



Hope Against Suicide

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Purpose

The goal of this course is to introduce seasoned and novice healthcare providers to evidence-based strategies focused on the:

- Identification of suicide risk and protective factors
- Development of suicide risk and lethality assessment skills
- Ability to engage in reflective practice to promote professional development and improved patient outcomes
- Evaluation of the care and safety of patients struggling with thoughts of self-harm
- Educational needs of the patient and family members
- Development of interventions designed to assist the patient in their recovery

Learning Objectives

After successful completion of this course, you will be able to:

- Discuss the impact of suicide rates in the United States
- Identify suicide risk factors
- Differentiate non-suicidal self-inflicted injury from suicidal behaviors
- Identify the nurse's role in suicide risk and lethality assessment
- Reflect and identify personal feelings about suicide, suicide prevention and responsibility.
- Describe the needs of high risk, vulnerable populations.
- Discuss individualized interventions designed to prevent suicide.
- Discuss educational and support needs of the patient and family members. Identify community resources

Introduction Suicide is an *important* topic to discuss because:

- More people die from suicide than from homicide
- Suicide occurs 129 times per day in the United States
- It is the second leading cause of death for 10 to 24 year-olds and 25-34 years old, the fourth leading cause of death for 35-44 years old and 45-54 years old, and the eighth leading cause of death for 55 to 64 year-olds in the United States
- It is the 10th leading cause of death nationwide in the United States, with approximately 47,000 lives lost each year
- Suicide is attempted in the United States approximately 1.4 million times a year
- Combined medical and work loss costs are \$44 billion per year in the United States
- Men die by suicide 3.5 times more often than women
- 20 suicides every day are veterans
- It is final

(American Foundation for Suicide Prevention, 2018; Centers for Disease Control and Prevention [CDC], 2019; U.S. Department of Veterans Affairs, 2018)

Suicide: An Uncomfortable Subject

Suicide is an *uncomfortable* topic because it:

- Involves the ending of one's own life
- Is an exclusively human response to extreme pain
- Is a desperate solution for an individual who has lost hope and can no longer see viable alternatives
- Affects everyone, the individual, the family, the community, the nation, and the world
- Is lethal

The Need to Know

Nurses in a variety of healthcare settings frequently come in contact with individuals in extreme emotional, psychological, and physical pain. At times, this pain may become overwhelming and result in suicidal thoughts and/or a suicide attempt.

This course is designed to provide nurses with the opportunity to learn to recognize risk factors that may lead to suicide, assess suicidal ideation, and intervene with individuals considering suicide as well as with those that have recently made a suicide attempt.

Suicide: A Public Health Concern

Suicide is a public health concern for the United States and the world. Many organizations have focused a great deal of time, attention, and resources to explore suicide prevention and treatment strategies. A great deal of this course is drawn from these studies, papers, and documents. Consider the resources provided at the completion of this program as they provide a solid foundation for your professional practice.

Did You Know?

One in 10 suicides are by people seen in an Emergency Department (ED) within two months prior to death. Many were never assessed for suicide risk (Suicide Prevention Resource Center, n.d. a)

Look for evidence of risk in all patients!

National Patient Safety Goal 15.01.01

Suicide has been recognized as not only an issue in mental health settings, but in potentially all healthcare settings. A 2012 study found that 22 percent of the reported cases of suicide (cases reported to The Joint Commission [TJC]) occurred in non-psychiatric settings, with 14 percent occurring on medical and surgical units, and eight percent occurring in the emergency department (McBroom, 2012). Recent studies report that between 8.6-9.9% of suicides that occur in acute care settings are not in a psychiatric setting but rather an inpatient unit. Additionally, 3.6-5% of suicides in healthcare occur in the emergency department. This means that currently between 12.2-14.9% of suicides in healthcare setting occur in non-psychiatric settings (Williams, Schmaltz, Castro, & Baker, 2018).

Patient Safety Goal (NPSG) 15 was added by TJC in 2007. The purpose of NPSG 15 is to reduce the risk of suicide. The goal includes conducting an environmental risk assessment in all organizations (TJC, 2018a).

For patients in psychiatric hospitals or have primary evaluation and/or treatment for behavioral health conditions in general hospitals, there are additional recommendations through NPSG 15. These include:

- Use of a validated screening tool to screen individuals for suicidal ideation
- Conduct an evidence-based suicide risk assessment
- Document suicide risk and plans to mitigate this risk
- Policies and procedures addressing at-risk patients should include training, competence, reassessment guidelines, and monitoring of those individuals
- Follow policies and procedures regarding counseling and follow up with at-risk patients
- Monitor implementation and effectiveness of policies and procedures

(TJC, 2018a)

Hospitals which are accredited through organizations other than TJC still use the NPSG as guidelines for patient safety and quality improvement.

Test Your Knowledge

TRUE or **FALSE**?

Patient suicides can occur in non-psychiatric settings

The answer is: **TRUE**. Studies have noted that between 12.2-14.9% of suicides in healthcare setting occur in non-psychiatric settings

Incidence and Epidemiology: A Numbers Game

In 2013, over 41,000 people committed suicide in the United States (CDC, 2015). That translates to approximately 112 suicides per day or one suicide every 12.95 minutes.

Worldwide, it is the leading cause of violent death; outnumbering homicide and war-related deaths. In 2016, there were approximately 793,000 suicides worldwide, which reflects a rate of 10.5 per 100,000 people (World Health Organization, 2018).

Gender, Ethnic and Racial Disparities

Gender Disparities

- Males take their own lives at nearly four times the rate of females and represent 78.8% of all U.S. suicides (Centers for Disease Control and Prevention [CDC], 2015).
- During their lifetime, women attempt suicide about three times as often as men (American Foundation for Suicide Prevention, 2015).
- Suicide rates for males are highest among those aged 75 and older (rate 36 per 100,000) (CDC, 2015).
- Suicide rates for females are highest among those aged 45-54 (rate 9 per 100,000 population) (CDC, 2015).

Ethnic and Racial Disparities

- In the United States, the highest rates of suicide are among Native Americans and Alaskan Natives (CDC, 2015).
- Among American Indians/Alaska Natives ages 15- to 34-years, suicide is the second leading cause of death (CDC, 2015).
- Hispanic and Black, Hispanic female high school students in grades 9-12 reported a higher percentage of suicide attempts (11.1% and 10.4%, respectively) than their White, non-Hispanic counterparts (6.5%) (CDC, 2015).

Age Disparities

Older adults and adolescents are disproportionately represented.

- In 2014, suicide was the second leading cause of death for young people ages 10-24.
- Suicide rates are increasing among adolescents 10-19 years of age, elderly males, and young black males
- Almost 16 percent of students in high school report having seriously considered suicide, with 7.8 percent actually attempting suicide at least once in the past year
- Of every 100,000 people ages 65-74 and older, 15 died by suicide in 2013. The rate increased to 17.1 per 100,000 for those ages 75-84, and 18.6 for those ages 85 and over. This figure is higher than the national average of 12.6 suicides per 100,000 people in the general population.

(American Foundation for Suicide Prevention, 2015; CDC, 2014; CDC, 2015).

Special Populations at Risk

There are several vulnerable populations defined in the literature as being at increased risk for suicide including:

- Youth ages 10-17
- Young adults ages 18-24
- Males over the age of 65
- Recent or current military association
- Older adults over the age of 65 (in general)
- Anyone with an alcohol or substance abuse issue
- Individuals with mental illness; especially those individuals diagnosed with depression and bipolar illness

(CDC, 2015)

Why Are Statistics Important?

Statistics such as incidence and prevalence help define the problem and document the extent to which a given problem (in this case suicide) is a burden to a community.

Statistics:

- Guide healthcare decisions
- Measure performance outcomes

- Guide data driven quality improvement projects to maximize efficiency and quality patient care outcomes
- Gauge the overall health and well-being of specific populations
- Provide observations that describe the characteristics of specific population samples

Statistics help us understand specific statistical determinants and demographics. These observations also assist healthcare professionals develop policies and practices to prevent suicide.

Statistical analysis helps to summarize and simplify complex human populations and thereby assist in understanding the thoughts, feelings, and emotions behind the action of suicide.

Based on the limited statistical data presented, suicide clearly is a significant public health problem both nationally and worldwide for individuals of all ages, ethnic background, economic status and religious preference.

In general, people contemplating suicide do seek assistance. In fact nearly 64 percent of all suicide victims visit a doctor one month prior to their suicide attempt, and 38 percent within a week of the attempt (Mental Health America, 2019). Eight out of 10 people thinking about suicide have some sign of their intentions (Mental Health America, 2019).

The Stigma of Suicide

What is Stigma?

- A set of beliefs that are negative and often unfair, which a group of people or society have about something
- An attempt to label a particular group of people as less worthy of respect than others
- A mark of shame, disgrace or disapproval that results in discrimination
- Not just a matter of using the wrong word or action – it's about disrespect

Stigma leads to:

- Fear, violence, and mistrust
- Discrimination

The Stigma of Suicide

- Stigma is a key reason that certain ethnic and religious groups are disinclined to seek treatment for mental illness or substance abuse.
- Mistrust of mental health services is an important reason for deterring people of color from seeking treatment.
- Their concerns are reinforced by evidence (both direct and indirect) of clinician bias and stereotyping.
- Older people, for whom depression is quite prevalent and who have the highest rates of suicide in the U.S., are especially unlikely to utilize mental health services as many believe that mental illness is associated with weakness of character

- Stigma against mental illness continues to discourage people in need from seeking treatment.

Did You Know?

Increased awareness coupled with the dispelling of myths about suicide and suicide prevention will result in a decrease in the stigma associated with suicide and life-threatening behaviors (National Alliance for Suicide Prevention, 2019; U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

Test Your Knowledge

TRUE or FALSE?

Stigma inhibits people from seeking mental health services out of shame and fear.

The answer is: **TRUE**. The stigma of mental illness remains a powerful reason that people in need of care hesitate to seek out services. Suicide itself is a source of stigma as the individual is often referred to as weak, a coward, giving up and selfish.

Interactive Activity: Video

There are many individuals who do not disclose that they suffer from mental illness or seek help as a result of societal stigma. The world was shocked with the suicide of Robin Williams, who suffered from depression and substance abuse. More light has come on the subject with celebrities stepping forward and showing support. This brief video has Wayne Brady, actor and comedian, discussing his own experience with depression.

https://www.youtube.com/watch?v=KFwJg_4uwM

How Are Stigma, Suicide, and Mental Illness Related?

Stigma denotes a shameful quality in a person. There are misbeliefs that mental illness is not a “true” illness (such as a physical organic disease), but rather a personal quality. This type of myth has been influenced by the media, such as portrayal of unpredictable violence and irrational behavior (National Action Alliance for Suicide Prevention, 2019; U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

It is estimated that one in 5 Americans have a mental disorder, yet nearly two-thirds of all people with a diagnosed mental illness do not seek treatment (National Alliance on Mental Illness [NAMI], 2015).

Despite the fact that effective treatments exist for these disorders and conditions, **the stigma of mental illness and substance abuse** prevents many people from seeking assistance due to fear, prejudice, lack of knowledge, rejection and discrimination. Approximately 60% of adults and 50% of children and adolescents did not receive mental health services within the previous year (NAMI, 2015).

Up to 90% of all suicidal behaviors are associated with some form of mental illness and/or substance use disorder. 15% of adult patients with major depression commit suicide, and 7% of adolescent patients (National Institute of Mental Health [NIMH], 2018). Many individuals continue to hold the belief

that mental illness is actually a character flaw rather than an illness. Therefore, symptoms that are treatable remain untreated as they are not considered part of an illness but a moral failing (NAMI, 2015).

Reflective Practice

Reflect on Your Own Feelings about Suicide

One of the ways to increase awareness and decrease stigma is to examine your own views on suicide. Reflective practice (a powerful tool) allows you to grow personally and professionally. Reflective practice promotes the exploration of feelings, thoughts, bias, prejudice, and preconceived notions about issues (in this case suicide), that you encounter in your daily life and practice.

The idea and concept of suicide has the ability to polarize individuals as they struggle to reconcile the difference (and potential conflict) between the clinician's goal to prevent suicide and the patient's goal to eliminate psychological pain via suicidal behavior.

In order to effectively assist individuals contemplating suicide, you must explore your own beliefs about suicide and practice unconditional positive regard for patients in your care. You are now ready to consider self-destructive behavior (Firestone, n.d.).

Suicide versus Self-Injurious Behavior

The focus of this course is the devastating act of suicide including its outcomes. To understand suicide, one must also understand what it is not.

Many providers have the misconception that suicide includes any self-destructive behavior. Suicide does not always include self-injurious behavior; an important distinction to make.

Self-Injurious Behavior

Self-injurious behavior (SIB) is the act of physically hurting oneself on purpose, causing direct and deliberate harm. These behaviors can include non-suicidal self-injury (NSSI) without the intent of committing suicide. SIB can also include suicide attempts and the actual act of suicide. The key between these behaviors is that a suicide attempt is done intentionally to commit suicide, not accidentally with the intent purpose of hurting oneself (Grandclerc et al., 2016; Hamza, Stewart, & Willoughby, 2012).

Self-injurious behavior is understood as a method of coping during an emotionally difficult time; a routine that helps some people temporarily feel better because they have a way to physically express and release the tension and the pain they hold inside.

Some individuals report that hurting themselves produces chemical changes in their bodies, promoting a sense of happiness and well-being for a period of time (Grandclerc et al., 2016; Hamza, Stewart, & Willoughby, 2012).

Non-Suicidal Self-Injury: A Distinct and Separate Phenomenon

The goal of non-suicidal self-injury is relief from pain and tension; not death. The lethality associated with self-injurious behaviors is generally low.

Non-suicidal self-injury is different from other self-destructive behaviors such as bingeing, drug abuse, smoking and other high risk activities in that the direct intent associated with self-injurious behavior is to physically harm oneself.

Non-suicidal self-injury Includes:

- The deliberate harm to one's own body without the aid of another person.
- Injury that is severe enough to cause tissue damage.
- A contained event in a short time span with an awareness of the consequences of the act.

Non-suicidal self-injury does not include:

- Behaviors that alter the body's appearance such as tattoos, body piercing, or ritualistic mutilation.
- An attempt to end one's life

(Grandclerc et al., 2016; Hamza, Stewart, & Willoughby, 2012).

Test Your Knowledge

Which statement is true regarding non-suicidal self-injurious behavior?

- A. It is an attempt to end one's life
- B. It includes body piercing and tattoos
- C. The purpose is usually reduction in tension or self-punishment**

Self-injurious behavior has as its intent the desire to harm oneself for the purpose of tension reduction, self-punishment, improvement in mood and distraction from intolerable feelings (Grandclerc et al., 2016; Hamza, Stewart, & Willoughby, 2012).

Self-Destructive Behavior

Self-destructive behavior is described as acting or intending to harm or destroy oneself (Merriam-Webster, 2019).

Direct Self-Destructive Behavior = Suicide**Direct**

- Suicidal ideation
- Suicidal threats
- Suicidal gestures
- Suicidal attempts
- Suicide completed

Indirect

- Drug or alcohol abuse
 - Cigarette smoking
 - Sexual promiscuity
 - Reckless driving
 - Socially deviant behavior
 - Non-compliance with medical treatment
- (Keltner & Steel, 2014)

Risk Factors

Risk factors are associated with a greater potential for suicide and suicidal behavior.

Understanding risk factors dispels the myth that suicide is a random act caused by stress alone.

Risk Factors at a Glance:

1. High risk demographic profile
2. Current or past history of psychiatric disorders
3. Current or past history of suicidal behavior
4. Current or past history of trauma, abuse and/or neglect
5. Family history of completed suicide
6. Presence of lethal means of self-harm
7. Presence of precipitating factors and stressors
8. Presence of symptoms associated with suicidal behavior

(CDC, 2015; National Action Alliance for Suicide Prevention, 2019; U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

Demographic Risk Factors

Top Groups at High Risk for Suicide

The following demographic factors are associated with an elevated suicide risk:

- Native American and Alaska Natives
- Youth ages: 10-24
- Medically ill (particularly terminal illness)
- Individuals with mental and substance abuse disorders
- Individuals with previous suicide attempts
- Individuals with a family history of suicide or violence
- Male
- Older adults over the age of 65 (especially those individuals who are isolated, widowed and multiple losses)
- Sexual identity crisis/conflict
- Rural populations
- Retired military personnel
- Individuals in justice or child welfare settings
- Individuals bereaved by a loss to suicide

(CDC, 2015; National Action Alliance for Suicide Prevention, 2019; U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

Current or Past History of Psychiatric Disorders

A mental health or substance abuse disorder is present in over 90% of suicide deaths (NIMH, 2018). Therefore, an identified mental health diagnosis places the individual at higher risk for suicide.

Assess for the presence of current or past mental health issues including:

Mood Disorders

- Depression
- Bipolar Illness

Schizophrenia

Anxiety Disorders

- Post-traumatic stress disorder (PTSD)

Substance Abuse Disorders

Personality Disorders

Did You Know?

A diagnosis of major depressive disorder (MDD) is associated with an increased risk for suicidal behavior. Antidepressants are generally used to treat depression and can potentially increase suicide risk in some situations:

- When physical energy returns before suicidal ideas have a chance to clear. This may happen in the first 7-10 days after starting an antidepressant. During this high-risk time, close monitoring is crucial
- When bipolar disorder is erroneously diagnosed as major depressive disorder. A manic phase may be provoked by giving the wrong medication

(Gotzsche, 2017)

*For more information on major depressive disorder, check out the RN.com course **Identification and Care of Patients with Mental Health Disorders***

Current or Past History of Suicidal Behavior

A previous history of suicidal behavior increases suicide risk. It may indicate a pattern of behavior that includes suicide as a potential option.

When questioning the patient about previous suicidal ideation or attempts, it is important to ascertain presence of previous attempts. If individual has a history of previous attempts determine:

- Method, circumstances, medical intervention, hospitalization
- Location of previous attempt(s)
- Lethality of attempt (Note: hanging and use of firearms indicate increased lethality)

(CDC, 2015; National Action Alliance for Suicide Prevention, 2019; U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012)

Current or Past History of Trauma, Abuse, or Interpersonal Violence

Research suggests that a significant proportion of victims of sexual assault and/or physical abuse are at increased risk for mental health disorders associated with suicidal behaviors.

This is an important statistic for emergency department (ED) nurses to acknowledge as it is vital that all nurses in the ED recognize the traumatic nature of abuse and the increased risk for self-destructive behavior. Follow-up care is vital with this population.

Not surprisingly, victims of interpersonal violence (e.g., child maltreatment, youth violence, community violence, sexual assault, and intimate partner violence) have a higher risk of suicide than non-victims.

Research also demonstrates that previous and current perpetrators of interpersonal violence are at increased risk for suicidal behavior (Wolford-Clevenger et al., 2015)

Family History of Suicidal Behavior

A family history of completed suicide and psychiatric illness significantly and independently increase suicide risk. Studies have revealed those with a family history of suicide were two and a half times more likely to take their own life than were those without such a history (National Action Alliance for Suicide Prevention, 2019; U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012)

A family history of psychiatric illness requiring hospital admission increased suicide risk by about 50 percent for those who did not have a history of psychiatric problems themselves. Both types of family history (mental illness and suicide) boosts risk, but the effect was strongest for individuals whose family history included both suicide and psychiatric illness.

Some research suggests that clustering of suicides within families occurs and that suicidal behavior in part might be genetically transmitted.

Nurses should evaluate family suicide history when assessing a person's suicide risk.

Presence of Lethal Means of Self-Harm

The concept of lethality is essential to the assessment of suicide risk. Lethality refers to the medical or biological danger to life. Methods of suicide may be characterized by their lethality. The presence of a lethal means of suicide in the home is associated with increased rates of suicide (National Action Alliance for Suicide Prevention, 2019; U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

It is incumbent upon all healthcare providers, especially primary care providers, to ask about the presence of a lethal means of self-harm in the home to help in assessing risk and lethality.

If the patient reports the presence of a lethal means of self-harm in the home or personal environment, engage family and friends to remove the items and secure the home. Lethality assessment is part of the suicide risk assessment.

Did You Know?

Antidepressants are the drugs of choice for depression and anxiety. However, the intervention itself can be a two-edged sword. How can this be?

- Depression is an identified risk factor for suicide.
- Older generation antidepressants have a narrow therapeutic index, there is a high potential for lethal overdose.

- Similarly, many of the newer generation antidepressants such as several SSRI's carry a black box warning for adolescent and young adult populations, warning of the potential for increased suicidal ideation when using the medication.

There have been significant improvements made in limiting the potential for lethal overdose with the newer generation antidepressants, yet many individuals benefit from the older antidepressants. Careful consideration must be made therefore, when ordering prescription refills to prevent potential overdose (Gotzsche, 2017).

Assessment of Precipitating Factors

Introduction

Precipitating factors and stressors include experiences or conditions that engender feelings of loss, humiliation, shame and despair.

Assessing these stressors provides valuable information; adding to the data needed for a determination of suicide risk potential.

Loss

- Loss of relationship due to divorce, illness, death
- Loss of employment or inability to secure employment
- Loss of home
- School related issues
- Loss of health: recent acute or chronic medical condition
- Loss of financial resources due to employment, bills, gambling, investments, etc.
- Anniversary of a loss

Shame/Despair

- History of abuse, neglect, or violence
- Interpersonal violence: bullying, cyber-bullying
- History of trauma
- Gender identity issues
- Legal issues
- Unwillingness to seek help due to stigma associated with mental and substance abuse disorders
- Fear of punishment or embarrassment

Drug and Alcohol Use

- Current and past use of drugs and alcohol
- Currently under the influence
- Currently detoxing or withdrawing from substance

(CDC, 2015; National Action Alliance for Suicide Prevention, 2019; U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012)

Symptoms of Suicidal Behavior

The following symptoms have been associated with an increased risk of suicide. Be sure to assess for the presence of these symptoms during assessments and re-assessments of individuals in your care. Do not be afraid to directly ask the patient about the presence of these symptoms:

- **Hopelessness**
Without hope or belief that the situation will improve
- **Helplessness**
Unable to see an alternative outcome for themselves

- **Impulsivity**
Acting on impulse with little thought to outcome/consequences
- **Command Hallucinations**
Internal voices instructing the individual to harm themselves
- **Anhedonia**
An absence of pleasure or joy in life with activities or events that previously brought happiness
- **Isolation**
Feelings of being cut off from other people.
- **Lack of plans for the future**
- **Anxiety and panic**
- **Sleep disturbance**
 - Difficulty falling asleep
 - Frequent waking
 - Excessive sleep
- **Feelings of anger, rage, and need for revenge**
- **Cognitive rigidity and negativity**
- **Low self-esteem**

(CDC, 2015; National Action Alliance for Suicide Prevention, 2019; U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012)

Protective Factors

Protective factors are associated with a reduced probability or potential for suicidal behavior and may serve to provide protection and promote resilience Keltner & Steel, 2014).

While protective factors may be present, they may not be enough to counteract the intensity of the risk factors. Protective factors may be used in the plan of care to reinforce adaptive alternatives and promote health.

Protective factors safeguard against rather than prevent suicide. Measures that enhance resilience are as essential as risk reduction in preventing and treating suicide.

Protective factors are transient rather than permanent and must be re-assessed and/or maintained.

As a nurse, it is important to assess these factors when considering suicide prevention strategies. Protective factors have been shown to reduce risk for suicide, but little is known about how to enhance these protective factors with individuals already at risk (Keltner & Steel, 2014).

Protective factors are categorized as **internal** or **external**.

Suicide risk and protective factors and their interactions form the empirical base for suicide prevention. A heightened awareness of the presence or absence of risk and conditions associated with suicide will result in better triage systems and better allocation of resources for those in need of specialized treatment.

Internal and External Protective Factors

The following factors have been found to be protective against suicidal thoughts; reducing the risk of suicidal behavior.

Internal protective factors include:

- **Personal resilience**
- **Spiritual beliefs**
Include a strong spiritual or religious faith, a sense of higher meaning or purpose in life, or a belief that suicide is wrong
- **Current and past effective coping strategies**
Problem solving, conflict resolution and non-violent resolution
- **High frustration tolerance and low impulsivity**
- **Intact reality testing**
- **Good health**
Physical, emotional psychological

External protective factors include:

- **Social support: intact and positive**
General measures of social integration have been found to be protective; Presence supportive family and friends
High frequency of social contact
Low levels of social isolation
- **Community connectedness**
Integration with school, work, community organizations
- **Responsibility for children**
Having the responsibility for children or for family communication is protective
- **Responsibility for pets**
- **Restricted access**
Lack of access to a means of suicide can help to reduce suicide risk
- **Early, effective treatment**
The early identification and effective treatment of mental health problems
- **Economic security**
Very protective; especially in older adults
- **Access to healthcare**

(National Action Alliance for Suicide Prevention, 2019; U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012)

Protective Factor: Social Support Family and Significant Others Play a Vital Role

The literature consistently identifies social support as a significant protective factor (Keltner & Steel, 2014). Family members, friends, and significant others play an important role in the care of individuals at risk for suicide. They are in a prime position to note changes in behavior, demeanor, and mood; changes that may signal a decline in condition.

The nurse is in an excellent position to work with the family and significant others, to teach them how to detect changes in behavior and mood and how to access care if a safe environment is required to prevent self-destructive behavior.

Test Your Knowledge

An example of an internal protective factor is:

- A. Social support
- B. Spiritual beliefs**
- C. Access to healthcare

Spiritual beliefs are considered an internal protective factor.

Case Study: Mrs. R

Mrs. R is a 42-year-old female with a history of bipolar illness. She often chooses not to take her medication as she does not like the way it makes her feel. She has verbalized thoughts of suicide for the past several years, yet clearly states that she has no plan to harm herself because 1) it would be a sin, and 2) she doesn't want to hurt her kids. She was admitted to the medical surgical floor at a local hospital with complaints of chest pain. What are your thoughts about suicide risk and protective factors with Mrs. R? What might be considerations when working with her?

After conducting a suicide risk assessment, you will likely discover that Mrs. R. is at low risk for suicide. She denies current intent or plan and has noted several protective factors that help her cope with her mental illness. Chronic suicidal ideation is something many people with chronic depression/bipolar illness experience and may be present for the rest of her life. Your plan should include regular risk assessments; monitoring for trends or changes in behavior. In addition, spend time providing education on current medications ordered including a plan to mitigate annoying side effects. Also instruct her to keep her doctor informed of side effects as well as current benefits of medications orders.

Suicide: When Stressors Overwhelm the System

Stressors can become overwhelming at any time in an individual's life. The option of suicide can appear suddenly or develop over a period of time and may be precipitated by an event, thought, or feeling that he or she may describe as "the last straw."

Suicidal thoughts and intention indicate the imminent failure of coping mechanisms.

Remember:

Take all suicide verbalizations and behaviors seriously.

Five Levels of Suicidal Behavior

In general, there are five levels of suicidal behavior. Each of the behaviors carries with it the potential for suicide. All suicidal behavior should be assessed and taken seriously.

1. **Complete suicide:** death or self-injury, poison, or suffocation where there is evidence that the decedent intended to kill him/herself.

2. **Suicide attempt:** any self-directed action taken by a person that will lead to death if not stopped or interrupted. The difference between a gesture and an attempt is the intent to die. Determining intention provides critical data in the assessment process.
3. **Suicide threat:** a warning, direct or indirect, verbal or non-verbal, indicating that an individual is planning to take their own life. Suicidal threats indicate the ambivalence that is usually present in suicidal behavior. It is important to remember that suicide threats are often indirect and can easily be overlooked if the nurse is not aware of subtle clues. Statements such as: "Sometimes, I wish I were dead," "My life is not worth living," "I can't go on any longer," "I hate my life," are all potential clues that someone may be thinking about suicide.
4. **Suicide gesture:** a suicide behavior that does not include the intent to die, but is more closely aligned with "a cry for help." It is an act of self-harm or self-injury that is unlikely to result in death. Examples include: scratching or superficially cutting the wrist, taking an "overdose" of five aspirin. Though gestures are generally not lethal, an accidental overdose or deep cutting on one's arm can become lethal if the individual is not found. Therefore, suicidal gestures should not be ignored or viewed as less important than an actual attempt.
5. **Suicidal ideation:** is the thought of self-inflicted death; either self-reported or reported by others. It often varies in seriousness and can be described as passive (passing thoughts of suicide without intent) or active (active plan developed or developing to cause one's own death). Suicide ideation can be acute or chronic. Many people with moderate and/or chronic depression may endorse suicidal ideation but deny thoughts of taking action to harm themselves. This is an important clinical distinction to make.
(U.S. Department of Health and Human Services, 2012)

Suicide Intention: An Important Consideration

Intention and lethality are two important concepts that must be carefully considered when assessing suicidal behavior.

Intention

It is important to ascertain the seriousness or intensity of the patient's wish to terminate his or her life. The level of suicidal intent is the most powerful predictor of eventual suicide after attempted suicide. Tools which are used to assess suicide risk and intent are included later in this course.

Case Study: Miss T.

Miss T is 18 years old. Her boyfriend decided he wants to see other people and broke up with her. On Facebook, she comments on the break up by saying: "I should just pack it in. I don't want to keep up this farce. I am just a worthless excuse for a human being." Based on this comment, what do you think is her suicidal behavior? What interventions, if any, should be done with Miss T?

Miss T is posting on her Facebook wall and expressing her pain. Based on this information alone, she is demonstrating a suicidal threat without expressed plan or intent. Miss T is at risk for suicide as demonstrated by her comments, recent loss, feelings of shame and worthlessness, and her age group. It would be important to recognize and validate her pain, further assess her intent and any plan, and insist on getting her into treatment ASAP.

Test Your Knowledge

The thought of self-inflicted death, either reported by the patient or others, is known as

- A. Suicide gesture
- B. Suicidal ideation**
- C. Suicide threat

Suicide Risk Assessment

Stressors can become overwhelming at any time. Suicidal behavior indicates the imminent failure of coping mechanisms. Unfortunately, suicide cannot be predicted with any certainty. However, the nurse can assess for suicide risk. A suicide risk assessment is a best practice procedure.

Research has identified thoughts, feelings, behaviors, and experiences that are correlated with an increase in suicide risk. Similarly, several factors have been identified and associated with protective factors. These factors, along with current suicidal ideation and intent, form a suicide risk assessment (National Action Alliance for Suicide Prevention, 2019; U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

Components of a Suicide Risk Assessment

- The absence or presence of suicidal ideation or intent is not static, but rather dynamic and changing.
- To keep individuals safe during a very vulnerable time in their lives, healthcare professionals must assess and re-assess suicide risk at regular intervals, whenever there is a change in the level of care or a whenever a change in behavior is noted.
- Suicide intent and risk assessment tools may be commonly used ones, or tools created specifically for a hospital. Some commonly used tools include:
 - Beck Suicide Intent Scale: this scale looks at specific categories, and the nurses uses the associated scores to determine suicide intent. This scale has had numerous modifications throughout the years. Categories include: isolation, timing, precautions against discovery, action for getting help before or after attempt, final acts in anticipating death, active preparation for attempt, suicide note, communication of intent, alleged purpose of attempt, expectations of fatality, conception of lethality of method, attempt seriousness, attitude towards living and/or dying, conception of chance of rescue, degree of premeditation, reaction to attempt, visualization of death, number of previous attempts, relationship between attempt and alcohol, and relationship between attempt and substance use. The Beck Suicide Intent Scale can be viewed at <https://deekim.files.wordpress.com/2011/09/becks-suicide-intent-scale.pdf>
 - Columbia Suicide Severity Rating Scale: this scale is available in 114 different languages, and can be used by multiple disciplines. It involves “yes” or “no” responses, based on patient responses that demonstrate the level of suicidal ideation. The categories include: wish to be dead, suicidal thoughts, suicidal thoughts with method, suicidal intent (with and without a plan), and suicide behavior. The Columbia Suicide Severity Rating Scale can be viewed at http://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf
 - The Suicide Assessment Five-step Evaluation and Triage (SAFE-T): this is a five step guide for professionals to evaluate suicide risk with patients. The steps include: identify

risk factors, identify protective factors, conduct suicide inquiry, determine risk level and interventions, and document. The SAFE-T can be viewed at

http://www.integration.samhsa.gov/images/res/SAFE_T.pdf

- The Suicide Behaviors Questionnaire-Revised (SBQ-R): this is a brief survey of four items that is provided to the patient for self-reporting. The items are then scored to determine suicide risk. The items include: lifetime suicidal ideation and/or attempts, frequency of ideation in the past year, threat of suicide attempt, and likelihood of future suicidal behavior. The SBQ-R can be viewed at <http://www.integration.samhsa.gov/images/res/SBQ.pdf>
- The SADPERSONS tool uses a mnemonic to assess components that are associated with a higher suicide risk, usually performed in the emergency department. Components include: **S**ex, **A**ge, **D**epression, **P**revious attempts, **E**xcessive alcohol or substance use, **R**ational thinking loss, **S**eparate/divorced/widowed, **O**rganized or serious attempt, **N**o social support, and **S**tated future intent. The SADPERSONS can be viewed at http://www.ebmedicine.net/media_library/aboutUs/Modified%20SAD%20PERSONS%20Scale%20Emergency%20Medicine%20Practice.JPG
- Unfortunately, there is not one definitive, valid, and/or reliable suicide risk assessment tool.

Suicide Risk Assessment: Key Points

Based on best practice principles, there are several common components that should be included in a comprehensive suicide risk assessment.

It is important to understand these components, their interaction, and their effects on suicide and suicidal behaviors (National Action Alliance for Suicide Prevention, 2019; U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012). They include:

- Identification of **risk factors**
- Identification of **protective factors**
- Systematic assessment of current **suicidal ideation, plan, intent (lethality assessment)**
- Determination of suicide **risk level**
- Development and implementation of a **plan of care**

Assigning a Risk Level

When assigning a risk level, your determination should be based on patient assessment and collective data.

Using the facility approved evidence-based tool, rate the suicide and lethality risk. Rating scales generally use a three tier scale: high, moderate, low based on the available data and the policy of the facility. Examples of risk assessment tools are discussed later.

Levels of Suicide Intent and Risk

Introduction:

There are three levels of suicide intent and risk.

Level One: Low Risk

- Passive or mild suicidal ideation
- No organized plan
- No expressed intent

- No history of previous intent
- Available social support
- Minimal risk factors
- Moderate protective factors

Level Two: Moderate Risk

- Moderate to intense ideation
- Vague plan, but have taken no action on the plan
- Some intent, not specific time frame
- A current and active relationship with a mental health professional (needs to be confirmed)
- No other acute risk factors
- Few protective factors

Level Three: High Risk

- Intense and persistent suicidal ideation
- Recent diagnosis of mental illness, especially major depression
- Psychosis, including hallucinations
- Organized plan (particularly if lethal)
- Strong intent
- History of threats or acts of aggression or impulsivity
- Other acute risk factors
- Lethality increased if there is a past history of suicide attempts, particularly a serious or nearly lethal attempt
- Minimal protective factors

(Suicide Prevention Resource Center, n.d. b).

Case Study: Mr. Q

Mr. Q is a 67 year old male. He is Caucasian, and was recently widowed within the past three months after being married for 41 years. He expresses feelings of hopelessness and helplessness to his primary care physician. When questioned, Mr. Q admits that he has had thoughts of suicide. Based on this information, what would you consider to be his suicide risk?

- A. Low risk
- B. Moderate risk
- C. High risk**

Mr. Q is exhibiting several major risk factors for suicide including: Male, age 65 years and older, hopelessness, living alone with thoughts of suicide. Mr. Q may require hospitalization for further assessment, safety and treatment.

Risk Assessment: Use of Therapeutic Communication Skills

How to Ask the Questions that need to be Asked

Non-Verbal Communication

- How you ask the questions affects the likelihood of getting a truthful response.
- Use a calm, accepting, matter of fact manner.

- Demonstrate unconditional positive regard.
- Maintain an open posture.
- Take the time needed to assess and explore. Don't be in a rush.
- Asking these important questions will not offend; but it will convey concern or acknowledgment of a cry for help.

Verbal Communication

- Do you ever feel like you just don't want to go on?
- Do you feel like you would like to just go to sleep and never wake up?
- Do you ever think about death and dying?
- Have you ever thought that life was not worth living?
- Have you reached the point of not wanting to go on?
- Have you ever thought about harming yourself or ending your life?
- Do you ever think of suicide as an option?

(Bolton, Gunnell, & Turecki, 2015; Perlman, Neufeld, Martin, Goy, & Hirdes, 2011)

Something to Ponder

While interviewing a patient, she discloses that she has had suicidal thoughts and a vague plan. As you are finishing your conversation, she says to you "Please don't tell anyone!" What do you think your response would be?

Answer: This is a promise you cannot make. While confidentiality is important, safety is primary. Your immediate concern is for the safety of the patient. Reassure the patient that you understand how difficult it must be to share such painful, personal information AND let them know you will do whatever you can to ensure their safety until they can get the help they need (therapy, medication, etc.).

Determining Suicidal Ideation

To determine current thoughts of suicide (suicidal ideation) and intent (level of desire to harm self), the nurse must conduct a face to face assessment.

To conduct a meaningful assessment, remember to use the following guidelines:

- Remain non-judgmental, calm, direct, and matter of fact.
- Encourage the patient to verbalize what lead up to the suicidal ideation and/or intent. Do not be afraid to discuss the incident. Discussing the incident will not encourage further attempts.
- Be sure to validate, empathize, normalize and listen.
- Consider leading into the question:
 "Many times, when people see no hope, they wonder if it is worth it to continue. Is that something you have ever felt?"
- Be direct with the patient when assessing for current suicidal ideation, intent and lethality. "Is dying something you are thinking about right now?"
 "Is death an option for you right now?"
 "Do you have a plan?" "Have you thought about how you would hurt yourself?"

(Bolton, Gunnell, & Turecki, 2015; Perlman, Neufeld, Martin, Goy, & Hirdes, 2011)

Sample Questions to Ask During a Suicide Assessment

Introduction

- Asking questions during a suicide assessment may be difficult. There are certain interview techniques that can be performed by structuring questions to elicit critical components for assessment (Coleman, 2013; Yasgur, 2016). These include:
- **Normalization:** This technique can overcome each patient's anxiety or hesitancy by letting them know that others have experienced the same thoughts, feelings, or behaviors. Patients are more likely to give valid details if they think their experience is "normal."
An example question is: "When someone feels very upset, they may have thoughts that life just isn't worth living. Have you had such thoughts??"
- **Gentle assumption:** This uses leading questions where the interviewer anticipates affirmative responses. Patients may feel less abnormal and are more likely to answer hard questions if they feel the interviewer is expecting a positive response.
 - An example question is: "What other ways of taking your life have you considered?"
- **Symptom amplification:** This technique overstates the anticipated range of answers to try and overcome the minimization of the patient's responses. If an exaggerated range of answers is given, then the patient may feel that their actual answer is more normal.
 - An example question is: "On a day when you have felt the most intense thoughts of suicide, how much time do you think of killing yourself? 70%? 80%?"
 - **Shame attenuation:** Using this technique assists the patient in limiting feelings of self-incrimination with his or her answer. It helps to understand the patient's rationale for thoughts or actions, and decrease reluctance to answer questions that may be considered shame-inducing. An example question is: "It must have been very disheartening when your boyfriend left you. Sometimes when people go through upsetting situations like that, they experience drastic thoughts, such as thoughts of suicide. Have you had any thoughts like those?"
 - **Behavioral incident:** This is asking for specific examples of behavior, instead of opinions or conclusions. A description of events decreases the chance of distortion of the story by the patient. An example question is: "Exactly how many pills did you take? What happened next?"
- **Denial of the specific:** This involves asking a patient if he or she has experienced anything from a list. This assists in soliciting lethality of suicidal ideation, and it is more difficult for a person to deny a specific question rather than a general one.
 - An example question is: "Have you ever thought of hanging yourself? Have you ever thought of overdosing?"

Presence of Current Suicidal Ideation

Determine the following:

- Does the individual express covert (passive) or overt (active) statement about suicide?
- Does the individual have a plan?
 - Is the plan specific or vague?
 - Lethality of plan
 - Does the individual have the means to carry out the plan?
 - Does the patient have access to the method?
- Does the individual immediately answer no?

Do not accept the first "no" from the patient/individual being assessed if: the patient has recently made an attempt, or endorses several risk factors.

(Coleman, 2013; Perlman et al., 2011; Yasgur, 2016)

Presence of Current Suicidal Ideation

Does “no” indicate there is no risk of suicidal thought or intention?

- Often the first attempt is the last attempt
 - The denial of suicidal ideation can be misleading
 - Continue to assess:
 - Watch non-verbal cues. What does their body language tell you? Is their body closed, arms crossed, eyes downcast, etc.?
 - Did the patient hesitate or pause before answering the question?
 - How have they responded to trauma, pain, or stress in the past?
 - Did they answer quickly with a NO and then change the subject?
 - Do they feel safe at the moment, but experience waves of suicidal thought and intentions?
 - Has the rapport between you and the patient had sufficient time to develop for the patient to feel a sense of trust?
 - After a suicide attempt, if the individual denies current suicidal ideation, ask them: “What has changed?”
- (Coleman, 2013; Perlman et al., 2011; Yasgur, 2016)

Safety remains the highest priority.

Test Your Knowledge

TRUE or FALSE?

Talking about the suicide event is not recommended.

The answer is **FALSE**. It is important to know the thought process that went into making the decision to suicide. It is also useful to determine what coping skills the patient employed, their frustration tolerance and judgment to determine the current suicide and lethality risk.

Analyzing Data from Risk and Lethality Assessments

Utilize the nursing process and evidence-based principles to analyze available data.

Review collected data.

What does the evidence say?

- Level of risk factors
- Evidence of protective factors
- Level of lethality (method, availability)
- Current suicidal ideation and intent
- Ability to carry out the plan (access, energy level)

What does your experience suggest?

- Develop nursing diagnoses, patient goals, nursing interventions and patient outcomes based on data collected.
- In the past, what data has assisted you in determining level of suicide risk?
- What interventions have been useful to patients in the past?

What does the patient say? What does the patient need?

- Are you able to integrate the patient's needs with your goal of providing a safe, therapeutic environment?

When to Conduct a Suicide Risk Assessment

The answer to this question depends on the patient, the setting, and the circumstances. Here are a few common examples:

Inpatient Setting:

In the inpatient setting a suicide risk assessment should be conducted during the initial admission assessment, and a reassessment performed:

- During a mental status examination
- With any change in behavior
- At the time of discharge

(U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

School Setting:

At the beginning of a school year all students should be screened for suicide risk and should be reassessed whenever a change of behavior is reported or observed. School staff need to be trained and aware of the warning signs. Suicidal youth are not likely to self-refer or seek help from school staff. For suicidal youth a plan of action should be developed for helping those at risk (U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

Jail/Prison Setting:

Suicide rates in jails have been estimated to be approximately nine times higher than that of the general population (U.S. Department of Justice, 2013).

During the initial intake prisoners are often intoxicated or in withdrawal. Other high risk situations may include:

- Inter-facility transfers
- When diagnosed with a mental illness
- Inmates under the age of 25

(U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

Formulating a Plan of Care

Employ the nursing process to identify, develop, determine, and make a plan for regular assessments.

Identify **nursing diagnoses**

- Use North American Nursing Diagnosis Association (NANDA) diagnoses in conjunction with available supporting data.

Develop **patient goals**

- Must be patient centered, patient focused.
- Encourage patients to collaborate in their own care.

Identify **nursing interventions**

- Nursing interventions must reflect what the nurse plans to do to help the patient reach the identified goal.

Determine **patient centered outcomes**

- Make them simple, patient focused and safety oriented.

Re-assess at regular intervals

- Adjust plan of care based on re-assessment data.

Nursing Diagnosis

Potential (NANDA) approved nursing diagnoses include:

- Risk for self-directed violence
- Risk for suicide
- Ineffective individual coping
- Ineffective family coping
- Spiritual distress
- Risk for self-mutilation
- Noncompliance

(Ackley & Ladwig, 2014).

Development of Patient-Centered Goals

Develop patient-centered goals. Patient-centered goals include both short-term and long-term goals. Examples include:

- Patient will seek out staff or family members when thoughts of suicide occur.
- Patient will list three potential coping strategies to use when suicidal feelings occur.
- Patient will demonstrate at least three coping strategies to use when suicidal feelings occur.
- Patient will not engage in direct, self-destructive behavior.

Important to Note:

The RN and the suicidal individual may have incompatible goals. Remember to separate your thoughts and feelings about suicide from your therapeutic interaction with the patient.

RNs must continually appeal to the healthy/adaptive part of the individual that still wants to live and convey a sense of hope.

Develop patient-centered goals in collaboration with the identified patient.

(Keltner & Steel, 2014)

Development of Nursing Interventions

It is important to formulate nursing interventions to identify what the nurse can do to:

- Assist the patient in working towards their goal
- Affect change in the patient
- Promote healing behaviors

Nursing interventions in the inpatient setting may include:

- Provide a safe and secure environment
- Continue to observe for suicidal behavior: verbal and non-verbal
- Assess and re-assess suicidal ideation and intent
- Administer medication to provide relieve from anger, agitation, anxiety and depression
- Encourage patient to continue to explore feelings related to suicidality including precipitating events
- Explore alternative coping strategies
- Provide hope, reassurance, and empowerment
- Develop a safety plan with the patient
- Offer supportive care
- Provide educational opportunities for patient and family
- Special note: although “safety contracts” are sometimes used, there is not enough evidence to support or not support their use
(Hogan & Grumet, 2016; Knesper, American Association of Suicidology, & Suicide Prevention Resource Center, 2011)

Identification of Outcome Criteria

The nurse needs to identify maladaptive self-protection responses as potential patient outcomes.

- The patient will not physically harm himself. The priority of care is preservation of life.
- The patient will seek out a staff member to report suicidal thoughts before acting on them.
- The patient verbalizes and accepts responsibility for own behaviors.
- The patient’s anxiety is maintained at a level at which he/she feels no need for aggression.
- The patient denies any ideas of self-destruction.
- The patient demonstrates use of adaptive coping strategies when feelings of hostility or suicide occur.
- The patient verbalizes community support systems from which assistance may be requested when personal coping strategies are not successful.

(Hogan & Grumet, 2016; Knesper, American Association of Suicidology, & Suicide Prevention Resource Center, 2011)

Test Your Knowledge

Which is an important consideration when setting patient goals?

- A. Goals should be patient-centered

- B. Goals should be both short-term and long-term
- C. Identify that the RN may have conflicting goals with the patient
- D. All of the above**

Summary: Plan of Care

In developing a plan of care for the patient with suicide ideation or post suicide attempt the following information should be reviewed:

- Collect demographic information
- Conduct a suicide risk assessment
- Assess for current suicidal ideation and intent
- Analyze data collected
- Determine risk level
- Develop plan of care
- Continue to re-assess at regular intervals and with change in behavior. A sudden change in behavior may be a warning sign!

Unique Settings and Vulnerable Populations

There are certain environments or physical settings in which suicide risk is increased. In addition, certain age groups, occupations, and gender also increase the risk of suicide ideation.

Suicide risk is greatly increased in:

- Emergency department
- Prison inmates

In addition, the populations at greatest risk for suicide are:

- Youth
- Older adults
- Men
- Military personnel

(U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

Emergency Department: Frequently the First Stop

Emergency department visits for attempted suicide or self-inflicted injury are relatively common. A 2015 report from the CDC included 575,000 visits for intentional self-inflicted injuries.

- ED visit rates were higher among female patients than male patients.
- The most common method of self-inflicted injury was poisoning (333,000) (CDC, 2015)

A 2014 from the Substance Abuse and Mental Health Services Administration (SAMHSA) also looked at drug-related suicide attempts, comparing year 2005 to 2011.

- There was a 58% increase in drug-related suicide attempts for ages 18-29 years old
- ED visits for these attempts increased by 104% for ages 45-64 years old

- There were increases in other groups as well, but these were not statistically significant. The age groups of 18-29 and 45-64 years old comprised 60% of all drug-related suicide attempts (SAMHSA, 2014). In addition, a Joint Commission Sentinel Event Alert warns that non-psychiatric patients are committing suicide in emergency departments and medical/surgical inpatient units (TJC, 2010).
- The alert urges greater attention to the risk of suicide for these patients and recommends education for caregivers about warning signs that may indicate when patients in general hospital units are contemplating harming themselves.
- Many patients in the ED are not identified as behavioral health patients or as individuals with suicidal ideation. However, not all individuals with suicidal ideation have a history of mental illness.

Risky Behaviors in the ED

Team members must be able to identify behaviors that may indicate potential suicidal ideation and intent; those at risk for imminent suicide. **Behaviors/conditions include:**

- Anxiety
- Agitation
- Intoxication
- Confusion
- Dementia
- Chronic pain
- Withdrawn behaviors
- Minimizing current status
- Emotional lability

(TJC, 2010)

Dealing with Suicidal Patients in the ED

It is recommended that nurses in the emergency department approach individuals post suicide attempt with a serious and non-judgmental approach.

These individuals are at greatest risk during this period of time. Acknowledging their pain and demonstrating the power of hope can go a long way in encouraging these individuals to seek treatment and learn alternative methods of coping with their overwhelming hopelessness and helplessness.

With an adolescent patient, part of the care may include an educational component with family members. Many family members tend to minimize suicide attempts. Help them to look at and accept the seriousness of the behavior and the need to immediately seek out intervention and follow-up care.

The literature shows that many emergency department nurses have strong feelings about caring for patients with a history of mental illness, substance abuse, chronic pain, or recent suicide attempt.

- It may be difficult for some nurses to suspend their own feelings about suicide and the taking of one's life in an area dedicated to saving lives.

- Engage in reflective practice, exploring your own values regarding suicide. Choose to interact with skill, care, and compassion.

The protocol in the emergency department should also include a safety check of the patient as a preventative measure; including search of personal belongings and the environment. Remove all potentially dangerous items.

(Suicide Prevention Resource Center, n.d. b).

Beyond the ED: Suicide Potential in the Acute Care Setting

Many patients who kill themselves in general hospital inpatient units do not have a psychiatric history or a history of suicide attempt – they are 'unknown at risk' for suicide. Compared to the psychiatric hospital and unit, the general hospital setting also presents more access to items that can be used to attempt suicide – items that are either already in or may be brought into the facility – and more opportunities for the patient to be alone to attempt or re-attempt suicide (TJC, 2010).

Nurses should be aware of potential risk factors and behaviors that may indicate a potential for suicide. The primary factor to look for is a change in behavior. This “change” often indicates a decision has been made.

Potential changes in behavior include:

- Sudden increase in energy level
- Acute signs of depression, anxiety, agitation, delirium, dementia
- Medical or psychological problems that impact judgment
- Chronic pain or debilitating problems; terminal illness
- Loss of interest in usual activities
- Change in eating or sleeping patterns
- Refusal of medication
- Request for increased medication or excessive use of prn's
- Impulsivity
- Decreased emotional reactivity
- Unrelenting pain
- Refusing visitors
- Crying spells
- Requesting early discharge
- Vegetative signs of depression
- Hopelessness, helplessness
- Decreased interest in treatment or prognosis

(Keltner & Steel, 2014)

Suicide in Prison Populations

Suicide is the leading cause of death in prison. The jail suicide rate is three times that of the general population; and significantly higher than state and federal prisons (U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

The risk factors in prison reflect demographic, institutional, and clinical risk factors. More than half of all inmates who commit suicide in prison are between 25 and 34 years old, and most often they are single with no job (prior to incarceration) or family support. Very young prisoners are especially at risk, as well as those placed in adult detention facilities. The suicide rate among juvenile offenders placed in adult detention facilities is almost eight times higher than those juveniles housed in juvenile

detention facilities (U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

Upper socioeconomic status and high degree of social and family integration before incarceration also increases the risk of suicide in prison.

An effort must be made to develop a means of early identification of inmate suicide behavior. A primary risk factor for suicide in prison includes a pre-existing psychiatric history, such as an attempted suicide, depression, bipolar illness, schizophrenia, or feelings of hopelessness prior to incarceration.

Research has demonstrated that providing a profile of suicidal behavior to corrections personnel has limited success due to limited available information about inmate behavior, thoughts, feelings, limited history, and proper training of corrections personnel (Suicide Prevention Resource Center, 2014).).

Risks for Suicide in Prison Populations

Risk Factors:

Several factors have been identified as risk factors that motivate inmates to commit suicide. These generally fall into two categories: circumstances of imprisonment and previous personal history.

Imprisonment factors:

- Viewing incarceration as a punishment and disgrace
- Loss of control of their life
- Loss of privacy
- Loss of family and friends
- Concern over transfer
- The closed social system (the convicts vs. the authorities)
- Living in an atmosphere of violence

(U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).)

Characteristics found in personal history of inmates:

- Deprived family backgrounds (abuse, neglect, criminal history)
- History of violence
- Financial issues
- History of mental illness and/or psychiatric treatment
- Drug and/or alcohol dependence and abuse

(U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

Other risk factors:

- Inmates are more likely to commit suicide in the early stages of incarceration (the first three to six months)
- Alcohol and drug use (more than half of the inmates have a history of drug and alcohol abuse)
- Placement in isolation (alters the inmates mental state, decreased communication)
- Type of crime (crimes against a person have a higher rate than crimes against property)

(U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

Risk Factors:

Similar to non-prison settings, the most significant risk factors of suicide among prisoners is mental illness; particularly depression, feelings of hopelessness, substance abuse, and a recent psychosocial stressor as a precipitant. However, many inmates who commit suicide have no psychiatric illness or warning signs (U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012.).

High risk factors specific to prison include:

- Being a young white male
- A maximum security prison
- Single-cell living
- Isolation
- Interfacility transfer (U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012.).

Methods of Suicide Used in Prison Populations

Methods Used:

- The majority of suicides are completed by hanging. Inmates quickly learn that the feet of the victim need not be off the floor for the attempt to end fatally
- Hanging suicides were done using bedding, clothing, or shoelaces as the instrument of hanging (Peckel, 2017)

Prevention:

Efforts to prevent suicides include:

- Increase staffing levels
- Increased education for correctional personnel
- Early identification of at risk inmates
- Early identification of suicidal behaviors
- Recruit family and friends to help identify at risk individuals
- Separate facilities to house suicidal inmates

(Peckel, 2017 U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

Intervention and Treatment

Care for inmates has been primarily custodial rather than therapeutic. In addition, treatment programs have primarily used a medical model rather than a social/recovery model. This is changing in some areas.

Nurses and healthcare professionals play a vital role in the assessment and treatment of inmates with suicidal behavior. Nurses conduct a full physical assessment and document their medical history within 24 hours of custody, and then make recommendations regarding the need for mental health intervention.

Nurses also see patients outside of the clinic; thereby making them more visible; and promoting a sense of trust, since inmates are more likely to confide in nurses they have a relationship with. Nurses

also generally administer medications to treat mental illness and relieve symptoms. They also function not only as a nurse, but as a case worker, therapist, care taker, crisis interventionist, group therapist, and suicidologist.

Peer support programs have demonstrated a great deal of success, utilizing a 12 step recovery/peer mentor model of care. Nurses often run these groups (Hayes, 2010)

Teen Suicide

High rates of suicide continue among adolescents (aged 15-19) and young adults (20-24). Along with older adults, they are the highest at-risk population (2015a).

- Suicide rates increase dramatically between early adolescence and young adulthood (Williams, 2011).
- Males are more likely to commit suicide than females.
- Females (particularly Hispanic females) are more likely to attempt suicide
- Gay youth are 2-3 times more likely to commit suicide when compared to their peers.

Precipitating Factors or Triggers for Suicide:

Multiple studies have confirmed that teens experience a great deal of stress during these formative years including the pressure to succeed, financial insecurity, sexual identity issues, the breaking apart of families through divorce or death, adjustment to step-parents and step-siblings, and moving to a new community (U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

They also struggle with developmental stressors and circumstances including fear of rejection, failing an exam, breaking up with boyfriend or girlfriend, interpersonal violence, cyberbullying, and sexual identity confusion.

These factors leave many teens with feelings of confusion, self-doubt, shame, and fear.

Many teens that commit suicide have mental health issues or substance abuse issues; making it even more challenging to cope with the identified stressors (NAMI, 2015).

Researchers continue to explore the possibility of a genetic component to suicide as well. It has been established that mental illness and substance abuse (common predisposing risk factors for suicide) disorders do run in families.

Risk Factors for Teen Suicide

Risk factors are similar to the general population and include:

- Mood disorder
- Alcohol and/or substance abuse
- Conduct disorder
- Personality disorders
- Impulsive behavior
- Violent behavior
- Chronic physical illness
- Being isolated
- Real or imagined loss (relationships, school, or financial losses)

- Gay, lesbian, bisexual, transgender or questioning youth, especially males
- Previous suicide attempt
- Physical or sexual abuse
- Exposure to intimate partner violence
- Family history of mental health issues or substance abuse
- Family history of suicidal behavior
- Familial conflict and stress (death, divorce)
- Access to lethal methods (especially firearms)
- Local suicide epidemics
- Barriers to access mental health treatment (U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012)

Symptoms of Teen Suicide

Common symptoms associated with suicidal behaviors:

- Frequent crying
- Isolation
- Weight loss or gain
- Fatigue
- Insomnia
- Irritability
- Behavior problems
- Violence
- Vague systemic complaints like headache, abdominal pain, syncope

(U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012)

Assessment of Teen Suicide

When assessing the risk of suicide in teenagers, the nurse should be aware of the need to be authentic and genuine with this population in order to establish a therapeutic alliance. Suicidal comments **MUST** be discussed and not ignored. Do not assume “they don’t mean it” or are “just upset.”

If the teen admits to suicidal ideation, immediately determine the level of intent, if they have a plan, and the means to carry out the intent. If the teen has an active plan and intent, an immediate evaluation is needed. Those teens with passive suicide ideation without intent or a plan should be evaluated by a mental health professional in the next few days.

In assessing the teenager, always inquire about school and friends including grades, truancy, drug use, and sexual activity. Be sure to let the teen know that while you appreciate how difficult it is to share such personal and intimate thoughts and feelings, it is your job to ensure their safety; noting that you will need to let others know who can help.

Studies have shown that there is an increased risk of suicidal thoughts and behaviors among adolescents and young adults treated with antidepressant medications compared to placebo. Drug companies have issued black box warnings noting this precaution.

The risks of antidepressant-associated suicidality must be weighed against the benefits of treatment and the long-term risk of suicide in untreated depression.

Current consensus among most mental health specialists is that the benefits of treatment with antidepressants outweigh the risks. However, treatment with antidepressants requires close medical monitoring.

Adolescents and young adults will often not seek out adults unless they feel that they can trust them to maintain respect, confidentiality, and provide useful, helpful information (KidsHealth, 2015).

Men, Depression and Suicide

Suicide remains a major cause of death for men (Conrad & White, 2010). Depression is the leading cause of disability in men; and one of the primary risk factors for suicide (Conrad & White, 2010). Suicide in men is a worldwide phenomenon, death by suicide peaks in the 20's and again in the late 60's and 70's.

Men accounted for 78.8% of the suicides (CDC, 2015), and young men are four times more likely to commit suicide than women. Men choose lethal methods to kill themselves (firearms and hanging in 75% of the incidents).

Risk factors associated with men and suicide (Conrad & White, 2010):

- Use of drugs and alcohol to cope with emotions, relationship issues, and pressures at work
- Social isolation
- Depression
- Living alone
- Not being able to form or sustain a meaningful relationship
- Divorce
- History of abuse
- Imprisonment
- Loss of a loved one (through death or divorce)
- Bullied
- Unemployment
- Loss of independent functioning

Presentation of Depression in Men

In men, depression often manifests in subtle ways, "without sadness" (Conrad & White, 2010). The following signs or symptoms may be the only visible sign of depression:

- Anxiety
- Physical discomfort
- Sleep disturbance
- Irritability
- Drug and/or alcohol abuse
- Decreased energy

In older men, suicide is associated with:

- Depression
- Physical pain and illness
- Living alone
- Feelings of hopelessness and guilt

Risk Factors for Male Depression

Studies have been conducted with depressed men to learn about how they relate to others and their capacity for intimacy and closeness.

Men with depression may lack social support and the means to express suffering and distress. They may not access support services or mental health treatment in time to help them.

Men may feel constrained in confiding with others and therefore lack confidants with whom they can share their troubles.

Men appear to have difficulties with closeness, intimacy, and self-disclosure.

- This involves their reluctance to reveal vulnerability and weaknesses to others
- They may fear being perceived as “weak”
- Men may feel conflict when their need for closeness and intimacy is perceived as dependent
- This conflicts with their image of themselves as independent persons

This may lead men to conceal their problems, especially if they are depressed and attempting to deal with problems on their own.

- For these reasons, confiding in male friends is particularly difficult
- Married men rely heavily on their marital partner for intimacy and support
- Single or divorced men may not have a similar relationship with another person
- The work environment may be a supporting factor for men but varies in its support of closeness or of confidant relationships (U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012)

Inability to Confide in Others

There are theories of the reasons men do not confide in other people. These include:

- Fear of being a burden
- Desire to keep things to themselves
- Waiting for the other to notice
- Belief that others would not understand
- The way they were brought up
- Belief that they are not being listened to
- Being told “You worry too much”
- Fear of rejection

- It can be difficult to talk
- Sense that “I must be okay”
- Being told to snap out of it

(U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012)

Behaviors to Watch For

Behaviors and statements to watch for include (Conrad & White, 2010):

- Talk of extreme work or school stress
- Experiencing a loss and refusing to reach out for help
- Describing self as unsuccessful, overwhelmed with work or school
- Taking action by buying a gun
- Ignoring trauma and refusing to talk or process the event
- Acting in a reckless manner (racing, drinking, sexual activity)
- Giving away treasured belongings

Older Adults and Suicide: Statistics

Older adults are defined by the American Psychological Society [APA], (2019) as adults over the age of 65.

Statistics:

- Older adults make up 12.4% of the general population in the U.S.
- Older adults account for almost 16.6% of all suicides.
- Elderly persons of over 85 were at the highest risk with a rate of approximately 18.6 suicides per 100,000 each year.
- White men over the age of 85, who are labeled “old-old” were at the greatest risk of all age-gender-race groups.
- Though older adults attempt suicide less often than other groups, the rate of completion is significantly higher.

(American Foundation for Suicide Prevention, 2015).

Older Adults and Suicide: Risk Factors

Risk factors in the elderly include:

- Social isolation such as living alone and loss of contacts with friends or relatives
- Widowed or divorced
- Debilitating painful medical illness
- Major illness of a spouse
- Major loss of health that produces significant impairment
- Experiences of recent losses of relationships, especially significant others
- Chronic illness

- Status changes such as retirement with subsequent loss of income, status roles, or independence

(Worthington, 2015)

Older Adults and Suicide: Depression

Depression in the elderly is sometimes mistakenly considered to be a normal consequence of aging. Responding to grief, loss, and brief feelings of sadness are considered adaptive responses to loss. Major depressive disorder is an illness requiring recognition and treatment; not a normal part of aging.

Still, older adults are disproportionately likely to die by suicide.

There are many financial and social hardships associated with aging. However, depression is not a normal response to these challenges.

Similarly, the belief that ongoing depression is a response to serious illness leads to the under-diagnosis of many older adults.

There are currently several healthcare initiatives focused on recognizing and treating depression in older adults as part of a prevention program (Worthington, 2015)

Older Adults and Suicide: Recurring Themes and Recommendations

There are certain recurring themes that commonly present in older adults contemplating suicide. These recurring themes include feelings of:

- Hopelessness
- Helplessness
- Uselessness
- Worthlessness
- Ambivalence
- Burden

Some suggestions for nursing interventions may include:

- Look for potential warning signs
- Monitor risk factors of those in your care
- Actively listen to the underlying concerns of patients in your care
- Conduct a suicide risk assessment in those individuals exhibiting signs and symptoms of depression
- Encourage the family to continue to stay involved with the older adult
- Offer support and encouragement to seek assessment and treatment
- Offer hope

(Worthington, 2015)

Military Personnel and Suicide: Statistics

Statistics:

- In 2011, 301 soldiers took their own life.
- Since the start of the War on Terror, 1,100 soldiers have committed suicide; with the percentages increasing each year for the past six years.
- 18 veterans commit suicide each day.
- Military experts are confused by this trend and have spent 75 million on studies to determine the cause and reverse the trend.
- A Department of Defense noted that over one third of military personnel who committed suicide in 2010 told at least one person they planned to take their life.
- Caucasian service members under age 25 and in the lower ranks were at the highest risk, the same as the year before.

(Burnette, Ramchand, & Ayer, 2015)

Military Personnel and Suicide: Depression

Research into this upward trend describes the moral anguish many soldiers experience upon return to the United States. They must balance a sense of duty with the atrocities experienced during the often confusing and unpredictable war being fought in the Middle East.

Multiple, lengthy deployments, the need to protect each other's back, and feeling responsible when not everyone in the squad returns home contributes to the depression and overwhelming feeling of responsibility that your friend's death was your fault.

In addition, many soldiers find it very difficult to shake off the remnants of this type of war; a war filled with uncertainty. Soldiers fighting in neighborhoods with woman and children; needing to constantly determine if the man walking toward them is a civilian or an insurgent.

Depression and post-traumatic stress disorder (PTSD) have become significant issues in the military. Many personnel return with symptoms including hypervigilance, hyper arousal, and avoidance.

All branches of the military have "gatekeeper" programs designed to educate everyone in suicide prevention (Burnette, Ramchand, & Ayer, 2015)

Military Personnel and Suicide: Risk Factors

The mental health system in the military is understaffed. Civilian contractors have been added to attempt to fill in some of the gaps.

The stigma in seeking mental health services is alive and well in the military. Members are fearful that seeking treatment means "suicide" for their military career. So rather than seek treatment, military personnel attempt to tough it out and succumb to depression and anxiety resulting in a suicide attempt.

There are certain socio-demographic risk factors that have been identified specifically for suicide ideation in military personnel. These include:

- Gender: Males are at highest risk.
- Rank: Enlisted ranks are at higher risk.
- Race: Caucasians are at the second highest risk, with "Other" races being the highest risk.

- Marital Status: Separated/divorced personnel are at highest risk, and single personnel are at the second highest risk level.
(U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012)

Note! The DHCC Clinicians Helpline contact information is: 1 (866) 559-1627 DSN: 662-6563
www.PDHealth.mil

Military Personnel and Suicide: Stressors

Stressors:

- Duty/occupation
- Marriage/other relationships—troubled or ending
- Recent loss or catastrophic event
- Legal issues
- Financial issues
- Serious change in physical health or injury
- Re-entry after deployment or new assignment
- Pending separation/retirement
- Multiple stressors in more than one area

(U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012)

Case Study: Mr. M

Mr. M is a 23-year-old white male who has recently returned home from the Middle East after his second tour and is living with his parents. His mother hears him up at night pacing the hallways. He doesn't seem to want to see any of his friends and frequently secludes himself in the house. His mother also notes that Mr. M is startled by loud noises and becomes easily irritated. What are your thoughts about Mr. M's behavior? What might you suggest for interventions?

Mr. M is at high risk for PTSD and suicide. He is a young man in the military and has been deployed to the Middle East twice. He is demonstrating signs and symptoms of PTSD, including isolation, anhedonia, sleep difficulties and irritability, increasing his suicide risk level. Though military personnel are provided with educational opportunities and encouraged to seek treatment, many young men are hesitant to reach out and ask for help. They are also fearful that such help may affect their military career. Encouraging Mr. M and his family to connect with resources, such as those available with the VA, can provide support that they need.

Family Support and Education

It has been shown that educating family members about how to understand, monitor, and intervene with family members at risk for suicide results in better management and treatment of those identified individuals.

The family knows the suicidal individual better than anyone else. Therefore, it is in the best interest of the patient to engage the family in the care of the suicidal individuals (if the patient agrees to this). After all, it is the family the patient will go home to and live with on a daily basis. However, in order to include the family, you must have the consent of the patient (if 18 or older).

There is great value in family education; especially as they attempt to negotiate the pain, frustration, and fear often associated with the suicidal ideation and behavior of someone they love.

Educational and support group opportunities have been shown to be extremely successful and useful to family members. Consider spending time with the family exploring this option. Education for the family must include how to participate in the care and safety of an individual expressing suicidal ideation (U.S Surgeon General and the National Action Alliance for Suicide Prevention, 2012).

Organizations such as the National Alliance on Mentally Illness (NAMI) have conclusively demonstrated the value of family education and support network education to improve the care of individuals who are at risk. Consider referring the family to this national organization. They offer education, support, and advocacy for mentally ill individuals and those they love (NAMI, 2019).

Caring for Suicide Survivors

A survivor of suicide is a family member or friend who has lost a loved one or to suicide. Survivors are not referring to a person who has lived following a suicide attempt. A suicide survivor may also include nurses and other healthcare professionals if a current or former patient has committed suicide (American Association of Suicidology, 2014).

Family and friends will require a great deal of support; possibly a group dedicated to suicide survivors. Some family members may require individual therapy to deal with the grief, loss, and devastation caused by a completed suicide.

Surviving the Loss of a Loved One

When a loved one commits suicide, the family and friends who survive experience tremendous emotional trauma. These survivors are often left stunned and troubled by the powerful reactions they experience:

- **Shock** is often the immediate reaction to suicide, along with a physical and emotional numbness. These are the ways of temporarily screening out the pain so that it can be experienced in smaller, more manageable steps.
- **Depression** may appear as disturbed sleep, fatigue, inability to concentrate, change in appetite, and the feeling that nothing can make life worth living.
- **Anger** may be part of the grief response, whether directed towards the deceased, another family member, a therapist, or oneself.
- **Relief** may be a part of the reaction when the suicide followed a long decline into self-destructive behavior and mental anguish.
- **Guilt** often surfaces as the feeling, "If only I had done," "If only I had said or not said."
- **Why?** Many survivors struggle long and hard with this question.
(American Foundation for Suicide Prevention, 2019; Wolfelt, n.d.)

Loss of a Loved One by Suicide

To lose someone to suicide is shocking, painful and often unexpected.

The grief that follows is complex and non-linear. The notion that grief follows specific stages is no longer the accepted norm. The evidence demonstrates that grief does not follow a scripted pattern, or time frame. It is different for each person.

Survivors may be struggling with volatile emotions; guilt, fear and shame, well beyond the limits experienced in other types of deaths.

Common emotions family members may experience include:

Shock	Denial	Pain	Guilt
Anger	Shame	Despair	Hopelessness
Sadness	Numbness	Abandonment	Confusion
Self-Blame	Depression	Helplessness	Rejection

Feelings are often frightening and hard to acknowledge; causing a great deal of confusion and fear. (American Foundation for Suicide Prevention, 2019; Wolfelt, n.d.)

Post-vention: Intervention after a Completed Suicide

In the Inpatient Setting:

What to Do if You Find a Patient During or After a Suicide Attempt

Inpatient suicide is the number one sentinel event reported to TJC and other accreditation agencies. Many nurses will come in contact with a patient actively engaged in an activity to end their life or enter a room where a patient has successfully ended their life.

If you find a patient actively engaged in a suicide attempt:

- Do not leave the patient
- Call for help; Code Blue if necessary
- Follow hospital protocol
- Attempt to intervene if safe to do so
- Provide emergency medical attention
- Transfer to ED for further assessment and intervention

If you find a patient that has completed suicide:

- Begin a time line
- Take notes
- Review and follow hospital policy
- Notify supervisor, MD, and next of kin

(Keltner & Steel, 2014)

***Any suicide in the inpatient setting is considered a sentinel event.
It is also considered a sentinel event if the suicide occurs within 72 hours post discharge.***

Post-vention: The Impact of Suicide on Staff Members

The completed suicide of a patient can have a severe emotional impact on nurses. A suicide represents a critical or sentinel event for the nurse and opens the door to self-blame, anger, sadness, and feelings of worthlessness as a nursing professional.

Staff-oriented programs post-suicide allow nursing staff members to process the catastrophic event. These may include:

- Group processing has shown to engender a sense of community among staff members, allowing them to feel less isolated and alone in their thoughts and feelings about the event
- An outside facilitator is often necessary to provide a safe, therapeutic environment
- Staff members may also require the assistance of the employee assistance program or referral to a community based therapist
- The goal: to allow staff to process the event, verbalizing their sense of loss, sadness, and feelings of responsibility for the death. The focus at this time is not education and prevention

(CISM International, 2018; Wang et al., 2016)

Suicide as a Reported Event

The Joint Commission has continued to report suicide in the top five reported events that occur in hospitals (TJC, 2018b).

The methods of suicide included hanging, asphyxiation by other than hanging, gunshot, jumping from a height, drug overdose, laceration, drowning, other methods (e.g., jumping in front of a moving vehicle, ingestion of poison, stabbing, or burning).

Approximately 75% of individuals that attempt suicide exhibit verbal or behavioral warning signs; though 25% of individuals do not show any warning signs at all (Caruso, n.d.).

In order to identify potential warning signs, healthcare providers must know what to look for, what to ask, and be prepared to intervene. Intervention must be immediate. Safety is the number one priority.

Warning Signs: Inpatient Setting

There are certain verbal and behavioral signs that can offer a warning of suicide ideation. According to the American Foundation for Suicide Prevention, the following verbal and behavioral clues should alert healthcare providers of possible suicidal intention:

Verbal Clues:

- Talking about wanting to die or to kill oneself
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Talking about seeking revenge
- Talking or writing about death or suicide
- Expressing excessive guilt or shame

- **Behavioral Clues:**

- Looking for a way to kill oneself, such as searching online or buying a gun
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing from family or friends
- Actively isolating from social activities
- Showing anger or rage
- Displaying extreme mood swings
- Acting impulsively
- Losing interest in activities
- Experiencing a change in sleeping or eating habits
- Performing poorly at work or in school
- Giving away prized possessions
- Writing a will

(Keltner & Steel, 2014)

Prevention

Suicide prevention is about:

- Promoting awareness that suicide is a preventable problem
- Reducing stigma associated with mental illness and substance issues
- Implementing training to assist healthcare professionals recognize suicide risk factors and behaviors that indicate suicide potential
- Obtaining effective treatment
- Developing and implementing suicide prevention programs
- Improving access to care
- Linking individuals up with community agencies
- Initiating/continuing research

(Keltner & Steel, 2014)

Support Organizations

There are several organizations dedicated to understanding and preventing suicide. These are listed in the Resources section at the end of this course.

Steps to Preventing Suicide

In order to initiate steps to prevent suicidal attempts, the nurse should clearly define the problem and identify risk and protective factors. Once these are identified and documented, interventions should be developed and tested to ensure reliability. Thereafter, interventions can be implemented and evaluated for effectiveness.

Documentation should be comprehensive and include notations on all the steps of the nursing process (Keltner & Steel, 2014)

Conclusion

Nurses are in the ideal position to recognize the warning signs and symptoms of a suicidal patient and make necessary interventions to improve outcomes. The nurse's role in assessing suicidal ideation and intention, conducting a lethality assessment and implementing suicide prevention strategies can have a significant impact on lowering suicide rates today.

The nurse is also involved in providing support and education to the patient and the family and making referrals to the appropriate community support services.

Resources

Historical documents:

- The President's New Freedom Commission on Mental Health. Achieving the Promise: Transforming Mental Health Care in America: <https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/downloads.html>
- Institute of Medicine. Reducing Suicide: A National Imperative: <http://iom.nationalacademies.org/~media/Files/Report%20Files/2002/Reducing-Suicide-A-National-Imperative/Suicide1pagerFINAL.pdf>
- Department of Public Health. The Surgeon General's Call to Action to Prevent Suicide: <http://www.sprc.org/sites/sprc.org/files/library/surgeoncall.pdf>
- The Joint Commission Sentinel Event Data: https://www.jointcommission.org/se_data_event_type_by_year/
- The National Strategy for Suicide Prevention. Department of Health and Human Services: <http://www.sprc.org/sites/sprc.org/files/library/nssp.pdf>

Other resources:

- American Association of Suicidology: <http://www.suicidology.org/>
- American Foundation for Suicide Prevention: <http://www.afsp.org/>
- SPRC: Suicide Prevention Resource Center: www.sprc.org
- Suicide Awareness Voices of Education: <https://save.org/>

National Suicide Prevention Lifeline

1-800-273-TALK (8255)

This 24-hour, toll-free hotline is available to those in suicidal crisis.

<http://www.suicidepreventionlifeline.org/>

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