Suicide Intervention and Prevention

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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:

- Discuss the epidemiology and etiology of suicidal behavior.

- Summarize the risk and protective factors for suicide.

- Describe the process of assessment and determination of level 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.

- Relate specific epidemiologic data, risk factors, protective factors, and interventions specific to the veteran population.

UNDERSTANDING SUICIDE

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. Suicide is the culmination of many and varied interactions between biological, social, and psychological factors that operate at the levels of the individual, the community, and society.

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 attitudes toward self-harming individuals are often negative—that many people, including healthcare professionals, believe people who are suicidal are weak, unable to cope with problems, selfish, cowardly, manipulative, or attention-seeking. 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 (Rothes & Henriques, 2018; Carpiniello & Pinn, 2017).

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 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)	

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

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

Copycat suicide
A suicide that resembles other highly publicized suicides

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

Interrupted suicide attempt
When an individual is stopped by an outside force (person or circumstance) before making an attempt

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 themself

Nonsuicidal self-injury

Deliberate, direct destruction or alteration of body tissue without a conscious suicidal intent, such as cutting, burning, or bruising oneself

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 (e.g., Japanese Kamikaze pilots)

Suicide

Death caused by self-directed injurious behavior with evidence, either implicit or explicit, of intent to die as a result of the behavior

Suicide attempt

Any non-fatal potentially injurious behavior with intent to end one's life

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

Suicide contagion

Exposure to suicide or suicidal behavior within one's family, one's peer group, or through media report which can result in suicide and suicidal behaviors (copycat)

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

(USDHHS, 2019a; Singer & Erreger, 2019; MSPP, 2020)

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)	

EPIDEMIOLOGY

Suicide Globally

- The World Health Organization reported in 2016 that globally close to 800,000 people die by suicide every year—a rate of 1 death every 40 seconds. Suicide accounts for 1.4% of deaths worldwide, making it the 18th leading cause of death in 2016.

- Suicides are most common in Asia and Eastern Europe. Lithuania has the highest suicide rate per 100,000 population (31.9), followed by Russia (31), Guyana (29.2), and South Korea (26.9).

- The only Western European nation with a particularly high suicide rate is Belgium, with 20.7 per 100,000. However, it is important to take note that Belgium has one of the most liberal laws on doctor-assisted suicide, which may be a factor in its statistics.

- Among the world's most troubled areas, Afghanistan has a suicide rate of 4.7 per 100,000, Iraq 3, and Syria just 1.9. The lowest suicide rates in the world are concentrated in the Caribbean Islands.
  (WHO, 2019; World Population Review, 2019)

Suicide in the United States

Suicide is the tenth leading cause of death in the United States, and on average, there are 129 suicides per day. In 2017, 47,173 Americans died by suicide and an estimated 1,400,000 suicide attempts were made, with an estimated cost to the country of $69 billion. In 2016, suicide was the second leading cause of death among people ages 10 to 34 years, the fourth leading cause among people ages 35 to 54, and the 10th leading cause of death overall. There were more than twice as many suicides in the United States as there were homicides (19,510).

Although the Healthy People 2020 target is to reduce suicide rates to 10.2 per 100,000 by 2020, suicide rates have steadily increased in recent years. Between 1999 and 2017, there was an

alarming 33% increase in suicides, with a 50% increase among girls and women, from 4 to 6 per 100,000, and a 21% increase among boys and men, from 17.7 to 21.4 per 100,000.

By gender: In 2017, men died by suicide 3.5 times more often than women, with white males accounting for 69.67% of suicide deaths. Among females, the suicide rate per 100,000 was highest for those ages 45 to 64 (10.0); and among males, the rate was highest for those ages 65 and older (31.0).

By sexuality: The risk of suicidal behavior is approximately two to three times greater in sexual minorities than heterosexuals: bisexual (16%), homosexual (11%), heterosexual (6%). Lifetime suicide attempts were approximately four times greater in sexual minorities than heterosexuals.

By age: In 2017, the highest suicide rate (20.2 per 100,000) was among adults ages 45 to 54 years. The second highest rate (20.1) occurred in those 85 years or older. Younger groups have had consistently lower rates than middle-aged and older adults. However, the suicide rate for those ages 15 to 24 years increased in 2017 to its highest point since 2000, with a recent increase especially in males and in ages 15 to 19 years.

By race/ethnicity: In 2017, the highest U.S. age-adjusted suicide rate was among whites (15.85), and the second highest rate was among American Indians and Alaska Natives (13.42). Much lower and roughly similar rates were found among black or African Americans (6.61) and Asians and Pacific Islanders (6.59). (Note: The CDC records Hispanic origin separately from the primary racial or ethnic groups of white, black, American Indian, Alaskan Native, and Asian or Pacific Islander, since individuals in all groups may also be Hispanic.)

By education: Fewer years of education have been found to be associated with higher suicide rates. The suicide rate per 100,000 in 2014 was approximately two times higher in men with a high school education (39) than in men with a college degree or more education (17). A similar pattern was seen in women with a high school education (10) and women with a college degree or more (6).

By urbanization level: By 2017, the age-adjusted suicide rate had increased with decreasing urbanization. The suicide rate for the most rural counties (20.0 per 100,000) increased to 1.8 times the rate for the most urban counties (11.1). Factors may include a higher prevalence of gun ownership, lack of access to mental health care, or economic issues.

By methods: In 2017, firearms were the most common method of death by suicide, accounting for a little more than half (50.57%) of all suicide deaths. The next most common methods were suffocation (including hangings) (27.72%) and poisoning (13.89%). Other methods accounted for 7.8 %.

Suicide attempts: Based on the 2017 National Survey of Drug Use and Mental Health, it is estimated that 0.6% of the adults ages 18 or older made at least one suicide attempt, which is approximately 1.4 million adults. Adult females reported a suicide attempt 1.4 times as often as males. (Data on breakdown by gender and race are not available.)

Based on the 2017 Youth Risk Behaviors Survey, 7.4% of youth in grades 9–12 reported that they had made at least one suicide attempt in the past 12 months. Female students attempted suicide almost twice as often as male students (9.3% vs. 5.1%). Black students reported the highest rate of attempts, at 9.8%, with white students at 6.1%. Approximately 2.4% of all students reported making a suicide attempt that required treatment by a physician or nurse. For those requiring treatment, rates were highest for black students (3.4%).

(CDC, 2018a; Winerman, 2019; Hedegaard et al., 2018; Schreiber & Culpepper, 2019; Phillips & Hempstead, 2017; AFSP, 2020; Miron et al., 2019)

More than half of people who died by suicide did not have a known mental health condition. Factors that contribute to suicide among those with and without known mental health conditions include:

- Relationship problem (42%)

- Problematic substance use (28%)

- Job/financial problem (16%)

- Loss of housing (4%)

- Crisis in the past or upcoming two weeks (29%)

- Physical health problem (22%)

- Criminal legal problem (9%)
  (CDC, 2018b)

Suicide among U.S. Veterans and Active-Duty Military

The United States Department of Veterans Affairs reported that in 2017, 6,139 veterans died by suicide.

In 2017, veterans constituted 7.9% of the U.S. adult population but accounted for 13.5% of all deaths by suicide among U.S. adults. Suicide rates per 100,000 population for veterans was 1-1/2 times the rate for nonveteran adults, and firearms were the most common method (70.7% of males and 43.2% of females).

From 2005 to 2017, there was a 43.6% increase in the number of suicide deaths in the general population and a 6.1% increase in the number of suicide deaths in the veteran population. An average of 16 veterans died by suicide each day during that same period, and in 2017 an average of 17 veterans died by suicide each day.

Between 2005 and 2017, the female veteran population increased by over 6%, and in 2017 the rate of suicide among female veterans was more than double the rate among nonveteran women. The 2017 rate of suicide among male veterans was nearly 1-1/2 times higher than the rate among nonveteran males.

In 2017, 58.7% of veterans who died by suicide had a mental disorder diagnosis (highest was bipolar disorder) or substance use disorder (highest was opioid use disorder).

Veterans ages 18 to 34 had the highest suicide rate in 2017, increasing 76% during the period from 2005 to 2017, and veterans ages 55 to 74 had the lowest rate. However, the absolute number of suicides was highest among veterans 55 to 74 years of age, accounting for 38% of all veteran deaths by suicide in 2017.

In 2018 the number of suicides among active-duty personnel was the highest in at least six years and roughly equal to the rates in the general U.S. population. Service members who died by suicide were primarily enlisted persons less than 30 years of age, majority male, and the primary method used was a firearm. The following are the number of suicides and the rate per 100,000 for each branch of the military:

- Army, 139 (29.5)

- Marine Corps, 58 (31.4)

- Navy, 68 (20.7)

- Air Force, 60 (18.5)

- Reserve members, 81 (22.9)

- National Guard, 135 (30.6)
  (U.S. DOD, 2018; Kime, 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. Genetic predisposition is a part of the explanation, but other biological, social, economic, lifestyle, and environmental factors also play important roles in the etiology of suicidal behavior. Mental illness is a major factor in the development of suicidal behavior (Strawbridge, 2019).

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.

GENETIC PREDISPOSITION

The risk of suicide increases in patients who have a family history of suicide. Studies have shown that if one sibling dies by suicide, the risk of remaining siblings for dying by suicide is increased among both men and women. Studies have also shown that if an identical twin

attempted suicide, their co-twin has a 17.5% increased risk of having made an attempt, and if an identical twin dies by suicide, the co-twin has an 11.3% increased risk of dying by suicide as well (Reiss & Dombeck, 2019a).

Twin studies also indicate that those patients with a family history of suicide most likely have both genetic as well as environmental components, and the risk of inheriting suicidal traits is in the range of 30% to 50%. It is unclear, however, whether or not the genetic component is primarily responsible for an underlying psychiatric disorder or the suicide itself.

It is also known that having an unrelated spouse who has a psychiatric disorder or who dies by suicide increases the risk of suicide by the surviving spouse, showing the importance of environmental effects within the family structure (Schreiber & Culpepper, 2019).

It is not quite clear which genes are related to suicide. Many suggest there is not a specific gene (or set of genes) that increase someone's risk for suicide, but rather what is being transmitted is the likelihood of developing specific types of mental illness that can increase the risk of suicide (Reiss & Dombeck, 2019a).

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).

Suicidal adults and adolescents tend to display certain temperaments attributed to the neurobiology of the brain. Two in particular are thought to be related to suicidal behavior. The first is referred to as a *depressive/withdrawn* temperament and the other as *impulsive/aggressive*.

Individuals with depressive/withdrawn temperaments show high levels of negative mood, have difficulty controlling their moods, and tend to overreact to daily stressors. They are more likely to develop depression and anxiety. In addition, many of these individuals often have histories of being abused or developing inadequate relationships with caregivers.

People with impulsive/aggressive temperaments also have difficulty controlling their emotions, particularly anger. They are more likely to die by suicide even without having a mood disorder and are often diagnosed with antisocial personality disorder. Impulsive/aggressive individuals are sensation seekers and often engage in risky behaviors, make poor or snap judgments, and abuse alcohol and/or other substances. Children with this temperament type often have a history of abuse, in particular sexual abuse.

Research suggests that a person's temperament type is related to genes that control regulation in the brain and nervous system of the neurotransmitters serotonin and norepinephrine, which influence control of our moods (Reiss & Dombeck, 2019a).

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. Low levels of the serotonin metabolite 5-HIAA are detectable in the brains of those who died from suicide and in the cerebrospinal fluid of those who attempted suicide but did not die. Abnormalities in the serotonin system are more pronounced with more lethal suicidal behavior, and levels in the CSF are a strong correlate of current and future suicidal behavior (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. Norepinephrine dysfunction may indirectly contribute to suicide through negative effects on mood (Khroud & 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.

In response to stress, the HPA axis produces glucose, cortisol, and steroids. Autopsy studies show that people who die by suicide have elevated cortisol levels and enlarged adrenal glands, suggesting their bodies were experiencing extreme stress. Exactly how the HPA axis influences suicidal behavior is not yet clear, but researchers believe that increased cortisol levels affect the mood-regulating neurotransmitter serotonin, making it hard for serotonin to get to the brain and nervous system receptors (Reiss & Dombeck, 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. Most volumetric MRI studies have shown smaller gray matter volumes mostly in the frontal and temporal cortical regions, the corpus callosum, and insula in persons with suicidal behavior with different psychiatric diagnoses. 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. Using positron emission tomography, participants' brains were scanned and signs of inflammation were found to be present in those persons with depression experiencing suicidal thoughts. They were found to have significantly higher levels of translocator protein (TSPO) than in those who were not experiencing suicidal thoughts. TSPO plays a role in the immune response system and cell death. In the brain, elevated TSPO activates the microglia, which are immune cells specific to the brain. Microglial activation indicates brain inflammation, strengthening the suggestion that inflammation is linked specifically with suicidal ideation.

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).

Deficits in cognitive processing and neurological activity have been found in suicidal persons that are specifically related to executive function (cognitive control), which allows for planning and executing goal-directed behavior including the ability to regulate emotions, exert inhibitory control, shift focus between multiple tasks, and flexibly modify behavior according to a situation.

Deficits relate to impairment of a broad range of cognitive functions such as long-term memory and working memory, attention, problem-solving, and decision-making. Executive dysfunction is said to have a direct impact on emotional regulation, preventing individuals from engaging in effective mood-regulating strategies, and has also been linked to a reduced ability to deal with the emotional disturbances commonly present in suicidal individuals (Thompson & Ong, 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. However, anxiety-, personality-, eating-, and trauma-related disorders, as well as

organic mental disorders such as dementia or physical illness, also contribute to risk (Bråbdvik, 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).

Differences have also been found between inpatients and outpatients treated for mental illness. Inpatient suicides (45%) were preceded by schizophrenia and organic mental disorders. Outpatient suicides (32%) occurred in those with depression; substance use; and somatoform, anxiety, and adjustment disorders. It has been suggested that inpatient status by itself may be a risk factor, as the lifetime suicide risk is much higher than in never-hospitalized outpatients (Bachmann, 2018).

It has been found that 41% of those who died by suicide had been psychiatric inpatients within the previous year, and as many as 9% of suicides occurred within one day of discharge from psychiatric inpatient care (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. The lifetime prevalence of depression and PTSD is 5 to 15 times higher respectively when compared to civilians (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

Recognizing that both fetal and early childhood influences have long-term effects on a range of adult conditions, 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. DNA methylation is one of several epigenetic mechanisms known to be influenced by the external environment and in turn affect transcriptional regulation and gene expression (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. A recent study found that emotional abuse tripled the likelihood of attempting suicide, physical abuse almost doubled the chances, substance abuse in the family more than doubled the chances, and violent treatment of the mother almost quadrupled the chances (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. Social networks offer opportunities for sharing emotions and feeling connected. 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.

The CDC (2019a) reports that youth who frequently bully others and youth who report being frequently bullied both are at increased risk for suicide-related behavior. Youth who bully others are at increased risk for substance use, academic problems, and experiencing violence later in adolescence and adulthood. Youth who bully others and are bullied themselves suffer the most serious consequences, are at greater risk for mental health and behavioral problems, and 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.

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 themself. 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. It is believed that marriage increases social integration and gives meaning to the life of the individual (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. The rate of suicide is greater in female physicians than the general population and is also greater in male physicians than 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. 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, 2019).

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, 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. Constant connection to social media also impacts self-esteem that contributes to an increase in anxiety, as it is hard for young persons to compare their life and social connections to what they see others posting on social media (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)

Medications and Suicide

There are several medications that have been linked to suicidal behavior, for which the U.S. Food and Drug Administration (FDA) requires a boxed warning (formerly known as a *Black Box Warning*).

- **Antidepressants**: The FDA warns that antidepressants increase the risk of suicidal thinking and suicidal behavior in children and adolescents with major depressive disorder and other psychiatric disorders, and that prescribing these medications requires vigilant monitoring following initiation. Controversy exists because these warnings have led to an increase in the rate of suicide following the decline in prescribing of antidepressants (Fornaro et al., 2019; FDA, 2018).

- **Anticonvulsants**: There have been reports over the past two decades of suicidal behavior after initiating anticonvulsant therapy such as lamotrigine gabapentin, carbamazepine, tiagabine, and oxcarbazepine. Providers are encouraged to exercise caution, carefully assessing behavioral comorbidities prior to initiation as well as frequent monitoring during the course of treatment (O'Rourke et al., 2019).

- **Analgesics**: Tramadol has been associated with a risk of self-harm for some people, including those with a history of depression or prone to addiction (Fookes, 2019; O'Rourke et al., 2019).

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).

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, 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)

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, 2019a).

Deaths from suicide as well as drugs and alcohol have risen steeply among white, middle-aged Americans. These are referred to as "deaths of despair" and are linked to declines in economic and social well-being among the white working class. Suicides have increased most sharply in rural communities where the loss of farming and manufacturing jobs have led to economic decline. Other factors include the lack of accessible and affordable mental health services and the availability of firearms (Weir, 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)

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* in the form of physician-assisted suicide. When a second party fulfills a dying person's request to be put to death, it is referred to as *active voluntary euthanasia*.

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 the United States, Oregon was the first state to legalize physician-assisted suicide in 1994. Since then, physician-assisted suicide has become legal in California, Colorado, Hawaii, Maine, New Jersey, Vermont, Washington, and the District of Columbia. Forty-one states consider assisted suicide illegal. Montana has legal physician-assisted suicide via Supreme Court ruling, as there is nothing in state law prohibiting a physician from honoring a terminally ill, mentally competent patient's request.

(Brauser, 2015; DD, 2019)

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

Other findings indicate that suicide attempts or deaths in patients with early-stage Alzheimer's disease could be a consequence of amyloid burden through its association with depressive symptoms that are frequently observed in patients with early-stage dementia. Amyloid burden is a potential risk for suicide through its effects on neurobiological pathways such as serotonergic dysregulation, dysfunctional stress response, and brain inflammation (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 factors that protect people from making an attempt or dying by suicide. These protective factors are both personal and environmental.

Personal protective factors include:

- Values, attitudes, and norms that prohibit suicide, such as strong beliefs about the meaning and value of life

- Strong problem-solving skills

- Social skills, including conflict resolution and nonviolent ways of handling disputes

- Good health and access to mental and physical healthcare

- Strong connections to friends and family as well as supportive significant others

- Cultural, religious, or spiritual beliefs that discourage suicide

- A healthy fear of risky behaviors and pain

- Optimism about the future and reasons for living

- Sobriety

- Medical compliance and a sense of the importance of health and wellness

- Good impulse control

- A strong sense of self-esteem or self-worth

- A sense of personal control or determination

- Strong coping skills and resiliency

- Being married or a parent

- Being pregnant (although pregnancy and motherhood has been studied as a protective factor, suicide remains a leading cause of maternal death in industrialized countries and vigilance in assessing for ante- and postpartum depression and anxiety must be strongly considered)
  (Weber et al., 2019)

External/environmental protective factors include:

- Opportunities to participate in and contribute to school or community projects and activities

- A reasonably safe and stable environment

- Financial security

- Responsibilities and duties to others

- Owning a pet

- Restricted access to lethal means
  (CDC, 2019b; SPRC, 2019c; WMU, 2019)

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 by 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

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.

Suicide Risk Assessment

The purpose of a suicide risk assessment is to determine a patient's risk and protective factors with a focus on identification of targets for intervention. There are a number of standardized scales available to evaluate risk of suicide, but none of them is associated with a high predictive value (Schreiber & Culpepper, 2019). The most effective assessment begins with the establishment of a therapeutic relationship with the patient.

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 them.

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, 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. 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 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:

    o Simple paraphrasing gives direction but involves rephrasing the core meaning of what the patient has said.

    o Sensory-based paraphrasing involves the interviewer using the patient's sensory words in the paraphrase (visual, auditory, kinesthetic, etc.).

    o 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. It works best when excellent rapport has been established, and it can be either gentle or harsh.

(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.	- 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.	- 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.	- What do you mean by "sleep"? - What is it you don't want to deal with anymore?
I want it to be over.	- What is it you want to be over? - How can you make it be over?
I won't be a problem much longer.	- How are you a problem? - What is going to change in your life so you won't be a problem any longer? - When will you no longer be a problem?
Things will never work out.	- What can you do to change that? - What, then, do you propose to do?
It is all so meaningless.	- What would make life more meaningful? - What are some aspects of your life that make it worth living? - What is happening in your life that makes it so meaningless?
(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. The patient should be asked if the thoughts are new and if there are changes in the frequency or intensity of chronic thoughts. It is also important to inquire about the patient's ability to control these thoughts.

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:

- Do you ever wish you were dead?

- Have you ever felt that life is not worth living?

- Have you been thinking about death recently?

- How long have suicidal feelings been present?

- 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?

- Do you know how to use the method you have chosen?

- Do you have a history of substance use or impulsive behaviors?

- Do you have a plan for others after death, such as leaving a suicide note, changing your will?

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).

Suicide Risk Assessment Tools

Although various suicide risk assessment tools are available, experts have repeatedly come to the conclusion that there is not any one tool that can predict who will die by suicide to any useful degree. 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 when positive results have been obtained with one of the screening tools mentioned above.

The following are validated/evidence-based suicide risk assessment tools:

- **Columbia-Suicide Severity Rating Scale (C-SSRS):** Risk assessment version provides a checklist of protective risk factors for suicide, used along with the C-SSRS screening tool. It is appropriate in all settings for all ages and special populations in different settings. The tool features a clinician-administered initial evaluation form, a "since last visit" version, and a self-report form (Oquendo & Bernanke, 2017).

- **Beck Scale for Suicide Ideation (BSI):** A 21-item self-report instrument that can be used in inpatient and outpatient settings for detecting and measuring the current intensity of the patient's specific attitude, behaviors, and plans to die by suicide during the preceding week. It assesses the wish to die, desire to make an active or passive suicide attempt, duration and frequency of ideation, sense of control over making an attempt, number of deterrents, and the amount of actual preparation for the contemplated attempt (TJC, 2018).

- **Scale for Suicide Ideation-Worst (SSI-W):** A 19-item interviewer-administered rating scale that takes approximately 10 minutes which measures a patient's intensity of specific attitudes, behaviors, and plans to die by suicide during the time period that they were most suicidal. Can be used in both inpatient and outpatient settings (TJC, 2018a).

Clinical Interview

The clinical interview is the "gold standard" for suicide assessment and intervention. A clinical interview focuses on three areas—the presenting problem, the psychosocial history, and the current situation and functioning. Rather than focusing on risk factors and suicide prevention, the interview should focus on eight suicide dimensions or drivers:

1. Unbearable emotional or psychological distress
2. Problem-solving impairments
3. Interpersonal disconnection, isolation, or feelings of being a social burden
4. Arousal or agitation
5. Hopelessness
6. Suicide intent and plan
7. Desensitization to physical pain and thoughts of death
8. Access to firearms
   (Sommers-Flanagan, 2019)

Although infrequent, homicide/murder and suicide are a reality. Any question of suicide also must be coupled with an inquiry into the person's potential for homicide. Suicide is considered aggression toward the self, whereas homicide is considered aggression toward others. Because suicide is an aggressive act, consideration of homicide must also be addressed. It has been found among homicide-suicides that most victims were

spouse/partners and/or children. Most of the perpetrators are male and most victims are female (Soreff et al., 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 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 25 unsuccessful ones, and 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 assessment 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).

Indicators of **high risk for suicide following a suicide attempt** include:

- Suicide attempt with a highly lethal method

- Suicide attempt that included steps to avoid detection

- Ongoing suicidal ideation or disappointment that a suicide attempt was not successful

- Inability to openly and honestly discuss the suicide attempt and what precipitated it

- Lack of alternatives for adequate monitoring and treatment

- Psychiatric disorders underlying the suicidal ideation and behavior

- Agitation

- Impulsivity
  (Schreiber & Culpepper, 2019)

Impulsiveness and Access to 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. These drugs can have very serious medical outcomes and can impact brain function. ADHD medications have the highest risk of a serious medical outcome (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, 2019b).

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. NSSI co-occurs with a variety of psychiatric disorders, including depression, substance abuse disorders, posttraumatic stress disorder, eating disorders, and other personality disorders. The age of onset is generally between 12 and 16, appears to decline in young adulthood, may be slightly more prevalent in females, and is associated with significant functional impairment.

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)

It has been found that higher impulsivity along with being connected with the suicide or self-harm thoughts of others, as well as the occurrence of physical or sexual abuse, worries about sexual orientation, and trouble with the law independently differentiated adolescents who regularly engage in NSSI from single-time and non-NSSI adolescents (Clayton, 2019; Hauber et al., 2019).

NSSI 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. Examples include:

- **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.

- **Suicide Attempt and Self-Injury Interview (SASII)** is a clinician-performed instrument that collects details of the physical aspects, intent, medical severity, social context, precipitating and concurrent events, and outcomes of NSSI and suicidal behavior during a specific period of time. Major SASII outcome variables are the frequency of self-injurious and suicidal behaviors, the medical risk of such behaviors, suicide intent, a risk/rescue score, instrumental intent, and impulsiveness.
  (Drzał-Fiałkiewcz et al., 2017)

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 Jenson 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).

MODELS OF CARE FOR PATIENTS AT RISK FOR SUICIDE

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).

MANAGEMENT OF THE PATIENT AT RISK FOR SUICIDE

Patients at risk for suicide are cared for in multiple healthcare settings, including primary care, emergency departments, outpatient facilities, and inpatient facilities.

Primary Healthcare Settings

In primary settings, the emphasis is on identifying those at risk for suicide, enhancing safety for those at risk, and referring to specialized care. **Screening** is recommended using a standardized scale. When screening results in a positive identification of an individual at risk, it is critically important for the primary care provider to further assess the patient's level of risk to determine if **referral** for a comprehensive mental health evaluation and risk formulation is warranted or to directly refer the high-risk individual to an emergency department for intervention. All patient information should be transferred on referral to ensure continuity of care.

For those who are not at high risk, the primary healthcare professional considers appropriate **interventions** to provide support to the patient. A brief safety planning intervention is conducted prior to discharge and, with the patient's consent, discussed with the family to gain support for safety activities. Part of the safety plan includes lethal means counseling and arranging for and confirming the removal or reduction of lethal means, as feasible. (See also "Suicide Safety Plan" and "Reducing Access to Lethal Means" later in this course.)

At **discharge**, the patient is provided with appropriate resource information, including crisis line contact details and support resources.

At-risk patients also receive a **post-discharge** follow-up caring contact within 48 hours of a visit or the next business day. This can include:

- Postcards and/or letters containing brief expressions of caring

- Texts or emails

- Telephone follow-up contacts

- Telephone calls combined with in-person contact
  (NAA, 2018: SPRC, 2020)

MAKING A REFERRAL TO MENTAL HEALTH SERVICES

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. This 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 provider 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 review 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)

Emergency Department Management

The emergency department is often the entrance into the medical system for individuals who have attempted suicide or are having suicidal thoughts. For patients who have attempted suicide, a focused **medical assessment** is completed to identify medical issues requiring emergent or urgent management. This relies primarily on a history and physical examination, including evaluation of cognitive and emotional status, identification of drugs ingested, trauma, or other medical conditions that may affect the patient's mental status. In addition, toxicology screening is often requested by mental health consultants.

Upon admission to the emergency department, patients who have harmed themselves, have mental illness or substance use disorders, or are receiving behavioral health treatment or psychiatric medications undergo **screening** using a standardized scale. For those found at risk for suicide, rapid referral for in-hospital or outpatient care is made as deemed appropriate. In instances where rapid transfer for inpatient management is not possible, the patient is placed in a space that is monitored and free of any items that can be used to harm oneself or others.

Following assessment and interventions, **discharge planning** is done to determine disposition (treatment and treatment setting). A small number of low-risk patients can be managed by the ED professional and discharged to home without a mental health consultation. The majority, however, do require a comprehensive risk assessment to adequately inform decision-making concerning disposition. Once disposition has been determined, a **referral** will be made (see box "Making a Referral to Mental Health Services" above) (SAMHSA, 2018; Betz & Boudreaux, 2016; NAA, 2018).

EMERGENCY DEPARTMENT DISCHARGE PLANNING

Providers in the emergency department determine whether to discharge and refer the patient for outpatient treatment or to admit for inpatient care. When being discharged to outpatient care from the emergency department, a plan for follow-up is provided. The following is a discharge planning checklist:

- Involve the patient, as well as family and friends, in the development of the discharge plan.

- Schedule an urgent follow-up appointment (preferably within 24 hours, or when possible within 7 days of discharge) with a mental healthcare provider, primary care provider, or other outpatient provider.

- Verbally review and discuss the patient care plan, including a review of medications, and confirm that the patient understands them. A safety plan may be used to address elements of patient care related to suicide risk (see box below).

- Discuss barriers, such as lack of health insurance, that may interfere with following the care plan and identify possible solutions or alternatives.

- Provide a crisis center phone number.

- Discuss limiting access to lethal means. (See "Reducing Access to Lethal Means" below.)

- Provide written instructions and educational materials.

- Share the patient's health information with referral providers.
  (NSPL, 2020)

SUICIDE SAFETY PLAN

Safety planning is a clinical process involving listening, empathizing with, and engaging the patient in the development of a safety plan, which is a collaboratively written list of coping strategies and sources of support a patient can use before or during a suicidal crisis. The plan is brief, written in the patient's own words, and easy to read. It involves the following steps:

1. Warning signs or triggers (thoughts, images, mood, situation, behavior) that a crisis may be developing

2. Internal coping strategies for diversion (relaxation technique, physical activity)

3. People and social settings that provide distraction

4. People whom the patient can ask for help when in crisis

5. Professionals or agencies the patient can contact during a crisis

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6. Making the environment safe, including lethal means removal

7. Optional step identifying reasons for living

When introducing the suicide safety plan process, the clinician:

- Explains how suicidal crises fluctuate over time and problem-solving capacity diminishes during crises

- Explains how the safety plan helps to prevent acting on suicidal feelings

- Explains when the safety plan should be used

- Explains how using the strategies enhances self-efficacy and sense of self control

- Identifies obstacles to carrying out the steps and problem solve around them

(ICRC-S, 2017)

CASE

JACOB *(continued)*

The emergency department 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 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.

Discussion

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)*

Outpatient Behavioral Health Management

Patients with elevated but not imminent risk of suicide need aggressive treatment that can be provided in an outpatient setting. **Interventions** are initiated at an intensity that is appropriate to the level of risk. Effective interventions in outpatient management include:

- Provide appropriate therapeutic treatment and aggressive treatment for psychiatric disorders.

- Involve family members/caregivers or those close to the patient in regular monitoring until safety has been further established:
    - Provide patients and caregivers 24-hour access to clinical support in case of urgent need.
    - Instruct family/caregivers to take the patient to the emergency department if decompensation occurs. If patient refuses, police should be called.
    - Inform patient that safety takes precedent, and that even though the patient may object, a clinician may reach out to others for additional history to alleviate the risk of suicide.

- Ensure restriction of access to all lethal means of suicide, particularly firearms and medications; discuss with family members and/or police about temporarily making them inaccessible to the patient. (See also "Reducing Access to Lethal Means" later in this course.)

- Schedule sufficient numbers of clinical contacts so that the patient will feel connected and supported.

- Educate the patient and family/caregivers about the disinhibiting effects of alcohol and other drugs.

- Discuss coping strategies and sources of support to manage suicidal ideation. (Schreiber & Culpepper, 2019)

Inpatient Behavioral Health Management

Inpatient hospitalization is the most restrictive option and is nearly always indicated for patients with a recent suicide attempt or at high risk of imminent suicide. Involuntary hospitalization may be necessary for patients who do not agree with plans for hospitalization (see below).

During hospitalization the risk of suicide is reduced, but the patient may be at higher risk immediately following discharge. Reasons for this are not known, and some studies hypothesize that there may be some harmful aspect to the experience of hospitalization itself or that patients perceive they have lost a therapeutic support system upon discharge. Therefore, hospitalization requires careful consideration (SPRC & NAASP, 2019; Schreiber & Culpepper, 2019; ICRC-S, 2017; AFSP, 2020b).

INVOLUNTARY HOSPITALIZATION

Involuntary hospitalization (or 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 "Ethical Issues and Suicide" later in this course.)

Management in the hospital is centered on the safety needs of the patient. The American Hospital Association and The Joint Commission require the following steps be taken to ensure that the **physical environment** is safe:

- On admission, the patient is searched and all belongings removed, labeled, itemized, and safely stored in a secure patient belongings locker.

- Environmental and housekeeping services are notified of a high-risk patient; they complete a behavioral health room safety check that includes ensuring cleaning supplies are kept secure and carts are always attended, which requires removing:

    o Plastic trashcan liners and replacing with paper liners

    o Extra items from closets (e.g., hangers, rods, items that can be used for hanging or strangulation)

    o Rubber gloves

    o Hand sanitizer from cage and soap in bathroom

    o Extra bed linens from the room

- o Extra chairs

- o Privacy curtains and supporting structures

- Nutrition services should be notified to provide disposable tray meals.

- Sitter or hospital staff should count disposable utensils before entering and before exiting the room.

- Nursing staff should:

  - o Remove unnecessary IV poles and medical equipment from the patient's environment.

  - o Remove any items in the room with a cord (phone, appliances).

  - o Lock all cabinets with zip ties.

  - o Place door designation signage.

  - o Request safety soap from supply.

  - o Change bed linens to flat sheets only to prevent the use of the elastic hem of a fitted sheet as a ligature.

  (Danovitch & Arnold, 2017)

A review completed by The Joint Commission has found that hanging is by far the most common method of inpatient suicide, and over half occur in the shower. Other ligature fixture points have been identified as a door, door handle, or door hinge. The Joint Commission requires that inpatient units must be ligature-resistant in patients' rooms and bathrooms, common patient areas, corridors, and transition zones between patient rooms and patient bathrooms, and that patient rooms and bathrooms must have a solid ceiling. In addition, in those areas where medical care is being delivered, one-to-one monitoring must be done, careful assessment of objects brought into the room by visitors must be done, and protocols for transporting patients to other parts of the hospital must be in place (Williams et al., 2018).

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 one-on-one continuous monitoring, or observation every 15 minutes for mood, behavior, and verbatim statement depending on the level of suicide potential, as well as 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 psychologist, 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:

- Patient will refrain from attempting suicide.

- Patient will refrain from self-harming behavior.

- Patient will identify situations that trigger suicidal thoughts.

- Patient will state willingness to learn new coping strategies.

- Patient will express a positive future orientation and the will to live.
  (APNA, 2015; Martin 2016)

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

- Jacob will not self-harm and will report an absence of suicidal ideation by the end of one week.

- Jacob will sleep six to eight hours each night by the end of two weeks.

- Jacob will consume three meals each day plus snacks by the end of one week.

- Jacob will begin psychotherapy to learn to identify negative and maladaptive thoughts and how to replace them with more positive and adaptive thinking.

- Jacob will begin to learn new coping skills, including problem solving and emotional regulation.

- Jacob will actively take part in the unit milieu.

- Jacob will actively take part in occupational and/or creative art therapies.

Interventions

- 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.

- 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.

- 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.

- 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.

INPATIENT DISCHARGE PLANNING

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:

- The patient is medically stable and treatment of any underlying psychiatric diagnoses has been arranged.

- A completed comprehensive suicide assessment and risk assessment is completed at the time of discharge, and an appropriate treatment plan is in place.

- Other collaborators and collaborators and consultants are in agreement with the discharge arrangements.

- A needs assessment, including questions regarding the patient's income, housing situation, insurance, and aftercare support, has been completed.

- An effective, collaboratively written safety plan is in place, and all attempts to remove potentially lethal means of harm have been made.

- A family member, friend, or other support person who will provide assistance to the patient following discharge has been identified and notified in advance of the patient's discharge.

- The patient and caregiver/family have been provided an explanation of the next planned level of care with written copies of the treatment plan, including details of any medications, safety plan, date of follow-up appointments, and crisis contact numbers.

- Contact information for outpatient and scheduling a follow-up appointment has been made within seven days of discharge.

- Follow-up with the patient will be conducted, ideally within 48 to 72 hours.
  (APNA, 2015; Martin 2016; OAHHS, 2016; VSG, 2019)

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. Following assessment, each practitioner in each setting determines which treatment modality would be of most benefit for that particular patient.

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) can be used with both adults and adolescents. It combines cognitive and behavioral therapies based on the premise that emotions are difficult to directly change, so CBT targets emotions by changing thoughts and behaviors that are contributing to distressing emotions.

CBT builds on a set of skills that enable a person to be aware of thoughts and emotions; identify how situations, thoughts, and behavior influence emotions; and improve feelings by changing dysfunctional thoughts and behaviors. It is designed to be provided by individual therapists on a one-to-one basis; however, because adolescents' suicidal crises occur within an environment that may include problematic relationships, abuse, family dysfunction, or poor school performance, CPT includes family interventions if needed (SPRC, 2019e).

Dialectical Behavior Therapy

Dialectic behavior therapy (DBT) is a type of cognitive-behavioral therapy that focuses on current situations and solutions and is used for individuals with severe and persistent suicidality. DBT involves a greater commitment on the part of both therapist and the patient, and involves four major components:

- Weekly individual (one-to-one) therapy sessions

- Weekly skills-training sessions, usually in the form of groups, meeting once a week for 24 weeks

- PRN consultation (phone coaching) between patient and therapist outside of sessions

- Weekly therapist consultation meetings in which the CBT therapists meet to discuss their DBT cases
  (ABCT, 2019)

Problem-Solving Therapy

Problem-solving therapy (PST) is a brief psychosocial treatment for patients experiencing distress related to inefficient problem-solving skills. PST aims to assist individuals to adopt a realistically optimist view of coping, to understand the role of emotions more effectively, and to creatively develop an action plan aimed at reducing psychological distress and enhance well-being. Interventions include psychoeducation, interactive problem-solving exercises, and motivational homework assignments (SPRC, 2017a).

Collaborative Assessment and Management of Suicidality

Collaborative assessment and management of suicidality (CAMS) is an evidence-based, suicide-specific clinical intervention that has been shown through extensive research to effectively assess, treat, and manage suicidal patients in a wide range of clinical settings. It is a flexible therapeutic framework in which patient and provider work together to assess suicidal

risk and patient-defined problems ("drivers") that made suicide compelling. That information is then used to plan and manage suicide-specific treatment (SPRC, 2017b).

Milieu Therapy

Milieu therapy is a type of psychotherapy that has been used in psychiatric hospitals, psychiatric wards in general hospitals, and group living situations for many years. Its goal is to control the environment to keep patients safe, improve their ability to learn new mental health skills, and encourage attitudes such as respect and positivity. The environment is typically well-ordered and complex enough to take normal daily activities and interactions into account. Recently it has been adapted to assist people who are receiving psychiatric treatment within their home community as well (Petti, 2019).

Group Therapy

Group therapy involves one or more psychologists leading a group of about 5 to 15 patients that meets for an hour or two each week. Groups are designed to target a specific problem, such as depression, and others focus more generally on improving social skills, thereby helping patients deal with issues such as anger, shyness, loneliness, or self-esteem. Groups can act as a support network and sounding board, and members may help with specific ideas for improving a problem situation or life challenge, holding members accountable along the way (APA, 2019c).

Creative Arts Therapy

Creative arts therapy facilities self-awareness, regulation, and resilience. Art therapy promotes the entire well-being of an individual—emotional, physical, cognitive, and social. Art therapists assist patients at risk as well as suicide survivors to explore coping strategies and implement prevention and creative strategies to support safety and reduce the risk of self-harm (AATA, 2018).

Dance movement therapy changes one's biochemistry and promotes feelings of well-being. Dancing is known to lift mood by elevating the neurotransmitters serotonin and norepinephrine. Dance movement therapy reinforces social cohesion and a feeling of belonging essential to suicide prevention. It also emphasizes the importance of creativity and laughter as important life skills (Payne et al., 2019).

Occupational Therapy

Occupational therapists educate patients to actively participate in identifying a patient's strengths and risk factors as well as physical, cognitive, and psychological components that may interfere with or facilitate engagement in meaningful activity and occupational performance. Therapists assist patients in developing self-awareness, identifying coping strategies and resources, and building skills in recognizing and challenging negative thoughts (Novalis, 2017).

MEDICATIONS

At this time, there is only one medication, **clozapine**, an antipsychotic medication, approved by the FDA for suicide risk reduction in patients with schizophrenia. There is one study of mood disorder patients that shows that treatment with antidepressants, atypical antipsychotics, and lithium reduced death by suicide. Studies have shown that suicide is reduced in those with either bipolar disorder or major depression in patients taking lithium, but the findings are controversial (AFSP, 2019b).

The antidepressants serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine inhibitors (SNRIs) are effective for treating depressed patients, especially those who are severely ill and may be at greater risk for suicide. SSRIs include:

- Citalopram (Celexa)

- Escitalopram (Lexapro) (approved for adolescents 12 years of age and older)

- Paroxetine (Paxil)

- Fluoxetine (Prozac) (currently approved for patients over the age of 8 years)

- Sertraline (Zoloft)

SNRIs include:

- Venlafaxine (Effexor)

- Disvenlafaxine (Pristiq, Khedezla)

- Duloxetine (Cymbalta)

The FDA requires labeling on all antidepressants to include strong warnings about risks of suicidal thinking and behavior in children, adolescents, and young adults.
(Anderson L., 2019)

SUICIDE PREVENTION STRATEGIES

Effective suicide prevention is a comprehensive undertaking requiring the combined efforts of every healthcare provider and addressing different aspects of the problem. A model of this comprehensive approach includes:

- **Identifying and assisting persons at risk.** This may include suicide screening, teaching the warning signs of suicide, and providing gatekeeper training (see below).

- **Ensuring access to effective mental health and suicide care and treatment** in a timely manner and coordinating systems of care by reducing financial, cultural, and logistical barriers to care.

- **Supporting safe transitions of care** by facilitating the exchange of information, establishing follow-up contacts, rapid referrals, and patient and family education.

- **Responding effectively to persons in crisis** by ensuring available crisis services are available that provide evaluation, stabilization, and referrals to ongoing care.

- **Providing for immediate and long-term postvention** to help respond effectively and compassionately to a suicide death, including intermediate and long-term supports for people bereaved by suicide (see "Postvention for Suicide Survivors" below).

- **Reducing access to lethal means** by educating families of those in crisis about safe storage of medications and firearms, distributing gun safety locks, changing medication packaging, and installing barriers on bridges.

- **Enhancing life skills and resilience** to prepare people to safely deal with challenges such as economic stress, divorce, physical illness, and aging. Skill training, mobile apps, and self-help materials can be considered.

- **Promoting social connectedness and support** to help protect people from suicide despite their risk factors. This can be accomplished through social programs and other activities that reduce isolation, promote a sense of belonging, and foster emotionally supportive relationships.
  (SPRC, 2019g)

MOBILE APPS

Over the last decade, the mobile app market has grown, and there are more than 10,000 mental health apps available, including an expanding number of apps offering suicide prevention strategies to persons at risk. Few of these suicide prevention apps, however, provide a comprehensive approach that includes evidenced-based clinical guidelines. Currently there have been no studies done to evaluate suicide prevention advice offered by apps, and few have been evaluated in clinical trials or by regulatory agencies such as the FDA.
Assessments of these apps consistently report serious flaws that may affect a user's health and well-being, and most may be inadequate and potentially dangerous if used as a stand-alone intervention. Therefore, it is recommended that mobile apps complement an ongoing patient-provider relationship and not replace professional advice. One recommended mobile app is SAMHSA's "Suicide Safe" (see "Resources" at the end of this course).

(Castillo-Sánchez et al., 2019; Martinengo et al., 2019; Larsen et al., 2016; Torous et al., 2018; SAMHSA, 2020)

Suicide Prevention in Healthcare Settings

Each individual provider in **any setting** can contribute to the prevention of suicide by:

- Thoroughly screening patients

- Collaborating with patients to write safety plans

- Responding immediately and effectively to a patient's suicidal thoughts and behavior

- Counseling about removal of lethal means (see below)

- Supportively following up with patients
  (SPRC, 2019f)

The following strategies are recommended for providers that care for patients in **primary care settings**:

- Establish protocols for screening, assessment, intervention, and referrals.

- Train staff in suicide care practices and protocols, including safety planning and lethal means counseling.

- Create agreements with specific behavioral health practices that will take referrals.

- Ensure continuity of care by transmitting patient health information to emergency care and behavioral healthcare providers to create seamless care transitions.

- Follow up with at risk patients by phone between visits.

- Provide information on the National Suicide Prevention Lifeline crisis line and services.
  (SPRC, 2019f)

Emergency care and urgent care settings strategies should include the following:

- Conduct universal or selective screening for suicide risk.

- Provide at-risk patients with a full assessment by a mental health professional trained in effective suicide care.

- Provide brief interventions while patients are still in the ED (e.g., safety planning, lethal means counseling).

- Ensure careful discharge planning and safe transitions of care to outpatient services.
  (SPRC, 2019f)

Public Health Suicide Prevention Strategies

The Centers for Disease Control and Prevention along with the National Center for Injury Prevention and Control and the Division of Violence Prevention have put forth strategies to support the 13 goals and 60 objectives of the National Strategy for Suicide Prevention (see "Resources" at the end of this course). These strategies acknowledge that prevention is best achieved by focusing on the individual, relationships, family, community, and societal levels across all sectors, both public and private, and upon the best available evidence for preventing suicide (CDC, 2019c). These strategies include:

Strengthening economic supports based on evidence that suicide rates increase during economic recessions and decrease during economic expansions. Buffering the risks associated with the effects of high unemployment rates, job losses, and economic instability can potentially protect against suicides. Approaches may include:

- Strengthening household financial security through unemployment benefits and other forms of temporary assistance

- Establishment of living wages

- Provision of medical benefits

- Retirement and disability insurance

- Housing stabilization policies that provide affordable housing, such as:
  - Government subsidies
  - Loan modification programs to avoid foreclosure
  - Financial counseling services

Strengthening access and delivery of suicide care based on evidence indicating that suicide correlates with general mental health measures. Evidence also finds that relatively few people with mental health disorders receive treatment, and a contributing factor is lack of access to mental health care. Approaches may include:

- Providing health insurance policies that cover mental health conditions

- Reducing provider shortages in underserved areas

- Changing delivery systems so that care is provided that supports suicide prevention and patient safety

Creation of protective environments is based on evidence that they can reduce suicide and suicide attempts and increase an individual's protective behaviors. Approaches may include:

- Reducing access to lethal means (see below). Evidence indicates the interval between decision and attempt can be as short as 5 or 10 minutes, and people tend not to substitute a different method when a highly lethal method is unavailable or difficult to access. These include intervening at suicide "hotspots" (places where suicide may take place easily) and safe storage practices.

- Community-based policies to reduce excessive alcohol use, which may include zoning limits or alcohol taxes

Promotion of connectedness based on evidence that lack of connectedness and weak social bonds are among the chief causes of suicidality. Approaches may involve:

- "Peer norm" programs that typically target youth and are delivered in school settings but can also be implemented in community settings

- Community engagement activities to provide opportunities for residents to become more involved in the community and to connect with other community members, organizations, and resources

Teaching coping and problem-solving skills based on evidence that the building of life skills prepares people to successfully tackle everyday challenges and adapt to stress and adversity. It has been deemed an important developmental component to suicide prevention. Approaches may include:

- Social-emotional learning programs that are typically delivered to all students in a particular grade or school and focus on developing and strengthening communication, emotional regulation, conflict resolution, help-seeking, and coping skills

- Parenting skill and family relationships programs to strengthen parenting skills, enhance positive parent-child interactions, and improve children's behavioral and emotional skills and abilities

Identifying and supporting people at risk based on evidence that vulnerable populations tend to experience suicidal behavior at higher than average rates. These individuals may include those:

- With lower socio-economic status

- Living with a mental health problem

- Who previously attempted suicide

- Who are veterans and active duty military personnel

- Who are institutionalized

- Who were victims of violence

- Who are homeless

- Individuals of sexual minority status

- Members of certain racial and ethnic minority groups

Approaches may include:

- Gatekeeper training designed to train teachers, coaches, clergy, emergency responders, primary and urgent care providers, and others in the community to identify people who may be at risk of suicide and to respond effectively, including facilitating treatment-seeking and support services

- Crisis intervention intended to impact key risk factors, including feelings of depression and hopelessness, and to increase subsequent mental health care utilization

- Treatment for people at risk of suicide, which may include various forms of psychotherapy delivered by licensed providers

- Treatment to prevent re-attempts that include follow-up contact using diverse modalities

(CDC, 2019c)

GATEKEEPER TRAINING PROGRAMS

The following are examples of the many gatekeeper training programs available to teach people to identify those who are showing warning signs of suicide risk and help them get the services they need.

- Applied Suicide Intervention Skills Training (ASIST): For ages 16 and older, healthcare providers, teachers and other school staff, clergy, community volunteers, first responders

- Ask Care Escort (ACE): To train soldiers

- Ask About Suicide To Save a Life: For K-12 educators and other adults

- BE A LINK!® Community Gatekeeper Training: For any adult

- Campus Connect: For college and university staff

- Kognito Suicide Prevention Simulations – Friend2Friend: For youth ages 13 to 18

- Kognito Suicide Prevention Simulations - College and University Students Training: For university and college students and student leaders

- Question. Persuade. Refer. (QPR): For individuals, organizations, or professional groups

- Working Minds: For workplace administrators and employees
  (SPRC, 2018a)

Lessen harms and prevent future risk based on evidence that risk of suicide has been shown to increase among people who have lost a friend/peer, family member, co-worker, or other close contact to suicide, and that postvention and safe-reporting/messaging have the ability to impact risk and protective factors. Approaches may include:

- Postvention implementation after a suicide has taken place, which may include debriefing sessions, counseling, and/or bereavement support groups for surviving friends, family members, or other close contacts

- Safe-reporting and messaging about suicide to the public that avoids sensationalizing events or reducing suicide to one cause

VETERANS HEALTH ADMINISTRATION PREVENTION FRAMEWORK

Within the Department of Veterans Affairs (VA), 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 public health perspective considers questions such as:

- Where does the problem begin?

- How can we prevent it from occurring in the first place?

The VA follows this systematic approach:

1. Define the problem by collecting data to determine the who, what, where, when, and how of suicide deaths.
2. Identify and explore risk and protective factors using scientific research methods.
3. Develop and test prevention strategies.
4. Assure widespread adoption of strategies shown to be successful.

Resources available for veterans and their families include:

- **Suicide Prevention Coordinator** available at each VA medical center who provides veterans with the counseling and services they require. As appropriate, callers to the Veterans Crisis Line are referred to their local coordinator.

- **Coaching Into Care** is a national telephone service for family members and friends seeking care or services for a veteran. Licensed psychologists and social workers help each caller find appropriate services at a local VA facility or elsewhere in the community.

Suicide prevention resources also available for former Guard and Reserve members include:

- **Veterans Crisis Line**

- **A Suicide Safety Plan** app

- **inTransition**, a free, confidential program offering coaching and specialized assistance over the phone for active-duty service members, Guard and Reserve members, and veterans who need access to mental health care

- **Make the Connection**, an online resource that connects veterans, family members, friends, and other supports with information and solutions to issues affecting their lives

- **Vet Centers' readjustment counseling services**

(VA, 2018)

Reducing Access to Lethal Means

There are many actions that can be taken by families, organizations, healthcare providers, and policymakers to reduce access to lethal means of self-harm. Examples include reducing access to medications and safe storage of firearms. When a person is at risk for suicide, other actions may be required that involve the entire removal of lethal means from the household. These may include:

- Storing firearms off the premises (perhaps with law enforcement), or locking up firearms and placing the key in a safe deposit box or giving the key to a friend until the crisis has passed.

- Asking a family member to store medications safely and dispense safe quantities only as necessary.

Collaborating with members of the community to increase safety can include:

- Instituting lethal means counseling policies in health and behavioral healthcare settings and training healthcare providers in these settings

- Passing policies that exempt at-risk patients from 90-day refill policies

- Working with gun retailers and gun owner groups on suicide prevention efforts

- Distributing free or low-cost gun locks or gun safes

- Ensuring that bridges and high buildings have protective barriers
  (SPRC, 2019h)

COUNSELING ON ACCESS TO LETHAL MEANS (CALM)

A protocol that is being used nationally is known as the CALM (Counseling on Access to Lethal Means) program, a 1.5- to 2-hour workshop that teaches providers ways to reduce access to lethal means by patients at risk for suicide. Goals of this program are to:

- Increase knowledge about the association between access to lethal means and suicide and the role of means safety in preventing suicide

- Increase skills and confidence to work with patients and families to assess and reduce their access to lethal means

This approach involves the following:

- Speak with both the person and family or friends.

- Discuss the risk of suicide and the rapid escalation of risk that may lead to an attempt.

- 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.

- Advise that all firearms be removed from the home until the situation improves.

- 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.

- 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.

- 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.
  (SPRC, 2018b; WADOH, 2019)

Legal issues to be considered when counseling on access to lethal means include:

- Challenges to the professional autonomy of doctors involving powers of state to limit the topics that physicians can discuss with patients. In Florida, for example, an act that prohibited physicians from asking patients about firearm ownership and storage was ruled invalid by the courts. There is the possibility of additional attempts to gag medical professions, but this ruling supports the rights of physicians (APHA, 2018).

Many states have laws that enable family members and police to petition a court to issue an emergency order to remove guns from an at-risk person who will not voluntarily give up their guns for safekeeping. Other barriers include universal background check laws that limit the persons to whom a firearm can be legally transferred for temporary safe storage (SPRC, 2019i).

Postvention for Suicide Survivors

All settings should incorporate postvention as a component of a comprehensive approach to suicide prevention. *Postvention* is a term often used in the suicide prevention field. It is an organized response in the aftermath of a suicide to accomplish any one or more of the following:

- To facilitate the healing of individuals from grief and stress of suicide loss

- To alleviate negative effects of exposure to suicide

- To prevent another suicide among people who are at high risk after exposure to suicide

Postvention involves:

- Working with the news media to encourage safe reporting immediately following a suicide

- Working with those affected by suicide death to aid mourning in ways that avoid increasing the risk of contagion

- Building capacity for ongoing support and treatment, including professional and peer-support options for those who require it

- Providing support and guidance for friends and family members of the bereaved to help them obtain effective ongoing support

Postvention interventions that may be beneficial in providing support for families following a suicide include:

- Information about the manner, timing, and circumstances of the death

- 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

- Advice on how to respond in social environments to questions about the suicide death

- 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 several times during the first year to reiterate offers of support and assistance and to provide information
  (RNAO, n.d.)

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, 2016).

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.

- Military OneSource offers 24/7 in-person, telephone, and online services to assist with emotional, bereavement, financial, and benefit issues.

- Veterans Affairs Bereavement Counseling offers bereavement support to parents, spouses, and children of active-duty and Guard or Reserve members who died while on military duty (Military One Source, 2019).

- Tragedy Assistant Program for Survivors (TAPS) is a national nonprofit veterans service organization that provides services to help stabilize family members in the immediate aftermath of a suicide. TAPS resources, programming, and events are offered throughout the year that support all types of military loss. Suicide loss survivors are welcome to join any programming that includes a focus on suicide loss specifically. These may include:
    o National Military Suicide Survivors Seminars, held each fall, offering an opportunity to connect with others. Includes peer-to-peer grief support, access to resources and experts, participation in intensive grief workshops, art therapy, relaxation, and family entertainment.

    o Survivor Care Team members who are trained survivors, available around the clock to help.

    o Peer Mentor Program trains survivors 18 months or more after their own loss to serve as mentors to new survivors seeking support.

    o Suicide Loss Online Community, an invitation-only, moderated Facebook peer group where members share stories and learn from others' experiences. TAPS also monthly hosts a live online chat moderated by suicide survivor staff members.

(TAPS, 2019)

CASE

ALICIA AND PHILLIP

Alicia and Phillip, ages 15 and 17, were aware that their father had 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.

Discussion

This case study outlines the efforts made to provide postvention care for a family that has experienced the loss of a loved one. The focus is on providing referrals to resources and support services, as well as efforts to teach the teen's schoolmates about suicide prevention.

ETHICAL ISSUES AND SUICIDE

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

Suicide prevention, however, offers several **ethical dilemmas**. Emergent intervention may include:

- Actions taken without the individual's consent

- Actions which limit a person's freedom

- Actions which often feel and are disempowering

These challenge ethical imperatives, including:

- The right of a person to autonomous choice versus the need to protect vulnerable people (do no harm)

- Confidentiality versus the release or solicitation of information in order to prevent harm

- Freedom of choice to decide to live or die versus everything necessary should be done to preserve life

The ethical principle of autonomy calls for respect, dignity, and choice, and therefore a person should not be coerced or manipulated into treatment if they are 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 (Marley, 2019).

Evidence is accumulating about harms inherent in civil commitment. Three arguments include:

- Inadequate attention has been given to the harms resulting from the use of coercion and the loss of autonomy.

- Inadequate evidence exists that involuntary hospitalization is an effective method to reduce deaths by suicide.

- Some suicidal patients may benefit more from therapeutic interventions that maximize and support autonomy and personal responsibility.
(Borecky et al., 2019)

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.

The **libertarian perspective** is centered on the idea of autonomy and generally rejects involuntary hospitalization because it:

- Takes away the person's freedom

- Restricts what the person can do with their 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

The **communitarian perspective** 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 **egalitarian-liberal perspective** emphasizes the equality of access to resources. This approach states that the government's role is to protect individual rights and that the right to health is a priority. If the right to health is 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. However, the question remains as to how a mental health professional can 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 (Sandu et al., 2018).

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

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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

Suicide Safe mobile app
https://store.samhsa.gov/apps/suicidesafe

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

Veterans Self-Check Quiz
https://www.vetselfcheck.org/welcome.cfm

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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 middle-aged white men.

    b. Suicide rates are higher among women than among men.

    c. The highest rate of suicide is among Native Americans.

    d. The lowest rate of suicide is among adult white males.

2. Recent data regarding suicide rates among veterans and active-duty military found that:

    a. Rates for veterans were lower than for nonveterans.

    b. Female veterans had a lower suicide rate than female nonveterans.

    c. In 2018 active-duty military had the highest number of suicides in at least six years.

    d. Male and female veterans had the same rates of suicide.

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. Economic decline.

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. 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 is a correct statement regarding suicide risk assessment tools?

    a. They are highly predictive of who will die by suicide.

    b. They are often used in place of a screening tool.

    c. They do not determine suicidal intent.

    d. They cannot predict to any useful degree who will die by suicide.

12. The gold standard for suicide assessment and intervention is:

    a. The clinical interview.

    b. The Beck Scale for Suicide Ideation.

    c. The Columbia-Suicide Severity Rating Scale (C-SSRS).

    d. Conducting an unstructured interview and psychiatric evaluation.

13. 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

14. 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

15. 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.

16. 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.

17. 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. Internal coping strategies (relaxation technique, physical activity)

18. The initial care plan for a suicidal patient admitted to an inpatient unit typically includes:

      a. Use of restraints.

      b. Occupational therapy evaluation.

      c. Monitoring 24 hours a day.

      d. Formulating long-term goals.

19. A type of cognitive-behavioral therapy that focuses on current situations and solutions and is used for individuals with severe and persistent suicidality is called:

      a. Dialectical behavior therapy.

      b. Non-demand caring contact.

      c. Interpersonal therapy.

      d. Problem-solving therapy.

20. A suicide-specific clinical intervention in which patient and provider work together to assess patient-defined problems ("drivers") that make suicide compelling is called:

      a. Milieu therapy

      b. Creative arts therapy

      c. Collaborative assessment and management of suicidality (CAMS)

      d. Dialectic behavior therapy (DBT)

21. Which is the only medication approved for use by the FDA for suicide risk reduction?

    a. Citalopram

    b. Paroxetine

    c. Clozapine

    d.Venlafaxine

22. Which is a suicide prevention strategy that teaches people to identify those who are showing warning signs of suicide risks?

    a. Crisis intervention programs

    b. Peer norm groups

    c. Gatekeeper training

    d. Social-emotional learning programs

23. A 1.5- to 2-hour workshop that teaches providers ways to reduce access to lethal means by patients at risk for suicide is called:

    a. Coaching into Care.

    b. CALM.

    c. A Suicide Safety Plan.

    d. Ask Care Escort (ACE).

24. A goal of postvention for the survivors of a loved one's suicide is to help them:

    a. Alleviate the negative effects of exposure to suicide.

    b. Acknowledge their own role in the person's death.

    c. Avoid grieving for the victim of suicide.

    d. Reconstitute their lives without missing their loved one.

25. Which is a postvention program for military families that offers multiple services throughout the year to stabilize family members in the aftermath of a suicide?

    a. Tragedy Assistance Program for Survivors (TAPS)

    b. Military OneSource

    c. Peer Mentor Program

    d. Bridges: A Center for Grieving Children

26. Which is a **correct** statement about the ethical issues involved in suicide prevention?

    a. The patient's right to self-determination is not affected.

    b. Involuntary hospitalization of a suicidal patient is always justified.

    c. Involuntary hospitalization conflicts with the principle of autonomy.

    d. There are no harms resulting from the use of coercion or loss of autonomy.