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Contact Hours: **3**

Suicide Prevention Training Program for Washington Health Professionals (3 Hours) Screening and Referral

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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 to address potential knowledge gaps include:

- Express an understanding of common myths related to suicide.
- Discuss the epidemiology and etiology of suicidal behavior.
- Summarize the risk and protective factors for suicide.
- Describe the process of screening and assessment for suicide and imminent harm via lethal means.
- Summarize actions to refer patients at risk of suicide.
- Discuss approaches for suicide prevention in Washington State.

UNDERSTANDING SUICIDE

Suicide is the culmination of many and varied interactions between biological, social, and psychological factors. 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.

Healthcare professionals play a critical role in the recognition and prevention of suicide. However, many 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 screening and referral. They can also develop a better understanding of this choice that ends all choices.

Changing the Language

The term *committed suicide* suggests that a person was involved in a criminal act. It implies that the person was a perpetrator and not a victim of a pathology that led to death. It ignores the fact that suicide is often the consequence of an unaddressed illness, such as depression, and it perpetuates harmful stigma. It also implies that suicide is an act of free will, a choice one makes to live or die.

There is a great deal of evidence indicating that thought processes are gravely impaired at the time of death by the effects of trauma, mental health conditions, or substance use, and many have reported experiencing something akin to command hallucinations right before attempting to kill themselves. So, if a person cannot rationally choose due to impairment of the mind, the decision is not a choice.

Stigma surrounding mental illness, and suicidality in particular, has been documented as an immediate and profound barrier to help-seeking behavior. The following table provides recommendations for changing the language that surrounds the topic of suicide in order to remove the harmful stigma that can profoundly affect both the person with suicidal thoughts or behaviors and those closest to them.

CHANGING LANGUAGE ABOUT SUICIDE	
Inappropriate	Appropriate
Committed suicide	Died of or by suicide
Successful attempt	Suicide death
Unsuccessful attempt	Suicide attempt
Suicide attempter	Person with suicidal thoughts or behavior
Completed suicide	Suicide
Manipulative, suicidal gesture, cry for help	Describe the behavior (e.g., nonsuicidal self-injury)
(Spencer-Thomas, 2019; MSPP, 2020; Carpiniello & Pinn, 2017; Keller et al., 2019)	



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. Following are ten common myths and associated facts:

COMMON MYTHS ABOUT SUICIDE	
Myth	Fact
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.	People who talk about suicide may be reaching out for help or support. They are looking for an escape and are unable to think of any other way than through death, and they do indeed need attention.
Once a person has made a serious suicide attempt, that person is unlikely to make another.	The opposite is often true. A prior suicide attempt is the single most important risk factor for suicide in the general population.
People who attempt or die by suicide are selfish.	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.
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.	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.
Only people who are crazy or have a mental disorder are suicidal.	Many people living with mental disorders are not affected by suicidal behavior, and not all people who die by suicide have a mental disorder. They may be upset, grief-stricken, depressed, or despairing, but extreme distress and emotional pain are not necessarily signs of mental illness.
Reaching out for help is the same as threatening suicide.	People who are suicidal are hurting, not threatening, and should be provided with the tools, support, and resources they need.



Suicide always occurs without any warning signs.	There are almost always warning signs, such as saying things like “everyone would be better off if I wasn’t here anymore.”
Once people decide to die by suicide, there is nothing you can do to prevent it.	Suicide is preventable. Most people who are suicidal are ambivalent about living or dying. Most do not want death but simply want to stop hurting. The impulse to “end it all,” however overpowering, does not last forever and can be overcome with help.
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.	It is important to talk about suicide with a person who is suicidal in order to learn more about the person’s intentions and thinking and to allow for diffusion of the tension that is underlying. Talking openly can give the person other options or time to rethink the decision.
When people who are suicidal start to feel better, they are no longer suicidal.	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.
(Naval Health Clinic Annapolis, 2018; The Samaritans, 2019)	

SUICIDE IN WASHINGTON STATE

According to the Washington State Department of Health and the CDC, the state ranks 21st in the nation, with a rate of 16.9 suicides per 100,000 population, compared to the national rate of 14.0. (Montana ranked the highest in the nation at 28.9 per 100,000, and New York ranked the lowest at 8.1.)

In 2017, 1,297 Washingtonians died by suicide, compared to 1,123 in 2016. On average, one person dies by suicide every seven hours. More than seven times as many people died by suicide in 2017 than in alcohol-related motor vehicle accidents. Suicide in the state is the:

- 8th leading cause of death
- 2nd leading cause of death for ages 15–34
- 3rd leading cause of death for ages 35–44
- 4th leading cause of death for 45–54
- 8th leading cause of death for 55–64
- 16th leading cause of death for ages 65 and older
(AFSP, 2020a; Hedegaard et al., 2018)



By gender: Suicide rates are higher for males than for females in all age groups. About 3 males die by suicide for every 1 female. From 2013 to 2017, 5,669 Washington residents died by suicide. Among those, 76.1% were male (4,313 suicides). From 2016 to 2017, suicides in Washington increased 20% in females and 14% in males.

By age: Suicides increased in all age groups, with the greatest percentage increases occurring in youth (10–24 years) and older adults (75 years and older). Youth ages 10 to 24 had a 27% increase in suicide from 2016 to 2017. Males 35 to 64 years of age accounted for 37% of all Washington suicides (2,095 suicides).

By race/ethnicity: In Washington, American Indian/Alaska Natives (AI/AN) have the highest suicide rate, followed by non-Hispanic whites. Whites had the highest number of suicides (4,721). Suicide rates for all races have increased in the last 10 years, with the greatest increases among AI/AN and non-Hispanic whites. Rates of suicide for whites increased 3.4% from 2016 to 2017.

By military service: In 2017, the Department of Veterans Affairs estimated a total of 560,000 veterans in Washington. From 2013 to 2017, 1,182 veterans died by suicide, accounting for 17.6% of all Washington suicides. Counties with the highest number of veteran suicides are King, Pierce, Snohomish, Spokane, and Clark, which also have the highest number of total suicides. Of these, 5.8% of those who died were ages 55 to 74.

By methods: The leading methods of suicide in Washington were firearms (48%), suffocation (27%), and poisoning (17%). The leading methods of suicide in males were firearms (54%) and suffocation (26%), while in females they were poisoning (36%), firearms (28%), and suffocation (26%). Firearms were the most common method across all ages except for youth under 18. Almost 3 out of 4 adults ages 75 years and older who died by suicide used a firearm. Suffocation is the most common method for youth under 18 years old. Suicide by poisoning was more common with middle-aged adults than other age groups.

By county/geography: In Washington, the counties with the highest number of suicides were King, Pierce, Snohomish, Spokane, and Clark, and, as it is nationally, suicide rates were higher outside urban areas. In Washington, the age-adjusted rate in small towns/isolated rural areas was 21.2 per 100,000 people. This was about 24% higher than the state rate. Rates in the various geographical locations were:

- Urban core, 15.4
- Suburban, 15.6
- Large rural town, 17.5
- Small town/isolated rural, 21.2

Self-inflicted hospitalizations: In 2016–2017, there were 7,425 hospitalizations in Washington due to self-inflicted injuries. Females accounted for 63% of hospitalizations, with females ages 15 to 24 accounting for 18% of hospitalizations (1,363). Hospitalizations for self-inflicted injuries have been decreasing in Washington since 2010. However, nationally and in



Washington, hospitalizations for females ages 10 to 14 have been increasing. In 2016–2017, there were 373 hospitalizations for females ages 10 to 14 (84.6 per 100,000). Part of the latest increase may be due to improved coding.

(WADOH, 2019)

ETIOLOGY AND RISK FACTORS

The exact cause of suicidal behavior is unknown, but it is clear that the etiology is multifactorial (Zalsman, 2019). Studies done to date have found that suicide is most often caused by a collection of risk factors and underlying vulnerabilities, as discussed below.

Biologic Factors

Biologic factors that contribute to suicide include a person's genetic predisposition and personality traits, neurobiology, structural brain changes, immune system dysregulation, neuropsychology, and psychopathology.

NEUROBIOLOGY

Suicide is the result of a complex set of factors reflected in the neurobiology of the suicidal individual. Data indicate that mental disorders are present in over 90% of suicides in our society, and many of them are associated with biological changes. However, there are many other factors that correlate with suicidality that also have biological aspects, including predisposing personality traits, effects of acute and chronic stress, gender, and age (NAS, 2019).

Serotonin and Epinephrine

Reduced serotonergic neurotransmission has been a long-standing hypothesis in the etiology of suicide and mood disorders, and evidence suggests that serotonin mediates inhibition of impulsive action (Underwood et al., 2018; NAS, 2019).

Suicidal individuals also appear to have lower levels of norepinephrine, also called *noradrenaline*, in the part of the brain called the *locus ceruleus*. Norepinephrine participates in modulation of numerous behaviors (including stress response) and promotes formation of and strengthens memories, especially those created in stress situations. It has profound effects on a small set of behaviors, including those that are commonly disrupted in depression (Khrouf & Saadabadj, 2019).

Hypothalamic-Pituitary-Adrenal Axis

The hypothalamic-pituitary-adrenal (HPA) axis is a system tying together the hypothalamus and the pituitary gland with the adrenal glands. It controls the body's responses to actual, anticipated, or perceived harm. It also controls the ability to adapt to stressors over time. Dysregulation of the HPA axis in vulnerable people can lead them to



develop severe depression, severe anxiety disorders, and suicidal behavior following traumatic events or chronic stress (Reiss & Dombek, 2019a; NAS, 2019).

STRUCTURAL CHANGES IN THE BRAIN

From brain scans, researchers have found there are significant differences in the volume of gray matter between people who have attempted suicide and those who have not. Those who attempted suicide had less gray matter in regions related to emotional regulation, emotional response, and memory. They also had a decreased amount of white matter connecting brain areas that are involved in these functions. Structural changes within the frontostriatal pathway may result in an impaired control of behavior and emotion, leading to suicidal behavior (Balcioglu & Kose, 2018).

INFLAMMATION

Mounting evidence implicates dysregulation of the immune system in the pathophysiology of suicidality, suggesting that inflammation is involved in suicidal behavior. Where inflammation of the brain was noted, it was usually in the anterior cingulate cortex, which is involved with cognition and emotional responses. Signs of inflammation were also noted to a smaller degree in the insular cortex, which plays a role in regulating emotional function, and in the prefrontal cortex, implicated in cognitive processes related to behavior (Holmes et al., 2018; Brundin et al, 2017).

NEUROPSYCHOLOGICAL DEFICITS

Neuropsychological deficits can develop during the prenatal, perinatal, and postnatal periods of life. Prenatal causes may include genetic or chromosomal disorders, metabolic conditions, brain malformations, or maternal disease. Perinatal causes may involve events during labor and delivery leading to encephalopathy. Postnatal causes may include hypoxic ischemic injury, infections, traumatic brain injury, and severe and chronic social deprivation, among others (Schofield, 2018).

PSYCHOPATHOLOGY

Psychiatric diseases account for a large majority of suicides and suicide attempts—at least 10 times as high as in the general population. Psychological autopsies (collected from family relatives, friends, and healthcare providers) from the middle of the previous century and onward have revealed that most (at least 90%) of those who have died by suicide were experiencing a mental disorder, the relevant risk factors being depression, substance use disorders, and psychosis (Brådvik, 2018; Bachmann, 2018).

Anxiety disorders more than double the risk of suicide attempts, and a combination of depression and anxiety greatly increases the risk. Symptoms of psychosis (delusions, command auditory hallucinations, paranoia) may increase the risk regardless of the specific diagnosis (Schreiber & Culpepper, 2019).



One in four active duty members of the U.S. military exhibit symptoms of mental illness, which are mostly the manifestation of posttraumatic stress disorder (PTSD), depression, traumatic brain injury, and/or stress related to transition back to civilian life (Shirol & Current, 2019).

Psycho-Sociocultural Factors

Psycho-sociocultural factors refers 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

A body of research indicates that early-life events occurring before or around the time of birth or in the first years of life can play a role in influencing susceptibility to suicide.

While studies suggest that early-life factors may predispose to suicide, the mechanisms involved remain unknown. It is possible that they can produce changes in DNA methylation that subsequently influence an individual's vulnerability to mental disorders and suicide (Björkenstam et al., 2017).

Epidemiology shows that major risk factors for attempted suicide or suicide are childhood adversities such as sexual and/or physical abuse, neglect, caregiver psychopathology, and family or community violence (Geoffroy et al., 2017).

SOCIAL FACTORS

Having a network of supportive family, friends, and colleagues is important to a person's self-esteem. Those with close social relationships cope better with stress and have better overall psychological and physical health. Isolation, however, can lead to feelings of depression and alienation, both of which can lead to suicidal thoughts and behaviors (Reiss & Dombeck, 2019b).

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 can lead to depression and anxiety, lowered self-esteem, or physical injury. It 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.



SOCIOCULTURAL FACTORS

Sociocultural factors are customs, lifestyles, and values that characterize a society. They include aesthetics, language, law, politics, religion, social organization, marital status, technology, material cultures, values, and attitudes.

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 themselves. 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 (Reiss & Dombeck, 2019b).

Marriage is considered a cultural universal. Suicide occurs more frequently in people who are not married than those who are, and the risk of suicide is nearly two times greater in the nonmarried than the married (Schreiber & Culpepper, 2019).

Occupation-related factors have an influence on suicidal behavior. Suicide may be greater in those who work in unskilled occupations. Among highly skilled workers, physicians have the highest suicide rate of any profession—more than twice that of the general population (Anderson, 2018).

Social norms dictate whether or not suicide is stigmatized. Many societies and religions, such as Christianity, ban suicide, considering it a taboo behavior or a sin. Others allow suicide (MPAC, 2019).

It has been found that the rise in suicide and suicide attempts by adolescents correlates with the rise in electronic communication and social media. Social media and internet use contribute to poorer sleep quality, which in turn contributes to depressive symptoms in this age group (Twenge et al., 2019; McCarthy, 2019).

Adverse Life Events

An extensive body of sociodemographic and psychological autopsy studies finds that almost all persons who died by suicide had experienced at least one stressful life event (usually more than one) within the year prior to death. Specific events that increase the risk of suicide include:

- Death of a family member
- Interpersonal conflicts (family or relationships with third parties)
- Separation/divorce
- Rejection



- Humiliation
- Physical illness
- Chronic physical pain
- Unemployment
- Problems at work
- Financial problems
- Serious injury or attack
- Sexual or physical abuse
- Rape
- Personal loss
- Domestic violence
- Problems with the law
- Change of residence/moving
(Maniou et al., 2017)

Factors Leading to Suicide According to Age

Suicide crosses all age groups in the United States, and suicide rates globally follow a standard pattern of increasing with age, with rates highest in people ages 70 years and older (IHME, 2018).

CHILDREN

Suicidal ideation occurs in prepubertal children, but suicide attempts and suicide deaths are rare. The number of young children who kill themselves has always been small, but it has been steadily increasing over time. For the very young (ages 5 to 11), suicide occurs in the United States at a rate of one every five days. These numbers, however, may not fully reflect reality, as failed attempts are not reported and some suicide deaths may be seen as accidents (Sheftall et al., 2016).

Parents often do not take talk of suicide by young children seriously because they believe kids do not understand the concept. By ages 5 to 7, however, children begin to understand death, though many do not grasp its irreversibility until about age 11 (Mink, 2018). Younger children who die by suicide are more likely to be of above-average intelligence, possibly exposing them to the developmental level of stress experienced by older children (Kennebeck & Bonin, 2017).

In a recent study of children ages 5 to 11 who died by suicide, the majority were black males who died at home by hanging, strangulation, or suffocation. Children were found to more often have had relationship problems with family members or friends. Very few left a suicide note, but nearly one third were found to have discussed suicide intent to another person before death. The



children were found to more often have attention-deficit disorder with or without hyperactivity and less often experienced depression or dysthymia compared to early adolescents (ages 12 to 14) (Sheftall et al., 2016).

ADOLESCENTS

Adolescents have a relatively higher rate of suicide attempts than adults, and the majority who attempt suicide have a significant mental health disorder, usually depression (AACAP, 2018).

As adolescents develop their capacity for abstract and complex thinking, they are more capable of contemplating life circumstances, envisioning a hopeless future, considering suicide as a possible solution, and planning and executing a suicide attempt (Kennebeck & Bonin, 2017).

In a study of adolescents who attempted suicide, the weakest influence was direct social pressures that promote suicide, and the three strongest motivators were:

- Extreme emotional or psychological pain
- Desire to escape from one's own thoughts, feelings, or actions
- Belief that things cannot get better or that one's situation cannot improve (Klonsky, 2019)

A systematic review of studies has found the high prevalence of adolescents consuming cannabis generates a large number of young people who are at risk for developing depression and suicidality (Gobbi et al., 2019).

YOUNG ADULTS

Among 18- to 34-year-olds, there has been a 25% increase in suicide deaths since 2007, which is a greater increase in suicide deaths than among other age groups, except for children and adolescents. This age group has a number of risk factors that increase vulnerability to suicide:

- Impulse control centers in the brain are not fully developed until the mid-to-late-20s.
- They take more risks with sexual and drug-use behaviors compared to older adults.
- They make up the highest percentage of the U.S. military.
- They face high costs of postsecondary education and mounting student debt.
- The housing market is largely out of their reach.
- They lack the protective factors other age groups typically have, such as a supportive physical and social environment and financial safety nets.
- They are the age group with the greatest nonmedical and prescription use of opioids.
- They are beginning and growing in their chosen career.



- They grew up with a succession of negative events, including the 9/11 terror attacks, the Iraq and Afghanistan Wars, and the Great Recession.
- The impact of the rise of social media impacts the sense of their future prospects. (TFAH, 2019; Anderson P., 2019)

MIDDLE-AGED ADULTS

Middle age (ages 35 to 64) is a time of maximum risk, with suicide rates increasing in both middle-aged men and women, although men are much more likely than women to die by suicide. Middle-aged men represent 19% of the U.S. population and account for 40% of suicide deaths (SPRC, 2019a).

The middle-age years are marked by heavy personal, social, and familial responsibilities and obligations, including growing and grown children and caring for aging parents. Issues such as unemployment, social disconnection, relationship breakdown, and job loss are sources of stress among this population (AFSP, 2019).

OLDER ADULTS

Suicide rates are high among adults ages 65 and older, and in particular among older men. Men ages 85 and older have the highest rate of any group in the country. Suicide attempts by older adults are more likely to result in death because:

- Older adults plan more carefully and use more deadly methods.
- Older adults are less likely to be discovered and rescued.
- Physical frailty of older adults means they are less likely to recover from an attempt. (SPRC, 2019b)

The main suicide risk factors for the older adult include:

- Grieving the death of a spouse (one of the most prevalent risk factors)
- Psychiatric and neurocognitive disorders
- Social isolation/exclusion
- Bereavement
- Transition in physical health
- Loss of independence
- Physical and psychological pain
- Cognitive impairment (Conejero et al., 2018a ; SPRC, 2019b)



Suicide Risk among Specific Populations

Although suicide affects all groups of the population, the risk and protective factors for suicide may differ. The following summarizes risk and protective factors among specific populations.

PERSONS WITH DEMENTIA

Recent study findings suggest that late-stage dementia could protect against suicidal ideation and suicide attempts. On the other hand, the risk of suicide is higher during the early phase of cognitive decline. The following factors may contribute to increasing the suicide rate in early dementia include:

- Awareness of cognitive decline and feelings of being a burden to significant others
- Anticipation of future loss of autonomy
- An increased prevalence of comorbid mood and adjustment disorders
- Presence of still good cognitive functions in the early stage that allow the person to plan and complete a suicidal act
- Deficits in executive functions, decision-making, and inhibition process
(Conejero et al., 2018b)

ADULTS WITH LEARNING DISABILITIES

The prevalence of lifetime suicide attempts among those with a learning disability, such as dyslexia, is much higher than those without a learning disability. Adults with a learning disability had nearly double the odds of having ever attempted suicide, even after adjusting for childhood adversities, mental illness, addiction history, and sociodemographics (Fuller-Thomson et al., 2018).

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. They report high levels of stress and have higher rates of depression and anxiety as well as poorer physical health than noncaregivers. Caregivers are often affected by a wide range of stressors, including exposure to domestic violence, financial difficulties, or stressful life events. This may be more marked among those caring for someone with dementia. Research has found that one fourth of caregivers looking after family members with dementia contemplated suicide more than once in the prior year, and almost a third said they were likely to attempt suicide in the future (Joling et al., 2017; Rosato et al., 2019).

MILITARY SERVICE PERSONNEL

Suicide is the second leading cause of death among U.S. military personnel. A recent study asked a group of active-duty soldiers why they tried to kill themselves, and out of the 33 reasons they



had to choose from, all of the soldiers included a desire to end intense emotional distress (MSRC, 2019).

Experiencing child abuse, being sexually victimized, and exhibiting suicidal behavior before enlistment are significant risk factors for service members and veterans, making them more vulnerable to suicidal behavior when coping with combat and multiple deployments.

Military personnel reporting child abuse as children have been found to be three to eight times more likely to report suicidal behavior. Sexual trauma of any type increases the risk for suicidal behavior. Men who have experienced sexual trauma are less likely to seek mental health care than females, as they may see it as a threat to their masculinity, a strong predictor of suicide attempts in military personnel. Service members who attempted suicide before joining the military are six times more likely to attempt suicide after joining the military (APA, 2019a).

A number of psychosocial factors are associated with suicide risk in the military, including relationship problems, administrative/legal issues, and workplace difficulties. Medical conditions that are associated with an increased risk for suicide among military personnel include traumatic brain injury, chronic pain, and sleep disorders (USUCDP, 2019).

Suicide among women in the military has increased at twice the rate of male service members. The primary reason is sexual trauma, particularly incidences of harassment and rape while stationed overseas. An estimated one in four military women are victims of sexual trauma. This number, however, is believed to be low due to the stigma and possible consequences associated with reporting. Sexual trauma combined with combat stress can result in a higher risk of dying by suicide (Gorn, 2019).

MILITARY VETERANS

There is strong evidence that among veterans who experienced combat trauma, the highest suicide risk has been observed in those who were wounded multiple times and/or were hospitalized as a result of being wounded.

Studies that looked specifically at combat-related PTSD found that the most significant predictor of both suicide attempts and the preoccupation with thoughts of suicide is combat-related guilt about acts committed during the times of war. Those with only some PTSD symptoms have been found to report hopelessness or suicidal ideation three times more often than those without PTSD (VA, 2019).

Suicide Protective Factors

Although there are many risk factors for suicide, there are also **many** factors that protect people from making an attempt or dying by suicide. These protective factors are both personal and environmental. One of the most important of these factors is restricted access to lethal means (SPRC, 2019c).



SUICIDE SCREENING

Suicide **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.

Screening Recommendations

There is debate about the benefits of screening all patients (**universal screening**) for suicide risk factors and whether screening actually reduces suicide deaths. The general view, however, is that such screening should only be undertaken if there is a strong commitment to provide treatment and follow-up, since there is some evidence that screening improves outcomes when it is associated with such close follow-up and treatment.

Instead of universal screening, some recommend that screening be done only for those presenting with known risk factors (**selective** or **targeted screening**). Despite this lack of uniform guidance, health systems are implementing suicide screening protocols, and screening tools are already widely used in primary care settings (Durkin, 2019; O'Rourke et al., 2019).

U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATIONS

In 2019, the U.S. Preventive Services Task Force issued a final recommendation statement concluding that current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in adolescents, adults, and older adults in primary care and to those who do not have an identified psychiatric disorder.

The recommendations further state that, although evidence to screen asymptomatic populations is inadequate, providers should consider identifying patients with risk factors such as a history of suicide intent or behaviors, especially those with mental health diagnoses, and those who seem to have a high level of emotional distress, and to refer them for further evaluation.

JOINT COMMISSION RECOMMENDATIONS

The majority of people who die by suicide visit a healthcare provider within months of their death, representing an important opportunity to intercede and connect them with mental health resources. However, The Joint Commission indicates that few healthcare settings routinely screen for suicide risk. In 2016, The Joint Commission issued a Sentinel Event Alert recommending that all patients in all medical settings be screened for suicide. For children and adolescents, screening should be done without the parent or guardian present. However, if the parent or guardian refuses to leave the room or the child insists that they stay, the screening should still be conducted.

Patients who are screened and found positive for suicide risk on the screening tool should receive a brief suicide safety assessment conducted by a trained clinician to determine whether a more comprehensive mental health evaluation is required.



The Joint Commission recommended that primary, emergency, and behavioral health clinicians look for suicidal ideation in all patients in both nonacute and acute care settings. The Commission advised:

- Reviewing each patient’s personal and family history for suicide risk factors
- Screening all patients for suicide risk factors using a brief, standardized, evidence-based screening tool, and reviewing screening questionnaires before the patient’s appointment is ended or the patient is discharged
- That research suggests that a brief screening tool is more reliable at identifying patients at risk for suicide than a clinician’s personal judgment or questions about suicidal thoughts that use vague or softened language
(TJC, 2018)

Screening Tools

The following are validated, evidence-based screening tools:

ASK SUICIDE-SCREENING QUESTIONS (ASQ)

A four-item suicide screening tool designed to be used for patients ages 10 to 24 in emergency departments, inpatient units, and primary care facilities. The tool takes two minutes to administer and asks the following four 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?
(NIMH, 2019)

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS) SCREENING VERSION

This screening tool is to be used in general healthcare settings for all ages and asks questions that address:

1. Whether and when the patient has thought about suicide
2. What actions they have taken, and when, to prepare for suicide
3. Whether and when they have attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition
(TJC, 2018)



PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

A nine-item tool used to diagnose and monitor the severity of depression used for ages 12 and older in all primary care and behavioral healthcare settings. Question #9 screens for the presence and duration of suicide ideation (TJC, 2018).

SUICIDE BEHAVIOR QUESTIONNAIRE-REVISED (SBQ-R)

A four-item, self-report questionnaire for use in ages 13 to 18 that asks about future anticipation of suicidal thoughts or behaviors as well as past and present ones and includes a question about lifetime suicidal ideation, plans to die by suicide, and actual attempts (TJC, 2018).

Recognizing Suicide Warning Signs

Besides screening for risk factors for suicide, it is important to be able to recognize behaviors that indicate an individual is at immediate risk for suicide. These are referred to as *proximal factors*, or *warning signs*, and are grounds for immediate action. Such warning signs include:

- Talking about or writing about death, dying, or dying by suicide
- Threatening to hurt or kill oneself
- Looking for ways to kill oneself, such as searching online for lethal methods or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped, like there is no way out
- Talking about being a burden to others
- Increasing use of alcohol or drugs
- Withdrawing from friends, family, or social activities
- Changing one's eating and/or sleeping habits
- Showing rage, anger, or talking about seeking revenge
- Acting anxious or agitated
- Displaying significant changes in mood, especially suddenly changing from very sad to very calm or happy
- Taking risks that could lead to death, such as driving extremely fast
- Losing interest in school, work, or hobbies
- Losing interest in personal appearance
- Visiting or calling people to say goodbye



- Giving away important possessions
- Preparing for death by writing a will and making final arrangements
(APA, 2019b)

CASE

GREGORY, AGE 12

Michaela is a school social worker serving children who have emotional disturbances. One of the students, Gregory, age 12, 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. I’m not sleeping very well lately.” He then started to say something else but stopped himself short. 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 that 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 thank you for all she’d done for him.

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.

Discussion

Michaela has worked to develop a trusting relationship with Gregory and has awareness of his baseline moods and behaviors. Today, Michaela became concerned that Gregory was not



behaving as usual. She recognized that he was trying to tell her something. She reached out by providing a phone number for him to call her if he decided he wished to talk. In her interactions with him today, she began to recognize the following warning signs that Gregory may be at a crisis point:

- He reported a change in his sleeping habits (not sleeping well lately).
- He displayed increased withdrawal (not wanting to talk).
- He left Michaela a note that could only be interpreted as a goodbye.

When Michaela received the distress call from Gregory with clear indications of suicidal intent, she reacted immediately to intervene, establishing his locale and calling 911. This was followed by calling his parents and reporting to designated authorities at the school.

If Michaela had not received Gregory's phone call, she would instead have called his parents or, if they could not be contacted, called 911 to have a welfare check completed for a young person who may be considering suicide.

Communicating with Patients with Suicidal Ideation

The most effective evaluation of the patient who has screened positive for suicidal ideation begins with the establishment of a therapeutic relationship.

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 important to note that often suicidal persons have recently perceived rejection, and a considerable amount of expertise may be required in order to establish rapport (IASP, 2019).

Basic Attending Skills

Basic attending and listening skills are valuable in establishing rapport and a therapeutic alliance in order to obtain information 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. Vocal qualities can be used to lead the patient.
- **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:

- Overuse of positive attending behaviors, which can become negative or annoying
- 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
(Grieve, n.d.)

Listening Skills and Action Responses

Effective communication 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.
(Sommers-Flanagan & Sommers-Flanagan, 2016)

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** is a classic psychoanalytic technique that can produce patient insight or a solution-focused way to help patients view their problems from a new and different perspective, also known as *reframing*.
- **Confrontation** involves pointing out discrepancies to help the patient see reality more clearly.
(Sommers-Flanagan & Sommers-Flanagan, 2016)

When attempting to elicit information from suicidal persons, it should be remembered that challenging or direct questions which could be interpreted as critical will rarely be of benefit. The individual who is suicidal should be encouraged and given the opportunity to express thoughts and feelings and allowed to discharge pent-up and repressed emotions. This can best be achieved by asking **open-ended questions** such as: “What are your feelings about living and dying?” Such questions allow an expression of the ambivalent feelings most often experienced by persons who are suicidal. Direct questions such as “Do you really want to kill yourself?” do not allow such an expression (IASP, 2019).

OPEN-ENDED QUESTIONING IN RESPONSE 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?
(Adapted from Videbeck, 2011)	

ASSESSING SUICIDAL INTENT

Once it is determined that suicidal ideations are present, the next step is to determine whether the patient has active (thoughts of taking action) or passive (wish or hope to die) intent.

Suicidal intent can be determined best by considering the degree of planning, the knowledge of the lethality of the intended suicidal act, and the degree of isolation of the person. At this point, **specific** and **direct questions** should be asked to gather specific information, such as:

- Did you ever think about suicide?
- Have you ever practiced or attempted suicide?
- Do you have a plan for suicide?
- What is your plan for suicide?
- Do you have your chosen means for suicide available or readily accessible?



Red flags to consider may include a sense of hopelessness, a feeling of entrapment, well-formed plans, a perception of no social support, distressing psychotic phenomena, and significant pain or chronic illness (Harding, 2019; Schreiber & Culpepper, 2019).

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 quickly establishes rapport with her by using basic attending and listening skills. He reviews the disease process, 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.

At each session throughout the course of Grace’s treatment, Alex engages her in conversation using open-ended questioning, during which he observes her and listens for red flags that may indicate suicidal thinking. During one session, he notices that she has become more withdrawn, appears sad and listless, and begins to talk about how she doesn’t think she can continue to deal with the pain much longer. Alex then asks her direct questions to screen her for suicide risk. After scoring the risk assessment tool, he contacts her physician for follow up.

Discussion

Alex has worked to establish a trusting relationship with Grace, and being aware of the potential outcome of this disorder, listens to her and observes her very carefully. When there is a change in her behavior and talk of feeling hopeless, he recognizes them as red flags and proceeds to screen her for suicide risk, asking the six questions included in the screening version of the Columbia Suicide Severity Rating Scale. Upon completion of the screening, he contacts her physician, who will determine management.

ASSESSING LETHALITY AND RISK

When suicide risk screening results in the positive identification of an individual at risk for suicide, it is vitally important that the healthcare provider further assess the patient’s level of suicide risk and lethality of plan to determine whether to refer the individual for outpatient management or to directly refer the individual for immediate mental health evaluation and suicide risk assessment.



When assessing lethality and risk, it is important to learn 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 attempted suicides that do not end in death. For every 25 attempts, there is one death. For drug overdoses, the ratio is around 40 to 1.

The following are methods of suicide and the likelihood that they will result in death:

- Firearms: 82.5%
 - Drowning/submersion: 65.9%
 - Suffocation/hanging: 61.4%
 - Gas poisoning: 41.5%
 - Jump: 34.5%
 - Drug/poison: 1.5%
 - Cut/pierce: 1.2%
 - Other: 8.0%
- (HSPH, 2020)

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.** Given the brief duration of some suicidal crises, a gun in the cabinet in the hall is a greater risk than a very high building 10 miles away.
- **Ability to abort mid-attempt.** 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.
(HSPH, 2020)

Level of Risk

A clinical judgment that is based on all the information obtained during evaluation should help to assign a level of risk for suicide and determine the setting of care.

Patients who are **low risk** of suicide:

- Have thoughts of death only
- Have no suicide plan
- Have no clear intent
- Have easily identifiable and multiple protective factors
- Have no history of suicidal behaviors
- Have evidence of self-control
- Are willing to talk about stressors or depression
- Have supportive family members or significant others
- Are willing to comply with treatment recommendations
- Have a high degree of ambivalence

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 they should live.

Patients who are at **moderate risk**:

- Have suicide ideation
- Have no clear plan for suicide
- Have limited intent to act
- Have some identifiable protective factors
- Exhibit fair/good judgment
- Have no recent suicidal behavior



- Have supportive family or significant others
- Are willing to comply with treatment recommendations
- Have a high degree of ambivalence
- Have no access to lethal means

Patients who are at **high/severe/imminent risk**:

- Have a specific suicide plan
- Have access to lethal means
- Have minimal protective factors
- Have impaired judgment
- Have poor self-control either at baseline or due to substance use
- Have a poor social support network
- Have severe psychiatric symptoms and/or an acute precipitating event
- Have a history of prior suicide attempt

(Yasgur, 2016; WICHE MHP & SPRC, 2017)

Psychiatric illness is a strong predictor. More than 90% of patients who attempt suicide have a psychiatric disorder, and 95% of patients who successfully die by suicide have a psychiatric diagnosis.

A **prior history of attempted suicide** is the strongest single factor predictive of suicide. One of every 100 suicide attempt survivors will die by suicide within one year of the initial attempt, a risk approximately 100 times that of the general population. Following a suicide attempt, the risk for suicide is greatest in patients with schizophrenia, unipolar major depression, and bipolar disease (Schreiber & Culpepper, 2019; Yasgur, 2016; WICHE MHP & SPRC, 2017).

Impulsiveness and Access to Lethal Means

Research has found that when people make a decision to attempt suicide, nearly half will attempt it within 20 minutes (Meinert, 2018). To define impulsivity in relation to suicide, however, is difficult. Some consider the duration from first suicidal ideation to actual attempt, and others define it as an absence of planning or preparation. Regardless of this uncertainty, it is common for suicide attempts to be considered impulsive acts, and there is evidence that strongly links the two.

Studies done among people who have attempted suicide have found that those with impulsive suicidal behavior, when compared to those with nonimpulsive suicidal behavior:



- Have less severe and intensive suicide ideations, suggesting they progress from vague suicide ideation directly to a suicide attempt
- Have significantly lower intent
- Use significantly less lethal methods
- Are relatively younger
- Rarely have significant risk factors such as being older; living alone; or being widowed, divorced, or separated
- Have psychiatric symptoms as the main reason for a suicide attempt

Impulsivity is considered a possible phenotype underlying self-harm and suicidal behaviors, and there is evidence that different facets of impulsivity follow different neurodevelopmental trajectories, with some factors more strongly associated with such behaviors than others. It is unclear, however, whether impulsivity is a useful predictor of self-harm or suicidal behavior in young people, a population already considered to have heightened impulsive behaviors (McHugh et al., 2019; Lim et al., 2016; Chaudhury et al., 2016).

There is substantial support for the idea that ease of access influences the choice of method. Having access to lethal means increases the risk for death by facilitating transition from thought to action. Approximately one half of all suicide deaths in the United States are the result of self-inflicted gunshot wounds, and the next most commonly used method is intentional overdose. The most lethal method, a firearm, is present in at least one third of all households in America (ASS, 2018).

Research in 2019 found that more adolescents were attempting suicide by overdosing on medications readily available in the home. These included over-the-counter medications such as ibuprofen and aspirin, or prescription medications such as antidepressants, antipsychotics, antihistamines, and ADHD medications (Spiller et al., 2019).

Another readily accessible means for suicide are common household chemicals. The use of toxic gases generated by a combination of these chemicals has become more prevalent recently. These are often referred to as “*detergent*” suicides or *chemical suicides* involving self-inflicted exposure to toxic gases in a confined space such as a car, bathroom, or closet (USDHHS, 2019).

It is of utmost importance for clinicians to recognize that these methods, as well as other highly lethal suicide methods, are widely accessible and must be considered when determining the disposition of someone who has suicidal ideations.

Differentiating between Non-Suicidal Self-Injury and Suicide Attempt

Healthcare professionals are increasingly confronted with another problem related to suicide attempts, called *non-suicidal self-injury (NSSI)*. NSSI is distinct from suicide because patients do not intend the acts to be lethal. DSM-5 defines NSSI as the “deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned” (APA, 2013).



The distinction between suicidal and non-suicidal self-injury has been discussed for the past two decades due to the fact that most people engaging in this practice also report suicidal ideation. Recent studies show that NSSI history increases the risk of suicide ideation, plans, and attempts (Kiekens et al., 2018).

Patients often injure themselves many times during a single episode and create multiple lesions in the same location, most often in areas that are easily hidden but accessible, such as the upper chest, torso, forearms, or front of thighs.

Self-injurious behaviors can include:

- Cutting, stabbing, or carving the skin with a sharp object, such as a knife, razor blade, or needle
 - Scratching or abrading the skin
 - Burning the skin (typically with a cigarette)
 - Head banging
 - Hair pulling
 - Self-punching, -pinching, -biting
 - Interfering with wound healing
 - Swallowing nonedible objects
 - Auto-amputation (rarely)
 - Eye enucleation
- (Hauber et al., 2019; Klonsky, 2017)

NSSI can be either self-focused or social/other-focused. The motivations are not clear, but there are indications that the functions of these behaviors include:

- Affect regulation or reduction of mental pain to achieve a sense of calm and relief
 - Transference of mental pain onto the body
 - Self-directed anger or punishment for perceived failings and faults
 - Influencing others (to cause reactions, to seek help)
 - Anti-dissociation (to avoid feeling disconnected from sense of self or reality)
 - Anti-suicide (to stop suicidal urges)
- (Klonsky, 2017)

NSSI is a complex issue that warrants referral for professional assessment and management. It is a stronger predictor of suicide attempts than other risk factors such as depression, anxiety, and personality disorders. It is theorized that both suicidal wishes and the capability to act on them



are necessary for potentially lethal suicide attempts. Among those people with high distress and strong suicidal ideations, the fear of pain, injury, and death may be a barrier to making a suicide attempt. A person who has experience and practice with self-inflicted injury and who has become accustomed to pain and injury may be more capable of overcoming these fears (Klonsky, 2017).

ASSESSMENT OF NSSI PATIENTS

Assessment of the patient who presents with non-suicidal self-injurious behavior includes:

- Determining what type of injury and how many types of injuries the patient has inflicted
- Determining how often non-suicidal self-injury occurs and how long it has been occurring
- Determining the function of NSSI for the patient
- Checking for coexisting psychiatric disorders
- Estimating the risk of suicide attempt
- Determining how willing the patient is to participate in treatment (Clayton, 2019)

Signs of NSSI that may be found during the physical examination include:

- Unexplained or clustered scars, fresh cuts, or other signs of bodily damage
- Unexplained use of bandages
- Blood stains on clothing
- Inappropriate dress for the weather (e.g., long-sleeved shirts in the summer) (Southard et al., 2017)

Once signs of NSSI are identified, an assessment tool can be used to aid in diagnosing NSSI and differentiating patients who are at increased risk of suicide. These may be either self-administered or clinician-administered. For example, **Self-Harm Behavior Questionnaire (SHBQ)** is a self-report instrument that examines the level of self-destructiveness and asks questions about thoughts, gestures, and suicide attempts. Questions are grouped in four sections that examine the range of self-harming suicide behaviors. This scale can be helpful in diagnosing future thoughts and behaviors that can lead to death.

CASE

NEALA

Neala, a 14-year-old female, has been referred to Jensen Huang, DPT, for physical therapy evaluation and treatment of persistent back pain localized to the paraspinal muscles of both



the thoracic and lumbar areas. Neala arrives with her mother and, during the clinical interview, tells Jensen that she carries a heavy backpack throughout the day at school, spends several hours a day sitting and playing video games, and is feeling depressed and anxious “because I hurt so much.”

Neala is asked to undress and put on a gown for her physical assessment. While examining Neala, Jensen notices multiple crescent-shaped bruises and scabs on her upper arms and the front of her thighs. When Jensen asks her what might have caused these marks, Neala shrugs her shoulders and replies, “Oh, I don’t know.”

As Jensen continues his examination, he again asks Neala if she has any idea what could have caused these strange marks, and Neala replies, “I just pinched myself.” On further questioning, Neala tells Jensen they were made by pinching her skin between her fingernails, and that she does this when she is feeling down and anxious. She tells Jensen she learned how to do this on a website she found on the Internet and that it “takes the miseries away.”

Discussion

Jensen identifies Neala’s behavior as most probably non-suicidal self-injury. Although the pinching is not a method for suicide, NSSI in adolescence is a risk factor for suicide attempts throughout adulthood and is a complex behavior that requires professional treatment. Following examination, Jensen meets with both Neala and her mother to discuss treatment options for her back pain and to inform them that he will contact the referring physician for a referral for evaluation of Neala’s NSSI behaviors.

Documentation of Risk Assessment

Good documentation is basic to clinical practice. Accurate, sufficiently detailed, and concise records of a patient’s treatment allow 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 goal of documentation is to explain the clinical reasoning and decision-making behind the suicide assessment and the treatment plan that follows the assessment. The following elements should be included in the documentation:

- What prompted the suicide assessment (includes direct quotes as well as more subtle indications)



- Summary of the presenting complaints, including a detailed assessment of suicidal ideation
- Record of past suicide attempts and outcomes
- Evaluation of current risk factors, protective factors, and warning signs
- Presence or absence of firearms
- Listing of individuals who participated in the evaluation, including the patient's family, friends, and any collaborative consultants
- Summary of treatment options discussed with the patient, including any suggestions and/or recommendations for hospitalization, if applicable
- Review of the treatment plan agreed upon with the patient, including why this plan provides the safest treatment in the least restrictive environment. Treatment plan may include:
 - Starting medications and/or therapy
 - Means restriction, and, if possible, verification from the patient's support system that it will be completed
 - Substance use reduction or formal treatment
 - Safety or crisis plan creation (a copy of which is placed in the medical record)
 - Referral to a mental health provider
 - Hospitalization
- Follow-up plan (appointment, phone calls, etc.)
(Weber et al., 2018)

There have been many court decisions involving patient suicide that clearly show that documentation is necessary to prove reasonable care occurred. The clinical record establishes exactly what data clinicians relied upon and how it was used to arrive at a suicide risk estimate. The goal of documentation in such instances is to show that reasoned judgment was exercised, not that the suicide risk estimate was right or correctly predicted suicidal behavior (Obegi, 2017).

DETERMINING PRIORITY FOR ACTION AND REFERRAL

Once an assessment of the patient's level of risk, lethality, and access to means have been completed, the next step is to determine the priority for action and where intervention can best be achieved. Disposition is determined according to level of risk:

- **High risk:** Patients who have a psychiatric diagnosis with severe symptoms or an acute precipitating event, have made a potentially lethal suicide attempt or have persistent



ideation with strong intent or suicide rehearsal generally should be managed with suicide precautions and admitted to a hospital for management.

- **Moderate risk:** Patients with multiple risk factors and few protective factors, who have suicidal ideation with a plan but no intent or behavior, may require referral for a more in-depth evaluation or hospital admission. If not admitted, a crisis plan should be developed and the patient should be given emergency/crisis numbers.
- **Low risk:** Patients with modifiable risk factors and strong protective factors who have thoughts of death, no plan, intent, or behavior should be referred for outpatient management and be provided with emergency/crisis numbers.

(SAMHSA, 2020)

Models of Care for Patients at Risk for Suicide

During triage, the appropriate intervention is selected, and there are several models of care to consider. A model of care is a set of interventions that can be consistently carried out in various settings to ensure that people get the right care, at the right time, by the right provider or team, and in the right place. Newer models of care for management of patients at risk for suicide include:

- Crisis support and follow-up
- Brief intervention and follow-up
- Suicide-specific outpatient management
- Emergency respite care
- Partial hospitalization with suicide specific care
- Inpatient hospitalization

(SPRC & NAASP, 2019)

CRISIS SUPPORT AND FOLLOW-UP

Crisis support and follow-up can include mobile crisis teams, walk-in crisis clinics, hospital-based psychiatric emergency services, peer-based crisis services, and other programs designed to provide assessment, crisis stabilization, and referral to an appropriate level of ongoing care. Crisis centers can also serve as a connection to the patient between outpatient visits. A full range of crisis services can reduce involuntary hospitalizations and suicides when paired with mental health follow-up care (SPRC & NAASP, 2019).

BRIEF INTERVENTION AND FOLLOW-UP

Brief intervention and follow-up are used when contact is limited and can be done in a single session or over several sessions. This involves teaching, informing, and education along with



planning for future crises. Outreach and follow-up are provided through phone calls, letters, and texts. This model may also include the development of a safety plan (SPRC & NAASP, 2019).

SUICIDE-SPECIFIC OUTPATIENT MANAGEMENT

Suicide-specific outpatient management involves intensive outpatient programs that may require appointments three days per week for three to four hours per day for patients with elevated but not imminent risk who express a desire to die by suicide but do not have a specific plan or intent and need aggressive treatment (SPRC & NAASP, 2019).

EMERGENCY RESPITE CARE

Emergency respite care is an alternative to inpatient or emergency department services for a person in a suicidal crisis when the person is not in immediate danger. Respite centers are usually located in residential facilities designed to be more like a home than a hospital. These facilities may include staff members who are peers who have lived experience of suicide. Respite care is increasingly being utilized as an intervention and may include help with establishing continuity of care and provision of longer-term support resources, as well as support by text, phone, or online following a stay (SPRC & NAASP, 2019).

PARTIAL HOSPITALIZATION WITH SUICIDE-SPECIFIC CARE

Partial hospitalization with suicide-specific care involves provision of treatment for six or more hours every day or every other day while the patient continues to live at home.

INPATIENT BEHAVIORAL HEALTH HOSPITALIZATION

Inpatient behavioral healthcare is brief hospital treatment for individuals who may be at high risk of suicide and who have made a suicide attempt. The emphasis is on keeping the patient safe while in the hospital and immediately following discharge (SPRC & NAASP, 2019).

Referring the Suicidal Patient

Clinicians who are the initial contact for patients who are at risk or who have made a suicide attempt most often refer them to one of the available treatment options, depending upon degree of risk.

A patient who is in acute suicidal crisis should be kept in a safe healthcare environment under one-to-one observation while arranging for immediate transfer to an emergency department. In certain instances where a patient is not willing to comply with disposition recommendations or is unwilling to provide informed consent for treatment, it then becomes the responsibility of the clinician to protect the patient by contacting legal authorities for assistance (TJC, 2016; Washington State Legislature, n.d.).

Other patients may require a referral to behavioral health for further evaluation and treatment. Making such a referral requires a smooth and uninterrupted transition of care from one setting to



another. In order to ensure that the patient is linked to appropriate care, the referring clinician follows these steps:

- Refer the patient to an outpatient provider for an urgent appointment for a date within a week of discharge.
- If unable to schedule the first follow-up appointment for a date within a week of discharge, refer for follow-up with a primary care provider and contact the primary care giver to discuss the patient's condition and reason for referral.
- Institute or revise a patient's safety plan before discharge or referral.
- Ensure that the patient has spoken by phone with the new provider.
- Send patient records several days in advance of the appointment to the new treatment provider and call to go over patient information prior to the first appointment.
- Troubleshoot the patient's access-to-care barriers (e.g., lack of health insurance, transportation needs) using information from the community resources list.
- Contact the patient within 24 to 48 hours after they have transitioned to the next care provider and document the contact.
(SPRC, 2019d)

WASHINGTON STATE SUICIDE PREVENTION INITIATIVES

Washington has been making great strides in the effort to prevent suicide. In 2018 there was a large increase in community and state efforts dedicated to suicide prevention, some of which include the following:

Washington State Suicide Prevention Plan is based on core principles identified by the State Suicide Prevention Plan Steering Committee as key values and attitudes. These principles state that:

- Suicide is preventable.
- Everyone has a role in suicide prevention.
- Silence and stigma are harmful.
- Known factors contributing to suicide must be changed.
- Prevention should be based on best available research and best practices.
- Persons deserve dignity, respect, and the right to make their own decisions.



Project AWARE (Advancing Wellness and Resilience in Education), through the Office of Superintendent of Public Education, equips adults to detect and respond to youth mental health issues.

The **Safer Homes, Suicide Aware** campaign was developed by Forefront Suicide Prevention at the University of Washington School of Social Work in collaboration with the Second Amendment Foundation. It offers training for healthcare clinicians, pharmacists, gun dealers, and firearms instructors in recognizing and responding to the warning signs of suicide. The campaign encourages the safe storage of firearms and medications in a variety of settings, including hospitals, gun stores, and homes. In collaboration with local gun rights advocates, Safer Homes has also piloted the distribution of free firearm locks and safety cases (SPRC, 2017c; UW, 2019).

Confident Action and Referral by Educators (CARE) is a free suicide prevention training module offered by the Office of the Superintendent of Public Instruction and designed for anyone who works with students (WAHCA, 2019).

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 learn the skills necessary to effectively screen and assess for suicide risk so they are equipped to refer their patients for appropriate interventions. 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 are having suicidal ideations by appropriately referring them to professionals who can effectively manage their treatment
- Providing suicide prevention education to others



RESOURCES

American Foundation for Suicide Prevention
<https://afsp.org>

Ask Suicide-Screening Questions (ASQ)
<https://www.nimh.nih.gov/labs-at-nimh/asq-toolkit-materials>

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 Strategy for Suicide Prevention (National Action Alliance for Suicide Prevention)
<https://theactionalliance.org/our-strategy/national-strateg/2012-national-strategy>

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/>

Suicide resources (CDC)
<https://www.cdc.gov/violenceprevention/suicide/resources.html>

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

Veterans Self-Check Quiz
<https://www.vetsselfcheck.org/welcome.cfm>

Washington State

Suicide prevention (WA State DOH)
<http://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/SuicidePrevention>

Washington suicide hotlines
<http://www.suicide.org/hotlines/washington-suicide-hotlines.html>

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

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TEST

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1. Which is **not** a common myth about suicide described in this course?
 - a. Most people who are suicidal are ambivalent about living or dying.
 - b. People who attempt or die by suicide are being selfish.
 - c. Only people who have a mental disorder are suicidal.
 - d. Suicide always occurs without any warning signs.

2. Which is a **true** statement concerning suicide in Washington State?
 - a. Washington residents living in rural areas have a lower suicide rate.
 - b. African Americans and Hispanics in Washington have the highest suicide rates.
 - c. The leading method of suicide for both males and females in Washington was poisoning by drug overdose.
 - d. Suicide is the 8th leading cause of death in the state.

3. Which statement **best** describes the role of serotonin in the etiology of suicide?
 - a. It negatively affects mood.
 - b. It dysregulates the immune system.
 - c. It impairs control of behavior and emotions.
 - d. It mediates inhibition of impulse control.

4. Psychiatric diseases account for:
 - a. A minority of suicides and suicide attempts.
 - b. At least 90% of suicide deaths.
 - c. Fewer than 10% of suicides and suicide attempts.
 - d. Five out of every 10 suicide attempts.

5. Suicide of adults ages 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. Relationship breakdown.



6. One of the most prevalent risk factors for suicide in the older adult is:
 - a. Being retired.
 - b. Grieving the death of a spouse.
 - c. Being in poor health.
 - d. Residing in a nursing home.

7. Which is a **correct** statement about suicide risk among specific populations?
 - a. Persons with late-state dementia have increased risk of suicide.
 - b. Adults with a learning disability have higher rates of suicide attempts.
 - c. Caring for a family member with dementia does not increase suicide risk.
 - d. Neurobiological pathways are not affected in Alzheimer's dementia.

8. Which is a **true** statement regarding suicide during military service:
 - a. Service members who attempt suicide prior to enlistment do not have an increased risk for suicide.
 - b. For females in the military, sexual trauma is the primary cause for the increased rates of suicide.
 - c. Medical conditions have no association with increased suicide risk.
 - d. A veteran who was wounded in combat does not have an increased risk for suicide.

9. The Joint Commission recommendations call for suicide screening for:
 - a. Adolescent patients in primary care settings.
 - b. Adult patients in acute care settings.
 - c. Older adult patients in primary care settings.
 - d. All patients in both acute and nonacute settings.

10. A nondirective listening response that involves rephrasing or restating what the patient has said is called:
 - a. Summarization.
 - b. Paraphrasing.
 - c. Validating feelings.
 - d. Confrontation.



11. A patient who has thoughts of death, no plan for suicide, and no history of suicidal behavior is considered to be at which level of risk?

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

12. Which patient is at **highest** risk for suicide?

- 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

13. When working with a patient who has suicidal ideations, it is of **utmost** importance for clinicians to recognize that:

- a. Lethal suicide methods are widely available.
- b. Even those who have a specific suicide plan are at moderate risk.
- c. Patients who are truly at risk will have a low degree of ambivalence.
- d. Death due to intentional overdose is not a common method of suicide.

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

- a. A standardized form is recommended for documentation.
- b. Documentation need not indicate the presence or absence of firearms.
- c. The documented risk estimate is measured to assess whether it correctly predicted suicidal behavior.
- d. It is not necessary to document past suicide attempts and outcomes.

15. A model of care that provides treatment for six or more hours every day or every other day while the patient continues to live at home is:

- a. Emergency respite care
- b. Partial hospitalization with suicide-specific care
- c. Suicide-specific outpatient management
- d. Brief intervention and follow-up



16. A Washington State prevention initiative that offers training for healthcare clinicians, pharmacists, gun dealers, and firearms instructors in recognizing and responding to warning signs of suicide is:

- a. Confident Action and Referral by Educators.
- b. Project AWARE.
- c. Washington State Suicide Prevention Plan.
- d. Safer Homes, Suicide Aware campaign.

