Suicide Assessment and Prevention

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Contact Hours: 1.5 (ANCC) and 1.8 (ABN) contact hours valid November 18, 2019 - November 17, 2021

Target Audience: All RNs, LPNs, and Advanced Practice Nurses. Especially Psychiatric/Mental Health Nurses.

Purpose/Goal: Nurses will be aware of suicidal warning signs and risk factors, where to find help for their own negative feelings and fears, and how to locate resources for patients.

Fees: ASNA Member - $ FREE Non-Member - $15.00

Instructions for Credit: Participants should read the purpose/goal and objectives and then study the activity on-line or printed out. Read, complete, and submit answers to the post-test at the end of the activity. Participants must complete the evaluation on line and submit the appropriate fee to receive continuing nursing education credit. The certificate of attendance will be generated after the evaluation has been completed. ASNA will report continuing nursing education hours to the ABN within 2 weeks of completion.

Accreditation: *The Alabama State Nurses approved as a provider of* ***nursing continuing professional development*** *by The Mississippi Nurses Foundation, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation*.

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Suicide Assessment & Prevention

Suicide, a public health concern has reached epidemic proportions in both the United States (U. S.) and globally. The World Health Organization has estimated that roughly 1 million individuals die each year from suicide. CDC published in 2013 that there were 41,149 suicides in the U. S., or one person every 13 minutes. During this same timeframe 1.3 million adults made an attempt, Included in this number is that 200,000 did not make a suicide plan. To further emphasize the magnitude of suicide are the results from a 2002 investigation by the Institute of Medicine (IOM) when they provided a comparison to the 58,000 who died during the Viet Nam War (1968-1973) due to war related causalities to the 220,000 U.S. citizens who took their own life during that same timeframe. The number of suicides exceeds homicides by a ratio of 3:2. In 2010 SAMHSA (Substance Abuse and Mental Health Services Administration) stated that yearly over 1,100,000 people attempt suicide and 8.4 million adults have serious suicidal thoughts. Worldwide methods differ by geographic areas. In Latin America and most Asian countries individuals select poisoning with pesticides. Drug poisoning is most common in Scandinavian countries and the United Kingdom. In U. S. fire arms are the most often selected. Citizens of Hong Kong and Singapore select as the preferred method of suicide, jumping from high places. Hanging is most common in Eastern Europe and Pakistan. It is important to note the geographic areas as the U. S. has a large immigrant population. Very often this public health concern is preventable.

Nurses are 'front line' in the prevention of suicide. Nurses and especially psychiatric mental health nurses are key providers of care for suicidal patients, which include crisis intervention, education in general about suicide, postvention after the attempt, and screening services. SAMHSA states that up to 45% of all individuals who die by suicide have visited their primary care provider within a month of their death. These individuals are not necessarily coming for psychiatric/mental health issues. Two-thirds of individuals who attempt suicide receive medical attention as a result of their attempt. All of these numbers are reinforcing that nurses are truly the front line and we have a unique opportunity to make a difference. Areas where we can intercede include the following: 1.) observation of mood and/or behavior and follow-up if warning signs are noted, 2.) enabling patients and/or family members to recognize that the physical complaints may be depression or other mental health issues, and 3.) providing information that there are alternatives to feeling depressed and you can help them find resources for help. The National Institute of Mental Health believes that individuals who commit suicide differ from others in the way they think, react, and engage in decision making. They state that there are differences in attention, memory, emotion, and planning. These differences often correlate with anxiety, depression, and substance abuse. It is not uncommon for suicidal behavior to be triggered by personal loss or violence. Therefore, it is crucial that we as nurses are cognizant of our patient's mental health and their recent life events in our assessments. It is also important to note that not all individuals with the same risk factors react the same way and not all attempt suicide. Reaction to stress by contemplating or attempting suicide is not normal. This behavior is not a harmless bid for attention but a sign of extreme distress. Before helping you must recognize overt and covert signs and symptoms of suicidal behavior. The following list is random as each individual may exhibit any one or combination of symptoms.

Suicidal warning symptoms/risk factors include the following:

- neglecting appearance or hygiene
- giving away cherished possessions
- isolating self from family/friends
- insomnia
- taking a sudden interest or losing interest in religion
- hallucinations (especially command where the voices tell you to hurt self)
- exhibiting sudden improvement in mood after being profoundly depressed or withdrawn
- feelings of being hopeless or helpless such as expressing that life has no meaning
- scheduling medical appointment for vague symptoms
- direct verbal clues such as, "I'm going to end it all" or "I wish I was dead"
- indirect verbal clues such as, "What's the point of going on (or living)", "Soon you won't have to worry about me", or "Who cares if I'm here or not"
- talking about death or suicide
- prior suicide attempts
- current psychiatric history especially bipolar, depression, schizophrenia, and/or has substance abuse issues (alcohol or drugs)
- stress which can either initiate or intensity suicidal impulses
- family history of suicide
- family history of a mental disorder or substance abuse
- family violence, including physical and sexual abuse
- firearms in the home
- incarceration
- being exposed to others' suicidal behavior (family member, peers, media figure)

The National Institute of Mental Health has identified certain medical conditions with a higher correlation with suicides as compared to other diseases. They are congestive heart failure, chronic obstructive lung disease, moderate to severe pain, urinary incontinence, any diagnosis of a terminal illness, HIV +, and anxiety disorders.

Women are more likely to attempt suicide as compared to men. Their usual methods are overdose or cutting their wrists - both methods have a lower incidence of success. Older Caucasian men have the highest rate of suicide as compared to other population groups. Often they are widowed. Their suicidal rate outnumbers women 3:1. The usual method is a gun, which has the highest rate of success. Men have fewer attempts per completed suicide as compared to other groups. Men usually plan well in advance; however, they often provide clues as to the proposed intent with non verbal clues such as changing their will, giving possessions away, and expressing thoughts about nothing to live for anymore . Suicide rates are higher in rural areas especially the Rocky Mountain and Western states. Individuals in this part of the country usually use a firearm and as stated before a firearm has the highest rate of death.

Suicide is the second leading cause of death for adolescents and young adults (ages 15-24). Although, they are less apt to be successful with approximately 11 deaths per 100,000. Several factors are involved.

One is increased alcohol and substance abuse, availability of firearms, and the onset of depression and schizophrenia. This group tends to have a dual diagnosis or impulsive/aggressive behavioral problems and legal issues (often related to aggression).

Unemployment is associated with an increased rate of suicide. It is known that alcohol consumption and marital discord increases with unemployment and both are indicators of an increased suicide rate. Economic status has an impact. Research has shown that the lowest - low incomes and highest - high income levels have the most incidences of suicide.

There are some protective factors in the prevention of suicide. One is being married. Divorced, widowed, or single individuals have a higher rate of suicide. Being a parent, especially being a mother has protective factors for prevention of suicide. Women who are pregnant have a much lower rate of suicide. Religion tends to have protective factor. There is really no quality research demonstrating which religion has the most protective impact. However, areas of the country with fewer individuals with religious affiliation have higher incidences of suicide. It is believed that religion provides a social support system and way to cope with stressors and it provides a sense of purpose. Also individuals with religious affiliation tend to abuse alcohol and drugs less often and have fewer divorces - all of which are associated with higher suicidal risks. All industrialized countries have higher rates of suicide as compared to more rural or agrarian economies. An exception is the U. S. which has only a moderate level of suicides especially as compared to Russia and Eastern European countries.

Myths about suicide include the following: Myth #1 is a belief that if individuals threaten suicide they are seeking attention & not really suicidal and often seeking secondary gains just to gain admission to a hospital. The truth - take all suicidal talk seriously and evaluate appropriately. Myth #2 is that if a person directs their anger at someone else they will not consider suicide. The truth - individuals may be suicidal and homicidal at same time. Myth #3 is the reliability of having a person sign a 'no harm contract' or 'no suicide promise'. The truth - these are not reliable, often misleading and do not prevent suicides. Myth #4 People who talk about suicide rarely harm self. The truth - over 80% of all individuals who attempt suicide have spoken to a health care professional, especially nurses before the attempt and the majority have visited a healthcare provider in the preceding month. Sometime the clues are covert such as, "No one will care if I live or not". Take all clues seriously, assess body language that might imply suicidal thoughts. Myth #5 if a person attempts suicide and is unsuccessful they rarely try again. The truth - somewhere between 25% and 50% (depending on references) of those with successful suicide attempts have previously attempted suicide.

Nurses' attitudes and beliefs about suicide impact their delivery of their care. Before discussing appropriate intervention by healthcare workers - especially nurses it is imperative to review attitudes and beliefs influencing care. The literature cites several reasons impacting nurses' attitudes. They include prior experience with suicidal patients, religious beliefs, and level of education. Nurses also cite lack of knowledge and training and unfavorable attitudes of some nurses regarding suicide. Cultural aspects can also factor into the equations. The gamut can run from believing that suicidal patients are immortal by nurses in Ghana to the belief that suicide is a crime and the suicidal person is blameworthy. Nurses with negative attitudes frequently exhibit anxiety, avoidance, hostility, and rejection. Negative attitudes impact the quality of care and result in patients feeling hopeless, rejected, and worthless. The literature

suggests that most nurses just do not know what to say to a suicidal patient and therefore choose to remain silent. The reason being a fear of making matters worse which could lead to additional harm. Other nurses are said to be unsure if the patient is really serious and choose just to remain silent. Nurses are not the only health care providers skeptical about prevention of suicide. Some relate apathy and do not think the person is truly ill. Nurses with intense personal responses about suicide may have difficulty in communicating about suicide. They will admit to having feelings of sympathy and not empathy and therefore are unable to assess the patient adequately. An overriding theme is fear that if I cannot help it then becomes a personal failure if the person commits suicide.

Assessing for suicidal ideations is time consuming. Negative attitudes are more often noted in nurses (and other healthcare workers) in the emergency room as compared to a psychiatric hospital/unit staff. Nurses in the emergency room tend to have the most difficulty communicating with these patients; probably because they work from a biomedical mode and this is not always appropriate with psychiatric/mental health patients. The nurse in the emergency has the goal to assess, treat, and discharge quickly. Oncology nurses usually have the most difficult time dealing with suicidal patients in general, probably because their values are dedicated to preserving life. The nurse population with the greatest ease in communicating with suicidal patients are older medical-surgical nurses who had a higher level of education and/or strong religious conventions.

Education and training helps to change values and improve nurses' detection skills. Nurses' beliefs and attitudes should be addressed in training programs. Yet suicide assessment/prevention is not in the curriculum of most schools. After graduation selected training is episodic in work settings. Often nurses must seek this information out because of a perceived need. Very few programs include firearm safety yet most successful suicides involve a gun. Two agencies known for suicide prevention training include the Suicide Prevention Resource Center (SPRC) and American Association of Suicidology (AAS) have both developed evidenced - based competencies and training programs for suicide assessments. Yet nurses have never been targeted nor has this evidenced - based training been incorporated into education or practice. Nurses who have received training show increased knowledge and most important of all, confidence in the ability to assess and intervene appropriately when necessary. Successful training programs include Gatekeeper training which enables the learner to communicate by interviewing using indirect interrogation. This training helps the learner to recognize warning symptoms and communicate effectively. Two different online programs especially helpful to nursing include QPR (Question, Persuade, and Refer) (www.qprinstitute.com) for nurses and ASIST (Applied Suicide Intervention Skills Training). QPR is 6 - 8 hours in length. Content includes knowledge and attitude about suicide, increasing the nurse's comfort level to assess suicide, perform a triage assessment (acute risk, address immediate patient safety needs, and determine most appropriate setting for care). ASIST (www.livingworks.net/programs/asist/) is 14 hours. The participant is taught "suicide first aid". You learn about suicide risk and how to respond in a manor to improve safety and how to link to resources. It does employ simulations for skill development. Other very successful programs include the Oklahoma Department of Mental Health and the Tennessee Lives Count Project. All of the programs contain the same basic information - knowledge and attitudes about suicide, interviewing in a non-threatening way using indirect interrogation to assess immediate safety needs, and determine a safety plan.

Recognition of the warning signs in the before mentioned are formal time consuming programs. However, many nurses at the point of direct care may not have access to these programs. The nurse's role is to identify the potential suicidal patient. There are assessments available that you can use keep your patients safe. Many screening tools are available. Two common ones are the Beck Depression Inventory (21 items) and the Geriatric Depression Scale, both readily available online. In fact the Geriatric Depression Scale is available as a phone app in the I-Tunes store. Screening tools are only for identification of at-risk individuals needing follow up. Depression and suicide often go hand in hand. There are several screening measures specific to suicidal ideation. They are the Index of Potential Suicide, Reasons for Living Inventory (available for various ages) and Suicide Attempt Self-Injury Interview. These are available online. The screening tools mentioned in this paragraph are somewhat lengthy and often only used by psychiatric/mental health nurses for a more in depth assessment. Multiple different short answer screening tools are available from local Mental Health associations. The tools may be completed by patients in the waiting room and provide a basis for discussion. Most of the tools involve yes/no answers and are 5 - 10 questions in length.

Specific assessments and questions that all nurses can use include the following:

- evaluate changes in behavior
- discuss with them (and family/significant others) that the underlying cause of the physical complaints may be depression (or other mental health concerns)
- let patients know there are other options to feeling depressed and you can help them find resources for help
- be alert to warning signs of suicide
- home health nurses should be observant for stockpiling medicines or buying a gun
- school nurses should be alert to special adolescent signs and symptoms such as volatile mood swings or sudden changes in behavior, abusive relationships, unexplained signs of trauma, self-mutilation, eating disorders, gender identity issues, sudden deterioration of appearance, fixation with death, depression
- Once the realization is made that the patient is at risk for potential suicidal ask addition screening questions in a non-threatening manor such as:
    - Sometimes when people are sad they have thought of harming or killing themselves. Have you had these thoughts?
    - Do you wish you could just go to sleep and never wake up again?
    - Are you thinking about hurting or killing yourself?
    - Have you been thinking about death recently?
    - Are you feeling hopeless?
    - Have you ever had a suicide attempt?
    - Do you have a plan for suicide? Will you share that plan with me? (NOTE: if they refuse to share the plan that are at greater risk of suicide.)

It is important to know that asking individuals if they have suicidal thoughts does not reinforce or initially give them the idea of suicide. The act of asking the questions implies that you care and the patient's welfare is important to you. Most mental health professionals feel the initial assessment often do not

include enough question to ascertain the essential evidence of a suicidal thought. The morale of the story is to ask more than one question more than one in a different format.

Once warning signs are identified, the next move is to keep the patient safe, while providing empathy and support. Call for help and depending of the severity of the issues either 911 or their mental health professional. If the person is not hospitalized it is imperative to access the mental health system or social services. Ensure that the person has a follow up appointment and inform someone close to the patient to not only monitor behavior but also ensure they keep the follow up appointment. Emphasize the need to never leave the patient alone until they keep the follow up appointment. Support the family and/or significant other and let them know how important they are in helping the patient through the crisis. It is absolutely necessary to limit access to a means of suicide, i.e., removing all firearms, or knives/other sharp objectives if a plan includes cutting their wrist, have someone else assume responsibility for all medications and remove stockpiles of medications, etc. In short, ascertain desired means of suicide and remove that object, but the one exception is always removal of firearms regardless of the person's plan as firearms are the number one means of suicide in the U. S.

Options for treatment include hospitalization, additional psychiatric evaluation, or close out patient supervision. Not every suicidal patient needs to be hospitalized if there is someone who can remain with them and ensure that the can be followed up immediately. At times patients are hospitalized against their will if they are in imminent danger of hurting self or others. Wherever the setting the usual treatment plan includes treatment for any underlying issue(s) such as depression, substance abuse, etc.; medication adjustment; counseling; self management techniques and education. Ongoing treatment will be evaluation of suicidal thoughts, developing self esteem and social support. Nursing care is essential in these areas.

Additional Resources include 911 if you feel there is imminent danger and remain with the patient (or on the telephone) until help arrives. Another resource is National Suicide Prevention Lifeline (1-800-273-TALK (8255). Carry this number with you if a home health nurse or have the number posted at home if there is a prior history of suicide. If the person is a veteran contact - the Veterans Crisis Line at (1-800-273-8255) (same as the National Suicide Prevention Lifeline) and press 1 for veterans. Veterans can also access an online chat at www.VeteransCrisisLine.net. Other resources include the Suicide Prevention Resource Center (http://sprc.org/) and Suicide Prevention at the National Institute of Mental Health. Additional resources include American Foundation for Suicide Prevention (www.afsp.org); American Association of Suicidology (http://www.suicidology.org), American Psychiatric Nurses Association (www.apna.org/i4a/pages/index.cfm?pageID=1/), Indian Health Service (www.ihs.gov/suicideprevention), and Emergency Nurses Association Practice Guidelines (www.ena.org/practice-research/research/cpq/documents/suicideriskassessmentcpq.pdf/); American Foundation for Suicide Prevention (http://www.afsp.org/); National Center for Injury Prevention and Control (http://www.cdc.gov/ncipc/); Suicide Prevention Action Network USA (http://www.spanusa.org/); and National Suicide Prevention Lifeline (http://www.suicidepreventionlifeline.org/).

Nurses can and do make a difference in the prevention of suicide. It involves asking a few additional questions, observing body language, and reflecting on past history. The take home message is that suicide is a preventable public health concern and we the front line workers can make a difference.

Selected bibliography:

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Suicide Assessment and Prevention

1.5 contact hours (ANCC) and 1.8 contact hours (ABN) ~ Activity #: 4-0.1006

POST TEST & EVALUATION

Name: _____ Fee and Payment Method

Address: _____ _____ ASNA Member free

_____ _____ Non Member $15

City/State/Zip Nursing License #: _____

Phone: _____ Email: _____

Check - Make Payable to ASNA _____ Visa _____ M/C _____ Exp. Date

_____ _____

Card Number Signature

Answer the following questions with the most appropriate answers.

1. Suicide is often associated with which of the following conditions?
   A. Depression and Alzheimer's Disease
   B. Hallucinations and depression
   C. Hallucinations and autism
   D. Autism and bullying

2. Which of the following statement are true?
   A. A no harm contract will make a person think twice before harming self.
   B. Any suicidal patient needs to be hospitalized.
   C. A homicidal person is unlikely to harm themselves.
   D. A previous suicidal attempt is a good indication of harming self in future.

3. According to SAMSHA at least _____ % of patients have visited a health care provider within one (1) month of their suicide.
   A. 40
   B. 45
   C. 50
   D. 55

4. List at least 6 suicidal warning signs.
   A.
   B.
   C.
   D.
   E.
   F.

5. Provide at least one (1) example of what you plan to incorporate into your practice or into private life to prevent suicides from occurring.

ACTIVITY EVALUATION

GOAL: Increase nurse's awareness of their value as the first line of defense and provide resources in suicide prevention.

Circle your response using this scale: 3 – *Yes* 2 – *Somewhat* 1 - *No*

Rate the relationship of the objectives to the goal of the activity	3		2		1
Rate your achievement of the objectives for the activity	3		2		1
Objectives:					
1. Recognize suicidal intentions and respond appropriately.	3		2		1
2. Provide resources for patients and families/significant others to support ongoing efforts to prevent suicide.	3		2		1
Program free of commercial bias	3		2		1
On a scale of 1 (low) – 5 (high) knowledge of topic before home-study	5	4	3	2	1
On a scale of 1 (low) – 5 (high) knowledge of topic after home-study	5	4	3	2	1

How much time did it take you to complete the activity? _____hours _____minutes.

ADDITIONAL COMMENTS:

_____

_____

Complete form and return to: ASNA, 360 N. Hull St., Montgomery, AL 36104
If paying by credit card, may fax to 334-262-8578