult, obtain releases for permission to speak with them.
2. Discuss the risk of suicide and the rapid escalation of risk that may lead to an attempt.
3. Ask if there are firearms in the home. If possible, speak with all adults in the home. It is important to ask about all firearms, as there is often more than one. If the person is a minor involved in a joint custody situation, ask about each parent's home.
4. Advise that all firearms be removed from the home until the situation improves.
5. If handling a firearm is too risky for the person, enlist a support person to make the transfer. Store firearms with a trusted relative or friend. Law enforcement may temporarily hold guns, and most will dispose of them if requested. Also some storage facilities, gun stores, or shooting clubs may hold guns.
6. If family is unwilling to remove guns from the home and storing them in the home is desired, a member of the household should unload the gun(s) and lock them up in a place with no glass fronts or hinges (such as a lock box or a safe) with trigger locks or cable locks. Ammunition should be stored separately in a locked container.
7. Prescriptions of lethal medicines should be removed from the home, and alcohol should be present only in small quantities, if at all. Clinicians should contact their state's Prescription Monitoring Program (PMP) for objective evidence of the patient's use of prescription medications and multiple prescribers.

Once a plan has been developed to reduce access, it is important to consider the person's reactions to it. It is helpful to consider:

- If the person is reluctant, this may indicate a strong commitment to the method.
- If the person is too eager, it may indicate a plan to substitute another method.

Once the plan has been finalized and mutually agreed upon as acceptable, roles and timetables should be assigned and set for restricting access, and the plan should be documented. Follow-up calls should be made to check on the progress, and on-going risk



assessment should be done (Heagerty, 2013; Nelson et al., 2014; SAMHSA, 2014; HSPH, 2016).

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.

SUICIDE WARNING SIGNS IN THE GENERAL POPULATION

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:

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
- Researching 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 goodbye
- Taking risks that could lead to death (e.g., driving too 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 patients 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 a social worker 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 that he wanted to say goodbye.

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 goodbye and hung up the phone. Michaela immediately dialed 911 and gave this 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. Gregory's mother told her she believed her son would welcome a visit from her as soon as he was feeling better.

TERTIARY PREVENTION STRATEGIES AND POSTVENTION

Tertiary prevention strategies are interventions **following attempted suicide** or **completed suicide** that aim to minimize the impact, reduce the likelihood of subsequent self-injury, and to diminish suicide contagion (cluster suicides) and copy-cat suicides. Tertiary prevention strategies also include helping and providing care to individuals who had personal connections to someone who died by suicide (known as "survivors").

Therapeutic treatments following suicidal behavior to prevent future attempts or to reduce the severity of injury may include voluntary and involuntary hospitalization, as well as referral for other supportive services. (See also "Ethics and Involuntary Hospitalization" later in this course.)

Caring for Suicide Survivors

Tertiary prevention strategies include those designed to identify survivors (i.e., family, friends, coworkers, healthcare professionals, therapists, teachers, and peers) who are at risk of suicide themselves, as well as to prevent posttraumatic stress disorder, complicated grief, and depressive syndromes (DHHS, 2012).



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 who died
- Feelings of betrayal or rejection by the person who died
- Fear because survivors such as themselves 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 tertiary postvention services are to help survivors grieve, understand why the person who died by suicide killed him- or herself, and decrease the assumption of inappropriate guilt for the death of the person. To achieve these goals, healthcare professionals must understand the intense emotions experienced by these survivors of suicide, recognize the stages of bereavement, and facilitate healing and wholeness in survivors.

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
(IABPG, 2015)

Following a suicide, the family may also 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 typically pay the proceeds (AFSP, 2015f).

POSTVENTION SUPPORT TO MILITARY FAMILIES

Military-sponsored programs for families and next-of-kin have been established to assist military dependents. Most commonly, a casualty assistance office works with them. Mental health and counseling services are available to all dependents, as are religious, financial, and legal services. A military family life consultant is available to work with the families. The program Military OneSource offers in-person, telephone, and online counseling to assist with emotional, financial, and benefit issues. Each branch of the military also offers a family readiness program to help deal with loss.

Nonmilitary-sponsored programs, such as Gold Star Wives, also provide support (Ramchand et al., 2015). The Tragedy Assistance Program for Survivors (TAPS) provides services nationally at no cost to the families of military personnel who have died from war-related injury or suicide. TAPS provides peer-based emotional support, grief and trauma resources, grief seminars and retreats for adults, Good Grief Camps for children, case work assistance, connections to community-based care, online and in-person support groups, and a 24/7 resource and information helpline (TAPS, 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. The school nurse recognized the surname of Alicia and Phillip and consulted the school psychologist and principal. She called the teens' mother, offering support and care. She referred the family to local resources, including an ongoing support group for suicide survivors offered by the local mental health agency. The nurse also arranged a suicide prevention workshop at the high school.

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.

Ethics and Involuntary Hospitalization

The question of whether or not involuntary hospitalization is ethically justified remains open for consideration. Healthcare providers are guided by a code of ethics based on these principles:

- **Autonomy:** Respect for the individual's self-determination
- **Beneficence:** Doing the greatest possible good
- **Nonmaleficence:** Preventing or minimizing harm
- **Justice:** Fairness and equal access to care

These principles come into play when a decision is being made regarding the disposition of a patient considering suicide, but they provide nominal protection to the suicidal patient.

The ethical principle of autonomy calls for respect, dignity, and choice, and therefore a person should not be coerced or manipulated into treatment if he/she is capable of autonomous decision



making. Taking away a person's freedom when no crime has been committed is a very serious enterprise. Cases involving a suicidal patient are the classic example of what is considered justified involuntary hospitalization. However, there is ambivalence concerning this, and it is argued by some that the risk of suicide by itself may not be sufficient justification.

Studies have shown that concerns relating to beneficence and protecting a patient from self-harm are more important to clinicians than a patient's ability to make an autonomous decision. Hospital emergency departments in the United States take this approach and protect the right of health even though doing so infringes on the person's autonomy (ANA, 2015; White, 2013).

DIFFERING PERSPECTIVES

Approaching the question of what should be done about a patient who has expressed verbally or by action the wish to die, there are several different perspectives. Three such points of view are the libertarian, the communitarian, and the egalitarian-liberal perspectives.

Libertarian perspective. Autonomy is the crucial concern of this perspective. From this vantage point, involuntary hospitalization:

- Takes away the person's freedom
- Restricts what the person can do with his/her body
- Prevents the person from protecting property (job, home)
- Is a means to manage people who do not adhere to social norms
- Coerces and manipulates patients into treatment
- Raises financial issues that may affect the patient and/or infringe on the property rights of other citizens (e.g., use of tax dollars)
- Does not recognize that suicide is sometimes a rational choice based on competent thought and decision-making skills

Communitarian perspective. This approach disregards the person's autonomy and exclusively considers the community values of the clinician making the decision. It views suicide as morally wrong and offensive to the dominant group, and intervention must take place to prevent it. The belief that suicide is bad and morally wrong is a common perspective in the United States.

Egalitarian-liberal perspective. This approach states that the government's role is to protect individual rights. But, if additional rights, such as the right to health, are not protected, then the rights of liberty and autonomy may not be possible. Involuntary hospitalization protects the person from a decision-impairing disease or disorder that puts the patient at risk for self-injury or death, and treatment of said disease or disorder gives the patient the right of health. Without health, it is said, other rights may not be possible. But how can a mental health professional know in advance that forcible treatment is justified, especially since there are no objective tests to verify whether or not a decision-impairing disease or disorder may or may not exist?



POSSIBLE OUTCOMES OF INVOLUNTARY HOSPITALIZATION

Hospitalization is a predictable outcome of expressing suicidal ideation and feelings and is often felt by the patient to be an undesired consequence of doing so. It is believed by some that legal holds can “train” a person to avoid expressing suicidal feelings unless they wish to be placed in a costly inpatient unit and experience the shame and stigma that is often the aftermath. On the other side of the argument, however, it can demonstrate to patients that their expressed wish or attempt to die is being taken seriously.

Legal holds and hospitalization may make society and providers feel better, but there are some possible consequences to be considered:

- The dual role of counselor/clinician as a trusted sounding board and as an agent for the state can impair future interactions with the patient and the patient’s future contacts with other healthcare professionals.
- When a clinician asks for a commitment warrant, confidentiality is, essentially, broken.
- These actions involve choosing between the rights of the many and the rights of one, the patient.
- Civil action is a viable option for those who believe they were falsely committed, and lawsuits are not uncommon.

(White, 2013; Sullum, 2012; Sjöstrand et al., 2015)

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 die by suicide, including biologic, psycho-sociocultural elements, and adverse life events. One important thing to consider is that most people are ambivalent about dying by 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
<https://afsp.org>

Ask Suicide-Screening Questions (ASQ)
http://www.nimh.nih.gov/news/science-news/2013/file_143902.pdf

Columbia-Suicide Severity Rating Scale (C-SSRS)
<http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english>

National Suicide Prevention Lifeline
<http://www.suicidepreventionlifeline.org>
800-273-TALK (8255)
866-833-6546 Teen Link
741741 Crisis Text Line

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

Veterans Crisis Line
<http://www.VeteransCrisisLine.net/chat>
800-273-8255 Press 1
838255 Text Line

Veterans Self-Check Quiz
<http://www.VeteransCrisisLine.net/quiz>

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DISCLOSURE

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TEST

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1. Which is a **true** statement regarding the prevalence of suicide in the United States?
 - a. The highest rate of suicide is among adults ages 45 to 64 years.
 - b. There is a higher suicide rate 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. A recent study regarding suicide rates among veterans found that:
 - a. Nondeployed veterans had a lower suicide rate than deployed veterans.
 - b. Female veterans had a higher suicide rate than male veterans.
 - c. Both deployed and nondeployed veterans had a higher suicide rate than the general U.S. population.
 - d. Male and female veterans had the same predictors of suicide.

3. 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

4. Which is considered a **social** factor that increases the risk for suicide among adolescents?
 - a. Higher intellectual ability
 - b. Verbal bullying
 - c. Religious beliefs
 - d. Early parental rejection

5. 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.



6. 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.

7. Studies regarding suicide among family caregivers of patients with dementia have found that:
 - a. Having anxiety and becoming unemployed during caregiving constitutes a higher risk of suicide.
 - b. Less than a third of caregivers experience signs of clinical depression.
 - c. More than 75% of caregivers told someone they were considering suicide in the future.
 - d. Being male is associated with increased suicidal ideation among caregivers.

8. Which is a **true** statement regarding suicide during military service:
 - a. Over 90% of suicides were completed by officers.
 - b. Approximately one third of suicide attempts are tied to preenlistment mental disorders.
 - c. Suicide rates are lowest among soldiers who are divorced or separated.
 - d. The majority of service members who attempt suicide give advance indications they plan to harm themselves.

9. 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.

10. During a clinical suicide assessment interview, the nondirective listening response that is solution-focused and attempts to lead the patient toward more positive interpretations of reality is called:
 - a. Summarization.
 - b. Intentionally directive paraphrasing.
 - c. Validating feelings.
 - d. Confrontation.



11. Which suicide assessment tool is labeled by the U.S. Food and Drug Administration as the “gold standard”?

- a. The Beck Scale for Suicidal Ideation (SSI)
- b. The Chronological Assessment of Suicide Events (CASE)
- c. The Beck Hopelessness Scale (BHS)
- d. The Columbia-Suicide Severity Rating Scale (C-SSRS)

12. The **best** approach for determining an individual’s risk for suicide 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.

13. As described in this course, perceived barriers to effective suicide assessment in the emergency department include:

- a. Scarcity of mental health professionals.
- b. Lack of staff compliance to facility protocols.
- c. Lack of effective screening tools.
- d. Language comprehension constraints.

14. A patient who has current suicidal thoughts, a plan without the intent to act, and no recent suicidal behavior is considered to be at which level of risk?

- a. High
- b. Moderate
- c. Low
- d. None

15. Which patient is at **highest** risk for suicide completion?

- a. A woman talking about suffocation by hanging
- b. A man with a suicide plan who possesses a firearm
- c. An adolescent planning to take a handful of pills
- d. A young woman with a history of depression



16. An assessment tool that is useful in helping to distinguish nonsuicidal self-injury from suicidal behavior is the:

- a. Beck Depression Inventory–Revised (BDI-11).
- b. Beck Scale for Suicide Ideation (SSI).
- c. Linehan’s Reasons for Living Scale.
- d. Beck Hopelessness Scale (BHS).

17. Which is a **correct** statement about the essential elements in documenting suicide assessment?

- a. Include the rationale for actions not taken.
- b. Avoid the use of a standardized form.
- c. Do not include the clinician’s view of the patient’s risk factors.
- d. It is not necessary to document a past suicide attempt outcome or aftermath.

18. 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

19. 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.

20. 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



- 21.** In accordance with an FDA warning, the clinician closely monitors an adolescent patient with major depression for suicidal thoughts or attempts when the patient is newly prescribed which drug?
- Amitriptyline (Elavil), a tricyclic antidepressant
 - Bupropion (Wellbutrin), an atypical antidepressant
 - Paroxetine (Paxil), a selective serotonin reuptake inhibitor (SSRI).
 - Tranlycypromine (Parnate), a monoamine oxidase inhibitor (MAO)
- 22.** Which is a suicide warning sign characteristic of military personnel in particular?
- Giving away personal possessions
 - Refusing to watch any news coverage of wars or military activity
 - Refusing to visit graveyards
 - Standing guard over the house
- 23.** An example of a **primary** intervention for suicide prevention is:
- Instituting crisis care for an individual exhibiting suicidal ideation.
 - Screening large populations for suicide risk.
 - Increasing public awareness and education.
 - Conducting family therapy sessions.
- 24.** A **secondary** intervention strategy for prevention of suicide is:
- Evaluating for imminent attempt or risk.
 - Providing effective psychotherapy.
 - Promoting help-seeking behavior.
 - Referring for counseling services.
- 25.** Interventions following an attempted suicide that aim to minimize the impact, reduce the likelihood of subsequent self-injury, and support surviving family members are known as:
- Primary prevention strategies.
 - Tertiary prevention strategies.
 - Secondary prevention strategies.
 - Involuntary hospitalizations.
- 26.** A goal of postvention for the survivors of a loved one's suicide is to help them:
- Understand why the person killed him- or herself.
 - Acknowledge their own role in the person's death.
 - Avoid grieving for the victim of suicide.
 - Reconstitute their lives without missing their loved one.

