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Contact Hours: **1**

Suicide Prevention and Screening

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LEARNING OUTCOME AND OBJECTIVES: Upon completion of this continuing education course, you will demonstrate an understanding of screening for suicide risk. Specific learning objectives to address potential knowledge gaps include:

- Express an understanding of common myths related to suicide.
- Discuss the risk factors for suicide.
- Describe the process of screening for suicide and imminent harm via lethal means.
- Summarize actions to refer patients at risk of suicide.

UNDERSTANDING SUICIDE

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

Healthcare professionals play a critical role in the recognition and prevention of suicide. However, many express concerns that they are ill prepared to deal effectively with a patient who is suicidal. By developing adequate knowledge and skills, these professionals can overcome feelings of inadequacy that may otherwise prevent them from effectively responding to the suicide clues a patient may be sending, thereby allowing them to carry out appropriate screening and referral. They can also develop a better understanding of this choice that ends all choices.

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.



<p>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.</p>	<p>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.</p>
<p>When people who are suicidal start to feel better, they are no longer suicidal.</p>	<p>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.</p>
<p>(Naval Health Clinic Annapolis, 2018; The Samaritans, 2019)</p>	

RISK FACTORS FOR SUICIDE

Suicide is most often caused by a collection of risk factors and underlying vulnerabilities, as discussed below.

Biologic Factors

Psychiatric diseases account for a large majority (over 90%) of suicides and suicide attempts—at least 10 times as high as in the general population. 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).

Psychological autopsies (collected from family relatives, friends, and healthcare providers) from the middle of the previous century and onward have revealed that most of those who have died by suicide were experiencing a mental disorder, the relevant risk factors being depression, substance use disorders, and psychosis (Brådvik, 2018; Bachmann, 2018).

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

Adverse Events

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



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.

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)



MILITARY SERVICE

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).

Military personnel reporting child abuse 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).

SUICIDE SCREENING

Healthcare settings provide professionals with an opportunity to play a significant role in the prevention of suicide. Suicide screening refers to a quick procedure in which a standardized instrument or tool is used to identify individuals who may be at risk for suicide and in need of assessment. It can be done independently or as part of a more comprehensive health or behavioral health screening.

Screening Recommendations

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

Instead of universal screening, some recommend that screening be done only for those presenting with known risk factors (**selective** or **targeted screening**). Despite this lack of uniform guidance,



health systems are implementing suicide screening protocols, and screening tools are already widely used in primary care settings (Durkin, 2019; O'Rourke et al., 2019).

U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATIONS

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

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

JOINT COMMISSION RECOMMENDATIONS

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

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

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

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



Screening Tools

Different kinds of organizations and settings may use different 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)

Assessing Suicidal Intent

Once it is determined that suicidal ideations are present, the next step is to determine whether the patient has active (thoughts of taking action) or passive (wish or hope to die) intent. Suicidal intent can be determined best by considering the degree of planning, the knowledge of the



lethality of the intended suicidal act, and the degree of isolation of the person. At this point, **specific** and **direct questions** should be asked to gather specific information, such as:

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

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

Assessing Lethality and Risk

When suicide risk screening results in the positive identification of an individual at risk for suicide, it is vitally important that the healthcare provider further assess the patient's level of suicide risk and lethality of plan to determine if a referral for a mental health evaluation is warranted or to directly refer the individual for a mental health evaluation and suicide risk assessment. Suicidal deaths are more likely to occur when persons use highly damaging, fast-acting, and irreversible methods—such as jumping from heights or shooting—and do so when rescue is fruitless.

METHODS OF SUICIDE AND LETHALITY

The desire for a painless method of suicide often leads individuals to choose a method that tends to be less lethal. This results in attempted suicides that do not end in death. For every 25 attempts, there is one death. For drug overdoses, the ratio is around 40 to 1. The following are methods of suicide and the likelihood that they will result in death:

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



Factors that influence the lethality of a chosen method include:

- **Intrinsic deadliness.** A gun is intrinsically more lethal than a bottle of pills.
- **Ease of use.** If a method requires technical knowledge, for example, it is less accessible than one that does not.
- **Accessibility.** Given the brief duration of some suicidal crises, a gun in the cabinet in the hall is a greater risk than a very high building 10 miles away.
- **Ability to abort mid-attempt.** More people start and stop mid-attempt than carry through. It is easier to interrupt a hanging or to call 911 after overdosing than if jumping off a bridge or using a gun.
- **Acceptability to the individual.** Must be a method that does not cause too much pain or suffering. For example, fire is readily accessible, but it is seldom ever used in the United States.
(HSPH, 2020)

It is of utmost importance for clinicians to recognize that lethal methods are widely available, and that accessibility is a crucial factor when considering the disposition of someone who has suicidal ideations. Besides firearms, lethal methods may include medications that are readily available in the home, as well as the use of common household chemicals that release toxic gases when combined in a confined space.

DETERMINING SUICIDE RISK

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

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 a significant other
- Are willing to comply with treatment recommendations
- Have a high degree of ambivalence



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 acute precipitating event
- Have a history of prior suicide attempt
(Yasgur, 2016; WICHE MHP & SPRC, 2017)

REFERRING THE SUICIDAL PATIENT

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

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



Other patients who are not in acute suicidal crisis may require a referral to behavioral health for further evaluation and treatment. Making such a referral requires a smooth and uninterrupted transition of care from one setting to another. In order to ensure that the patient is linked to appropriate care, the referring clinician follows these steps:

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

(SPRC, 2019)

CONCLUSION

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

It is imperative that healthcare professionals learn the skills necessary to effectively screen patients for suicide risk so they are equipped to refer their patients for appropriate interventions. These skills include recognizing who is at risk, especially those who may be at high risk in the near future, and responding to the needs of persons who are having suicidal ideations by appropriately referring them to professionals who can effectively manage their treatment.



RESOURCES

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

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

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

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

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

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

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

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

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

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TEST

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

2. 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.

3. Which is **not** considered an **adverse event** that may increase the risk of suicide?
 - a. Caregiver psychopathology
 - b. Early childhood neglect
 - c. Gender
 - d. Cyberbullying

4. 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.

5. Which suicide screening tool is intended for use in all healthcare settings for all ages?
 - a. Columbia-Suicide Severity Rating Scale (C-SSRS) Screening Version
 - b. Patient Health Questionnaire-9 (PHQ-9)
 - c. Suicide Behavior Questionnaire-Revised (SBQ-R)
 - d. Ask Suicide-Screening Questions (ASQ)



6. Which question does the clinician use to assess suicidal **intent**?
 - a. “Have you increased your use of alcohol or drugs lately?”
 - b. “Do you have thoughts of being a burden to others?”
 - c. “Do you feel trapped, like you have no way out of your troubles?”
 - d. “What is your plan for suicide?”

7. The appropriate disposition for a patient in an acute suicidal crisis is:
 - a. Referral to an outpatient provider for an appointment within one week.
 - b. Referral to behavioral health specialist for further evaluation.
 - c. Immediate transfer to an emergency department.
 - d. Referral to the patient’s primary care provider for an appointment.

