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Contact Hours: **2**

# Suicide Risk and Prevention for Kentucky Nurses


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LEARNING OUTCOME AND OBJECTIVES: Upon completion of this continuing education course, you will demonstrate an awareness of the prevalence of suicide among the general population and Kentucky nurses, and strategies for suicide prevention, including:

- Recognize the impact of suicide among the general population and among nurses.
- Identify risk and protective factors for suicide.
- Discuss how to screen and assess those at risk for suicide.
- Review systems of care and best practices for patients at risk for suicide.
- Describe suicide prevention strategies.
- Summarize legal and ethical considerations when caring for a person who is at risk for suicide.

## IMPACTS OF SUICIDE

Despite increasing awareness that suicide is preventable, suicide continues to be a major health problem in the United States and around the world. In 2020, suicide was the 12th leading cause of death for all ages in the United States, and in 2021 suicides totaled 48,183 (CDC, 2022a, Stone et al., 2021).

Certain groups are at higher risk for suicide than others. In 2021, these included:

- **By gender:** Suicide among males was four times higher than among females (Curtain et al., 2022).

- **By sexual orientation:** Suicide risk was three to six times greater for lesbian, gay, and bisexual adults than for heterosexual adults, with suicidality highest among transgender youth (Austin et al., 2022; Ramchand, 2022).
- **By age:** People ages 10–14 had the lowest rate (2.8 suicide deaths per 100,000), while those 85 and older had the highest rate (20.9 per 100,000).
- **By race/ethnicity:** the highest U.S. age-adjusted suicide rate was among Non-Hispanic American Indians/Alaska Natives (28.1 per 100,000) (Stone et al., 2023).
- **By occupation:** Nurses are four times more likely to die by suicide than people working outside of medicine, and about 1 in 18 nurses yearly experience suicidal ideation. (Fischer, 2022; NCOA, 2021)

In 2021, a study was completed that found members of the nursing profession were 18% more likely to die from suicide than the general population, and among female nurses, the risk of death by suicide was found to be nearly double the risk observed in the general population (Davis et al., 2021).

Among healthcare workers, more nurses than any other segment of the healthcare workforce have died during the COVID pandemic: 1,140 nursing professionals in the first year. The pandemic has affected every nurse, leading to higher rates of anxiety, distress, and traumatic stress, which have resulted in the development of depressive states. Isolation, loss of social support, and loneliness associated with the lockdowns all contributed to traumatic experiences (McGuinness, 2021).

In Kentucky, approximately 58 nurses have died by suicide since 2016, and in response, the Kentucky Board of Nursing has mandated that all nurses must complete nurse suicide-prevention continuing education with the goal of teaching them how to identify signs of suicide risk in themselves and others and how to intervene effectively (Cross, 2022).

## SUICIDE ETIOLOGY AND RISK AND PROTECTIVE FACTORS

Suicide etiology and risk are complex and include family history, genetics, epigenetics, neurobiology, medication use, gender, mental health disorders, psycho-sociocultural factors, age, life experiences, and other considerations.

Nurses face the same risk factors for suicide as any other member of the population. These risk factors may include:

- Family history of suicide or neuropsychiatric conditions
- Previous suicide attempt(s)
- Having a mental health disorder (e.g., depression, substance use disorder, posttraumatic stress disorder, traumatic brain injury)
- Being a divorced or widowed female

- Socioeconomic factors (especially for men), including occupation, education, and income
- Personality factors (e.g., paranoid personality features, obsessive-compulsive features)
- Developmental factors (e.g., behavioral disinhibition, negative emotional states)
- Life experiences, including history of trauma or abuse
- Impulsive/aggressive tendencies
- Cultural and religious factors
- Barriers to accessing mental health care
- Lack of or poor supportive social networks
  (NV DPBH, 2021)

## Suicide Risk Factors for Nurses

In addition to the risks noted above, the profession of nursing presents many factors that can result in physical, mental, and emotional fatigue, referred to as ***nurse burnout***. The majority of nursing professionals experience burnout at some point in their careers, and burnout affects approximately 38% of nurses each year (Clark, 2022).

Burnout can affect job performance, change how nurses perceive their role, and place patients in danger. Burnout increases the risk of suicide among nurses and results from:

- Exposure to repeated trauma (secondary trauma)
- Working long, consecutive shifts
- Repeated requests to work overtime
- Workplace incivility, violence, and bullying
- Inadequate self-care
- Isolation from family and friends
- Fearing for one's safety or the safety of loved ones
- Financial stressors
- Access to and knowledge of lethal substances
- Chronic, high workplace stress
- Issues with management
- Work/life role conflict
- Feeling unsupported in the role
- Lack of feeling of belonging
- Feeling unprepared for the role

- Fear of harming a patient
- Being evaluated for substance use disorder
- Depression
(ANA, 2023)

## 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
- Strong sense of cultural identity
- 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

**External/environmental protective factors** include:

- Opportunities to participate in and contribute to school or community projects and activities
- Strong relationships, particularly with family members
- A reasonably safe and stable environment

- Availability of consistent and high-quality physical and behavioral healthcare
- Financial security
- Responsibilities and duties to others
- Cultural, religious, or moral objections to suicide
- Owning a pet
- Restricted access to lethal means
(WMU, 2023; CDC, 2022b)

**BARRIERS TO SEEKING HELP AMONG NURSES**

Mental health stigma is the primary reason that 80% of people with mental health issues do not speak up and do not seek help (Project Helping, 2023). Nurses struggling with substance use, mental health issues, and job problems face mental health stigma, limited access to treatment, and licensure issues. A recent study found that nurses were much more likely to have positive blood toxicology results for nearly all substances compared to the general population. However, these nurses were also less likely to have a documented diagnosis of substance use disorder or treatment before suicide (Handzel, 2022).

Nurses with suicidal ideation are less likely to seek out professional help. Barriers to accessing mental health services include:

- Concerns about potential negative impact on one's career
- Feelings of being judged or unsupported by peers, managers, and/or senior leadership for seeking behavioral healthcare
- Concerns about confidentiality, especially when care is accessed at or provided by clinicians at the same hospital or health system
- Difficulties in getting time off work for treatment
- Challenges with scheduling appointments with providers

Additionally, many states inquire about mental health history on applications for nursing licensure, which may impact nurses' attitudes about seeking help. Although it is not legal under the Americans with Disabilities Act, many state boards ask non-ADA-compliant questions about mental health, targeting specific diagnoses, focusing on historical data in the absence of current impairments, and/or requiring a prediction of future impairment. Consequently, applicants and nurses may hide mental health issues, resulting in the underuse of mental health resources by those in need (Handzel, 2021).

# SCREENING AND ASSESSING THOSE AT RISK

Because a significant proportion of individuals who die by suicide have seen a health professional within a few days prior to their suicide attempt, suicide screening and assessment of risk for suicide are important steps to be taken in all healthcare settings.

## Suicide Screening

*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.

The following are validated, evidence-based suicide risk **screening tools**:

- Beck Fast Scan: Seven questions that can help determine the intensity and severity of depression
- Suicide Risk Screen: 10-item questionnaire often used to screen for suicide in young people
- Patient Health Questionnaire (PHQ): Nine questions about self-harm, also used to identify patients at high risk of suicide
- SAFE-T: Can be used in an outpatient setting; offers insight into the extent and nature of suicidal thoughts and harmful behavior
- Columbia-Suicide Severity Rating Scale (C-SSRS): Available in multiple languages for prehospital use to assess for the presence of harmful behavior; also assesses for any known suicide attempts and suicide ideations and behaviors
- Ask (ASQ) Suicide Screening: Four brief questions to screen medical patients ages 8 years and above
- SBQ-R: A psychological, four-item questionnaire to identify risk factors for suicide in adolescents and adults
  (NIMH, 2022; Columbia University, 2021; CEBC, 2020)

## Recognizing Suicide Warning Signs

Besides screening for risk factors for suicide, it is important to be able to recognize statements, behaviors, and moods that indicate an individual may be at immediate risk for suicide.

**Statements** by a coworker or patient that constitute a suicide warning sign include language about:

- Killing oneself

- Feeling hopeless
- Having no reason to live
- Being a burden to others
- Feeling trapped
- Having unbearable pain

**Behaviors** that may signal risk—especially when related to a painful event, loss, or change—include:

- Increased use of alcohol or drugs
- Searching for a method to end their life, e.g., online search
- Withdrawing from activities
- Risky behaviors
- Isolating from family and friends
- Sleeping too much or too little
- Visiting or calling people to say goodbye
- Giving away prized possessions
- Aggression
- Fatigue
- Writing a will and making final arrangements

People considering suicide often display one or more of the following **moods**:

- Depression
- Anxiety
- Loss of interest
- Irritability
- Humiliation/shame
- Agitation/anger
- Relief/sudden improvement
(AFSP, 2023)

## Suicide Assessment for Those at Risk for Suicide

The most effective assessment of the individual who has screened positive for suicidal ideation begins with the establishment of a therapeutic relationship. In order to effectively intervene with someone who may be at risk for suicide, it is essential that healthcare professionals are skilled at establishing rapport quickly. It is imperative that the person be given privacy, be shown courtesy and respect, and be made aware that the concerned individual wants to understand what has happened or is happening to them.

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 with suicidal thoughts should be encouraged and given the opportunity to express thoughts and feelings and be allowed to discharge pent-up and repressed emotions. Asking **open-ended questions** encourages the person to elaborate on their answers, which can provide important context on their level of risk, access to means, and presence of intent (Aamar, 2021).

| OPEN-ENDED QUESTIONING IN RESPONSE TO PERSONS WITH SUICIDAL IDEATION | |
|---|---|
| **Person's Statement** | **Appropriate Responses** |
| Everyone will be better off without me. | • Who would be better off?<br>• What would be better for those people?<br>• Where are you planning to go? |
| I just can't bear it anymore. | • What is so hard to bear?<br>• What would make your life better?<br>• 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"?<br>• 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?<br>• How can you make it be over? |
| I won't be a problem much longer. | • How are you a problem?<br>• What is going to change in your life so you won't be a problem any longer?<br>• When will you no longer be a problem? |
| Things will never work out. | • What can you do to change that?<br>• What, then, do you propose to do? |
| It is all so meaningless. | • What would make life more meaningful?<br>• What are some aspects of your life that make it worth living?<br>• What is happening in your life that makes it so meaningless? |

## 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.

The next step is to determine if the patient has developed a suicide plan and their degree of intent. This includes asking whether or not they have made any preparations and what they are. It is also important to determine whether the patient has a history of impulsive behaviors or substance use that may increase impulsivity, and whether they have a past history of suicidal ideation and behavior.

In addition, the clinical interview includes observing whether the patient is disconnected, disengaged, or shows a lack of rapport, as these signs are associated with an increased risk of suicide (Schreiber & Culpepper, 2022).

### *Suicide Risk Assessment Tools*

There are many tools available to assist healthcare professionals in determining suicidal intent. These assessment tools are used to assess a person's intent to carry through. They are often used 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. The risk assessment version of this tool provides a checklist of protective and risk factors for suicide and is used along with the C-SSRS screening tool. It is appropriate in all settings for all ages and for special populations in different settings. The tool features a clinician-administered initial evaluation form, a "since last visit" version, and a self-report form. The Columbia protocol questions have also been incorporated into the SAMHSA SAFE-T model with recommended triage categories.

- **Beck Scale for Suicide Ideation (BSI).** This 21-item self-report instrument 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, 2023)

### *Clinical Interview*

The clinical interview is the **"gold standard"** for suicide assessment and intervention. Topics covered during this interview include suicidal ideation, plans, self-control, intent, and safety planning.

There are three effective **approaches** to asking about suicide:

- Use a normalizing tone. About 60% of people who died by suicide denied suicidal ideation when asked by a healthcare provider, indicating the presence of psychological and interpersonal barriers to disclosure. It is helpful to use a statement that normalizes suicide ideation, such as: "I asked you this question because almost all people at one time or another have thoughts about suicide."
- Use gentle assumption. To make it easier for patients to disclose suicidal ideation, the interviewer assumes that certain thoughts and behaviors are already occurring in the person and gently structures questions accordingly. So, instead of asking if the person has been thinking about suicide, ask "When was the last time you had thoughts about suicide?"
- Assess the person's mood. An exploration of mood states might include asking permission to discuss mood, and then asking patients to rate their mood using a zero–10 scale. This is followed by questions that refer to the worst or lowest mood rating the person has ever had as well as what was happening at those times that made them feel so down. In order to end with a positive note, the patient is asked about the best mood rating they've ever had.

**Explore suicidal ideation.** When the patient discloses the presence of suicidal ideation, collaboratively explore the frequency, triggers, duration, and intensity of the suicidal thoughts. During this process, it is important to show curiosity, empathy, and interest instead of judgment. If the patient denies suicidal thoughts and the denial appears to be genuine, acknowledge and accept the denial, but if the denial seems forced or is combined with symptoms of depression or other risk factors, acknowledge and accept the denial but return to the topic later.

**Explore suicide plans.** Once rapport is established and the patient has talked about suicidal ideation, it is important to explore suicide plans. If patients admit to a plan, further exploration is crucial. Evaluation includes assessing the specificity of the plan, its lethality, availability of the means, and proximity of social support (i.e., availability of individuals who might intervene and rescue the patient) (see "Assessing the Plan, Lethality, and Risk" below).

**Assess self-control**. This requires asking directly about self-control and observing for agitation, arousal, or impulsivity. Arousal and agitation adversely affect self-control and are the inner push that drives persons toward suicidal acts (Sommers-Flanagan, 2022).

**STEPS TO TAKE WHEN A PATIENT REFUSES ASSESSMENT**

- Obtain information from other sources, such as:
  - Collateral reports from staff
  - Patient's past medical records

        - Past suicide attempts
        - Past nonsuicidal self-injury
        - Past episodes of suicidal thinking
    - Mental status assessment
- For patients who are competent and refuse services, document efforts made to gain cooperation.
- Document an explanation of the limitations of assessment and how level of risk was determined.

(Obegi, 2021)

## 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.

### IMPULSIVITY AND SUICIDE

Some suicides are carefully planned and deliberate, while others appear to have been impulsively decided upon, involving little or no planning. Impulsiveness is thought to play an instrumental role in suicide because of the presumption that suicidal behaviors are carried out via rash decisions with little consideration for the consequences. A study of survivors of nearly lethal suicide attempts found that 1 in 4 individuals deliberated for less than 5 minutes. Another study found that 48% reported deliberating less than 10 minutes (HSPH, 2023a).

### *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%
- Jumping: 34.5%
- Drug/poisoning: 1.5%
- Cutting/piercing: 1.2%
- Other: 8.0%
  (HSPH, 2023b)

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.

**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 to stop a method such as jumping off a bridge or using a gun.
- Acceptability to the individual. The method must be one that does not cause too much pain or suffering. For example, fire is readily accessible, but it is a method seldom used in the United States.
  (HSPH, 2023b)

**MOST COMMON SUICIDE METHODS USED BY NURSES**

The use of firearms in death by suicide has been more common among male nurses, whereas opioids or other medications have been more commonly used as a suicidal method in female nurses. A recent study, however, has reported a distinct shift from using pharmacological agents to firearms among female nurses (UC San Diego Health, 2023).

### *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.

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

- Are experiencing recent suicidal ideation or thoughts
- Have no specific current suicide plan
- Have no clear intent to act
- Have not planned or rehearsed a suicide act
- Have identifiable and multiple protective factors
- Have limited risk factors
- Have no history of suicidal behaviors
- Have evidence of self-control
- Have supportive family members or significant others
- Have a high degree of ambivalence

Most people with suicidal ideation 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 such persons. Almost everyone with suicidal thoughts 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.

People who are at **moderate risk**:

- Have current suicide ideation
- Have no clear plan for suicide
- Have had no preparatory behavioral or rehearsal of act
- Have limited or no intention to act
- Have limited identifiable protective factors
- Are able to control the impulse
- Have the ability to maintain safety, independent of external support
- Have no recent suicidal behavior
- Have supportive family or significant others
- Have a high degree of ambivalence

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

- Have strong, persistent suicidal ideation
- Have strong intention to plan or act
- 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 inability to maintain safety, independent of external support
- Have a poor social support network
- Have severe psychiatric symptoms and/or an acute precipitating event
- Have a history of prior suicide attempt
(VA, 2022b)

**PREDICTING SUICIDE BY RISK LEVEL**

There has been no improvement in the accuracy of predicting suicides in the past 40 years.

- 95% of "high-risk" patients will not die by suicide.
- 50% of suicides are from "low-risk" patients.
- 50% of individuals who complete suicide have no prior history of suicide attempts.

(PsychDB, 2021)

## DOCUMENTATION OF SUICIDE 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. The best records reflect awareness of risk and the process of professional judgement that recognized it, took steps to reduce it, and balanced it with patient needs. The following documentation should be present in the record:

- Reason for suicide assessment
- Review of past available records
- Evaluation of warning signs and risk and protective factors
- Initial and ongoing suicide risk assessment
- Access to lethal means and mitigation
- Consultations with colleagues
- Referrals to behavioral health
- Rationale and follow-up for treatment options
- Safety planning and discharge coordination

- Plans for follow-up
(Stefan, 2020)

## SYSTEMS OF CARE FOR PATIENTS AT RISK FOR SUICIDE

A system 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 (e.g., center hotline)
- Brief intervention and follow-up
- Suicide-specific outpatient management
- Emergency respite care
- Tele–mental health
- Inpatient psychiatric hospitalization, with suicide-specific treatment
(EDC, 2022)

### 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 and are helpful for patients with barriers to accessing outpatient mental health services. Crisis services also include care coordination. Mobile crisis teams provide care in the community at the location of the person who is considering suicide (EDC, 2022).

### Brief Intervention and Follow-Up

Brief interventions range from a single, in-person session, to a computer-administered intervention in a primary care office, to an online screening and feedback intervention that can be done on a personal electronic device. Brief interventions can be an immediate intervention and also can be used in conjunction with any other level of care. Safety planning is recommended for those who refuse outpatient care. Outreach and follow-up are provided through phone calls, letters, and texts (EDC, 2022).

### Suicide-Specific Outpatient Management

Suicide-specific outpatient management involves several sessions that may include dialectical behavior therapy, cognitive therapy for suicide prevention (CT-SP), and collaborative assessment

and management of suicide (CAMS). It is critical that outpatient mental health providers monitor patients between appointments and follow up when patients miss appointments (EDC, 2022).

### 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 (EDC, 2022).

### Tele–Mental Health

Tele–mental health involves electronic communication to provide clinical mental health services from a distance. Healthcare organizations can use these services to provide emergency assessments and treatment, especially for those patients located in remote geographic regions and for organizations with limited access to mental health resources (EDC, 2022).

### Hospitalization

Inpatient hospitalization is the most restrictive option for addressing suicide risk. Research has found that patients may be at higher risk immediately after discharge from inpatient care. The reasons why this may happen are not known; however, experts have questions as to whether there is something about the experience of hospitalization itself that may be harmful. Involuntary hospitalization has been found to be associated with increased risk of suicide both during the hospitalization and afterward. It is therefore recommended that hospitalization be carefully weighed against other options (EDC, 2022).

**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

According to Kentucky Stat. Ann. § 202A.026 statue 202A.026 no person shall be involuntary hospitalized unless such person is a mentally ill person:

1. Who presents a danger or threat of danger to self, family, or others as a result of the mental illness
2. Who can reasonably benefit from treatment; and

3. For whom hospitalization is the least restrictive alternative mode of treatment presently available
(Treatment Advocacy Center, 2023)

**SUICIDE SAFETY PLAN**

Safety planning is a clinical process involving listening, empathizing with, and engaging the patient in the development of a series of action steps to be taken in the event the patient experiences suicide ideation, arranged in order of increasing response intensity. A safety plan also includes a collaboratively written list of coping strategies and sources of support the patient can use before or during a suicidal crisis. The plan is brief, written in the patient's own words, easy to read, and 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) without contacting another person
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
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 takes these steps:

- Informs the patient that the purpose of the plan is to help them recognize when a crisis may escalate so that they know to refer to their plan and take action to reduce risk
- Helps the individual identify strategies that are simple and easy to use
- Obtains feedback from the patient about the likelihood of using the strategies
- Identifies barriers and problem-solves ways to overcome them

After the plan has been developed, the clinician does the following:

- Assesses the likelihood that the overall safety plan will be used
- Discusses where the safety plan will be kept and how it will be located during a crisis
- Reviews the plan periodically when the patient's circumstances or needs change
(Stanley, 2021; Hindman & Fleming, 2022)

# BEST PRACTICES FOR PATIENTS AT RISK FOR SUICIDE

Patients with suicidal thoughts 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) is a "solutions-oriented" type of talk therapy that can be provided for both adults and adolescents. It is based on these core principles:

- Psychological issues are partly based on:
  - Problematic or unhelpful patterns of thinking
  - Learned patterns of unhelpful behavior
  - Problematic core beliefs, including central ideas about the self and the world
- People experiencing psychological issues can learn better ways of coping with them.

CBT aims to help the patient identify harmful thoughts, assess whether they are an accurate depiction of reality, and if they are not, to employ strategies that challenge and overcome them.

Internet-delivered cognitive behavior therapy between a patient and therapist has also been shown to significantly decrease suicidal ideation among patients with severe depression (Cleveland Clinic, 2023a; CDC, 2022f).

### Dialectical Behavior Therapy

Dialectic behavior therapy (DBT) is a type of cognitive-behavioral therapy that focuses on current situations and solutions. It is used for individuals with severe and persistent suicidality and who experience emotions very intensely. DBT is a 6-month to year-long therapy that involves a greater commitment on the part of both therapist and patient. It consists of four types of sessions:

- DBT pre-assessment to ascertain if DBT is a good fit for the patient
- Individual therapy to lessen suicidal and self-harming behaviors, to restrict actions that interfere with effective therapy, to remove obstacles to success, and to assist in replacing harmful behaviors with new skills
- Skills training in groups
- Telephone crisis coaching
  (Cleveland Clinic, 2023b; VYAS, 2022)

### Problem-Solving Therapy

Problem-solving therapy (PST) is a brief form of treatment that teaches and empowers patients to solve the here-and-now problems contributing to suicidal ideation, self-directed violence, and hopelessness. Interventions include psychoeducation, interactive problem-solving exercises, and motivational homework assignments (VA, 2022c).

### Collaborative Assessment and Management of Suicidality (CAMS)

CAMS is a therapeutic framework that emphasizes a collaborative assessment and treatment planning process between the patient and the clinician. Central to the CAMS approach is the use of the Suicide Status Form (SSF), which is a multipurpose clinical assessment and treatment planning, tracking, and outcome tool. CAMS and SSF can be used in a single session context or for ongoing care. When used in ongoing care, it assists the clinicians in organizing the sessions to target and treat suicide "drivers" and resolve suicidality (CSPAR, 2021).

### 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. Milieu therapy provides a healing culture rich in therapeutic interpersonal relationships and provides for optimum safety and comfort. It is a structured environment designed for teaching psychosocial skills and limiting maladaptive behavior (Belsiyal & Rentala, 2022).

### Group Therapy

Group therapy offers numerous advantages as a suicide prevention strategy. Groups diminish social isolation and increase social support with those experiencing similar problems. Social relationships are critically important suicide risk and protective factors. Suicide group interventions can directly target social relationships by fostering a sense of community and belonging among group members (Sullivan et al., 2021).

### Creative Arts Therapy

Creative arts therapies can support mental health. These therapies facilitate dialogue, reduce stigma, and enhance expression, coping skills, empathy, and personal and cultural resonance, all of which address risk factors for suicide. They can also address the motivational phase, facilitating expression of emotions such as entrapment, loneliness, and burdensomeness, thereby cultivating belonging and protecting against suicidal ideation (Sonk, 2021).

### Medications

Some medications have been shown to be effective related to suicide prevention. These include:

- **Clozapine (Clozaril):** The only medication to date with FDA approval for suicide risk reduction; has significant side effects that require close lab monitoring
- **Ketamine:** Leads to rapid reduction of depressive symptoms and suicidal ideation in as little as one day, which is especially critical for people at high risk for self-harm; given by infusion under careful medical supervision or as a nasal spray (eskatamine/Spravato) along with an oral antidepressant
- **Antidepressants:**
    - SSRIs:
        - 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:
        - 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, 2023; Black, 2023; DeGiorgi, 2022).

## 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 formal referral protocols, interagency agreements, cross-training, follow-up contacts, rapid referrals, and patient and family education.

- Responding effectively to persons in crisis by ensuring 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.
- 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, 2020a)

## Public Health Suicide Prevention Strategies

The Centers for Disease Control and Prevention "Suicide Prevention Resource for Action" details the strategies based on the best available evidence to help states and communities prevent suicide.

- Strengthen economic supports
  - Strengthen household financial security
  - Stabilize housing
- Create protective environments
  - Reduce access to lethal means among persons at risk of suicide (see below)
  - Reduce substance use through community-based policies and practices
- Improve access and delivery of suicide care
  - Cover mental health conditions in health insurance policies
  - Increase provider availability in underserved areas
  - Provide rapid and remote access to help
  - Create safer suicide care through systems change
- Promote healthy connections
  - Promote healthy peer norms
  - Engage community members in shared activities

- Teach coping and problem-solving skills
    - Support social emotional learning programs
    - Teach parenting skills to improve family relationships
    - Support resilience through education programs
- Identify and support people at risk
    - Train gatekeepers (see below)
    - Respond to crises
    - Plan for safety and follow up after an attempt
    - Provide therapeutic approaches
- Lessen harms and prevent future risk
    - Intervene after suicide (postvention) (see below)
    - Report and message about suicide safely

(CDC, 2022d)

## GATEKEEPER TRAINING PROGRAMS

Gatekeeper training (GKT) is one of the most widely used suicide prevention strategies. It involves training people who are not necessarily clinicians to be able to identify individuals experiencing suicidality and refer them to appropriate services. GTK improves people's knowledge, skills, and confidence in helping those who experience suicidal ideation and enhances positive beliefs about the efficacy of suicide prevention (Hawgood et al., 2023).

One example of gatekeeper training, QPR, involves three steps—Questions, Persuade, and Refer—that can be learned in as little as two hours (Purdue University, 2022).

## THE AMERICAN RESCUE PLAN ACT OF 2021

The American Rescue Plan Act of 2021 includes over $3 billion to support improved mental health care. The bill includes $50 million to support and promote the mental health of healthcare professionals. Without having a basic understanding of the issues involved in the mental health of nurses, interventions will not be effective unless leaders undertake a fundamental transformation of nurses' work environments to mitigate stressors and restore the joy in doing the work of nursing. A nursing workforce that is supported, safe, and healthy will provide many benefits to our society (Lee & Friese, 2021).

## HEAR PROGRAM FOR NURSES

The Healer Education, Assessment, and Referral (HEAR) program for nurses is designed to help managers respond to situations that may bring about stress in their staff. Managers receive

training on how to run emotional debriefings. Such debriefings can help staff communicate with each other about stressful situations they have experienced.

This program uses an anonymous method to provide proactive screening focusing on identifying, supporting, and referring nurses for untreated depression or suicide, as well as providing education (Davidson et al., 2021).

### Strategies for Prevention of Suicide by a Colleague or Coworker

When a colleague is experiencing a mental disorder or suicidal ideation despite direct or indirect signs, the following strategies can be helpful to handle this type of situation:

- Be aware that silence does not help the health professional in trouble.
- Avoid "corridor" discussions and find a quiet, private place to talk without interruptions.
- Try to be empathic, nonjudgmental, and nonstigmatizing.
- Underline the benefits of early help-seeking as a healthy coping strategy.
- Focus on the coworker's strengths and competencies.
- Offer advice on alternatives for appropriate treatment or help, including free, easy access, and confidential programs that may help the person overcome initial resistance to obtaining appropriate treatment.
- If a coworker may be in immediate danger of suicide, call to ask for immediate assistance.
  (Draquehais & Vargas-Cáceres, 2022)

## 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

Involuntary hospitalizations and compulsory treatment can raise legal and ethical issues, as they violate basic civil rights, restrict the freedom of individuals, and impose significant responsibilities on physicians. This high sense of responsibility may cause physicians to cross their limits and ignore the autonomy of individuals while exercising their authority.

Healthcare providers' duty to do no harm (nonmaleficence) can contradict the autonomy of a patient with suicidal ideation. Reporting suicide ideation to members of the healthcare team not providing direct care to a patient complies with the beneficence principle; however, this would breach patient confidentiality. This leads to a dilemma; neither can be chosen without violating the other.

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 patient considering suicide 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 and can increase the risk of suicide following discharge.

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 patients with suicidal ideation may benefit more from therapeutic interventions that maximize and support autonomy and personal responsibility.
  (Borecky et al., 2019; Colack et al., 2021)

## 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
- Providing suicide prevention education to others
- Establishing prevention efforts in the healthcare workplace to reduce the risk of suicide related to work stress and difficult working conditions

**RESOURCES**

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

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

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

My American Nurse
https://www.myamericannurse.com/wp-content/uploads/2021/01/Nurse-suicide-Online-ADD-RESOURCES.pdf

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

Suicide & Crisis Lifeline (Kentucky)
https://988.ky.gov/
988 (call or text)
800-273-TALK (8255)

Suicide prevention (National Institute of Mental Health)

https://www.nimh.nih.gov/health/topics/suicide-prevention

Suicide Prevention Resource for Action (CDC)
https://www.cdc.gov/suicide/pdf/preventionresource.pdf

Suicide resources (CDC)
https://www.cdc.gov/suicide/resources/index.html

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# TEST

[ Take the test online at wildirismedicaleducation.com ]

**1.** Which statement is **correct** regarding the impacts of suicide among specific groups in the United States?

a. The suicide rate for Non-Hispanic American Indians/Alaska Natives is lowest among racial/ethnic groups.
b. Individuals ages 85 and older have the lowest rate of suicide.
c. Nurses are 18% more likely to die from suicide than the general population.
d. By sexual orientation, transgender youth had the lowest risk of suicide.

**2.** Which risk factor for suicide is specifically associated with burnout and especially affects those in the nursing profession?

a. Impulsive/aggressive tendencies
b. Cultural and religious factors
c. Socioeconomic factors
d. Chronic, high workplace stress

**3.** Which characteristic is an **external/environmental** protective factor for suicide?

a. Good impulse control
b. Strong sense of cultural identity
c. Strong relationships
d. Strong problem-solving skills

**4.** For which reason would 80% of people with mental health issues avoid seeking help?

a. Limited access to treatment
b. Mental health stigma
c. Concerns about confidentiality
d. Lack of support from family

**5.** Which action is considered the "gold standard" for suicide assessment and intervention?

a. Reviewing the patient's history of mental disorders
b. Conducting a clinical interview
c. Administering the Patient Health Questionnaire (PHQ)
d. Screening with the Scale for Suicide Ideation-Worst (SSI-W)

**6.** At which **level of risk** would a patient having thoughts of death, no plan for suicide, and no history of suicidal behavior be categorized?

a. High
b. Moderate
c. Low

d. None

**7.** Which statement is **correct** about a suicide safety plan?

a. It assesses the likelihood that the patient is going to attempt suicide.
b. It is written by the healthcare provider.
c. It determines which risk category the patient falls within.
d. It is collaboratively written in the patient's own words.

**8.** Which suicide prevention strategy provides training on emotional debriefings to help staff communicate about stressful situations?

a. Suicide Prevention Resource for Action
b. Gatekeeper Training Program
c. Healer Education, Assessment, and Referral (HEAR) program
d. American Rescue Plan Act of 2021

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

a. The patient's right to self-determination is not affected by suicide interventions.
b. Involuntary hospitalization of a patient considering suicide does not increase risk of suicide post discharge.
c. Involuntary hospitalization conflicts with the principle of autonomy.
d. There are no potential harms inherent in civil commitment.