Suicide Prevention

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Purpose

The purpose of this course is to provide current information about suicide prevention and the effects of toxic stress and secondary traumatic stress on suicide among nurses as well as preventive measures and ethical concerns.

Goals

Upon completion of this course, the nurse should be able to:

- Discuss current statistics regarding suicide.
- List the 3 most common methods of suicide.
- Discuss at least 8 risk factors for suicide.
- Discuss at least 10-warning signs for suicide.
- Describe 5 screening tools to assess suicide risk.
- Discuss the SAFE-T guidelines.
- List 4 crisis/hotlines.
- Explain issues related to guns and suicide.
- Discuss 7 elements of a safety plan.
- Discuss 3 types of treatment.
- Discuss 4 workplace issues that may contribute to toxic stress.
- List at least 7 common indications of toxic stress.
- Discuss 4 steps to reducing stress in the workplace.
- Discuss 4 types of symptoms associated with secondary traumatic stress.
- List at least 8 factors that increase risk of suicide in nurses.
- Describe 5 screening tools for health professionals.
- Discuss assessing nurses for suicide prevention.
- Discuss 2 special considerations as part of safety planning for nurses.
- Discuss 4 issues regarding referrals for a substance use disorder program.
- Describe the NIMH 5-Step Prevention.
- Discuss 6 ethical and legal considerations.

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Introduction

Suicide is the 12th leading cause of death overall in the United States but the third leading cause of death in young Americans. Suicide is an increasing problem. In the United States, the rates of suicide increased 30% between 2000 and 2020.

In 2020 alone, approximately 46,000 people died by suicide with an estimated 1.4 million suicide attempts. Males are almost 4 times more likely to commit suicide than females. There is a marked increase in suicides at about age 15. With males, suicide rates are highest in those age 75 and older, likely because of limitations associated with aging. However, among females, suicide rates are highest during middle age, 45 to 64.

According to the CDC:

> In 2020, suicide was the second leading cause of death for people ages 10–14 years and 25–34 years, the third leading cause for people ages 15–24 years, the fourth leading cause for people ages 34–44 years, the seventh leading cause for people ages 45–54 years, and the ninth leading cause for people ages 55–64 years.

Additionally, military veterans are especially at risk. Suicide is the second leading cause of death in veterans under age 45. In 2020 alone, 6,146 veterans died by suicide.

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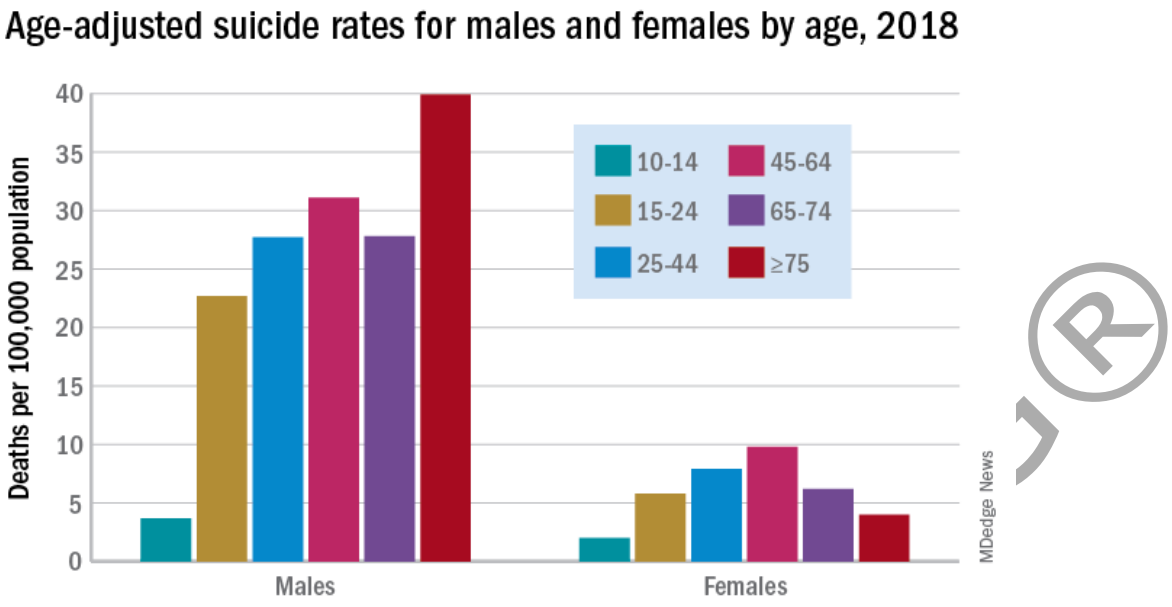

Note: Based on data from National Vital Statistics System.
Source: National Center for Health Statistics

The most commonly used method of attempted suicide is drug overdose, but this results in about a 4% fatality. Guns, however, are the most lethal means of attempted suicide, resulting in about an 85% to 90% fatality.

Methods of suicide include:

- Firearm suicides: 50%
- Suffocation suicides: 27%
- Poisoning suicides: 12%
- Other: 11%

The highest rates of suicide are among non-Hispanic Native Americans and Alaska Native people followed by non-Hispanic White people. People who live in rural areas are more likely to commit suicide than those in urban areas, perhaps because of less access to services and more isolation. People facing transitions, such as those retiring from work or moving from high school to college are at increased risk.

Some people are more resilient than others, and these people are often able to navigate difficulties without increasing their risk of suicide. Protective factors are those that promote resilience and decrease the risk of suicide:

- Effective coping skills.
- Strong sense of identity.
- Strong support system

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- Access to mental and physical healthcare.

Risk factors

The first step in suicide prevention is to identify those at risk. The primary risk factors for suicide include:

- Mental health disorders (personal or family history), such as depression, bipolar disorder, and schizophrenia.
- Substance use disorders (personal or family history).
- Chronic illness and pain.
- History or previous suicide attempts. (While most people do not go on to commit suicide, about 1 in 10 do.)
- Exposure to family violence: physical, sexual.
- Presence to guns/firearms in the home.
- Recent incarceration.
- Exposure to other's suicidal behavior: family, friends, celebrities.
- Being a White male: This group has the highest rate of suicides. White males accounted for almost 70% of suicidal deaths in 2020.
- Military service: Veterans have a 57% higher risk of suicide than the general public. They are especially vulnerable during times of transition, such as when they return from combat or leave military service. LGBTQ+ veterans have 7 times the rate of suicide than non-LGBTQ+ veterans. Up to 31% of veterans suffer from PTSD after returning from combat, and 10% experience substance abuse disorders. Federal statistics regarding veteran suicide do not include drug overdose deaths, which are often related.

Warning signs

Sometimes, life stresses may push a person toward suicide, especially if they also have other risk factors. Some behaviors or factors that indicate that a person is at serious risk of suicide include when the person:

- Talks about feeling trapped (family obligations, bills, responsibilities, bad marriage, unfulfilling job).
- Complains of unbearable emotional or physical pain.
- Believes he or she is a burden to others, such as friends or family.
- Increasingly relies on drugs or alcohol to deal with stress.
- Exhibits anxiety, agitation, and/or reckless behavior.
- Sleeps too much or too little.
- Becomes increasingly withdrawn and isolated.
- Becomes enraged and/or talks about seeking revenge.
- Exhibits wide mood swings.

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- Experiences bullying.
- Changes eating habits.
- Talks about feeling great guilt or shame.

Behaviors that indicate more immediate risk for which the person should be referred immediately to a mental health professional or emergency services include when the person:

- Directly expresses the wish to die or to commit suicide.
- Begins searching for a means to carry out suicide, such as by obtaining a gun or searching the Internet.
- Expresses the feeling that life is hopeless and there is no reason to live.

While most people who are unsuccessful in a suicide attempt do not go on to commit suicide, a previous attempt does increase the risk of suicide.

Provide screening tools/Services

It's important to have screening tools readily available to assess risks for suicide, especially for those who have risk factors, but screening should be done routinely because people may be at risk of suicide without outward indications. Nearly half of those who commit suicide visited their primary care doctors in the month prior to their deaths and a quarter were seen in emergency departments for nonpsychiatric reasons in the year prior to their deaths.

Because firearm suicide is so common (and is the most common method of suicide among male nurses), screening should always include asking the person about access to firearms.

The National Institute of Mental Health provides the **ASQ** (Ask Suicide-Screening Questions) suicide screening tool, which is designed for use by outpatient primary care and specialty clinics.

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NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

The Next Steps outlines actions to take based on responses.

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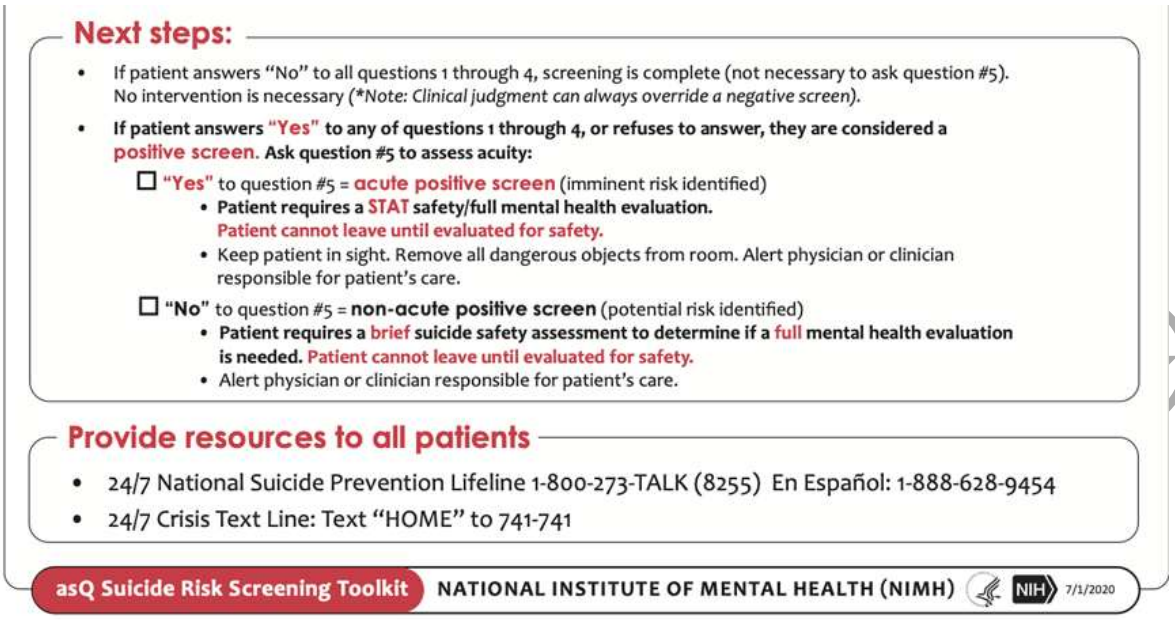

Another screening tool that is often used for patients in primary care is the **Patient Health Questionnaire-9 (PHQ-9)**. This tool asks about 9 problems, such as feeling depressed or having little pleasure in doing things and the frequency and a 10th questions about how difficult the problems have made functioning.

The 19-item **Scale for Suicide Ideation-Worst** is appropriate for inpatients and outpatients and is interviewer administered. It measures a patient's attitudes, behaviors, and plans to commit suicide to estimate suicide risk.

The 21-item **Beck Scale for Suicide Ideation** is a self-screening tool for inpatients and outpatients to measure the degree of suicidal ideation within the previous week. There are an initial 5 screening items and if the patient reports any desire to end life, then the patient responds to the additional 14 items.

The **Columbia-Suicide Severity Rating Scale (C-SSR)**, an evidence-based tool developed by the Columbia Lighthouse Project, is free to use and requires no license. Different versions of the rating scale are available at < https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/healthcare/>. For example, there are protocols for families, friends, and neighbors, healthcare, schools, miliary, corrections, first responders, governments, and researchers.

This version can be used by primary care clinicians or by individuals to self-report.

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Columbia-Suicide Severity Rating Scale (C-SSRS)

*Screen with Triage Points for **Primary Care***

Ask questions that are in bold and underlined.

Ask Questions 1 and 2	Past month YES	NO
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you had any actual thoughts of killing yourself?		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Have you been thinking about how you might do this? e.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it."		
4) Have you had these thoughts and had some intention of acting on them? as opposed to "I have the thoughts but I definitely will not do anything about them."		
5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
6) Have you ever done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: Was this within the past 3 months?**	**Lifetime** / **Past 3 Months**	

Recommended response protocol:

Response Protocol to C-SSRS Screening (use protocol in accordance with clinical judgment)

Risk Level	Suggested Interventions
High Risk Suicidal ideation with intent or intent with plan in past month (C-SSRS Suicidal Ideation #4 or #5) ***or*** Suicidal behavior within past three months (C-SSRS Suicidal Behavior)	Call 911 for transport to the emergency room or contact community crisis line in your area to provide on-site evaluation. Place individual in a room that is away from exits but close to staff where patient is observed at all times until help arrives.
Medium Risk Suicidal ideation WITHOUT plan, intent or behavior in past month (C-SSRS screen #2 or #3) ***or*** Suicidal behavior more than three months ago (C-SSRS Suicidal Behavior)	If patient is already receiving mental health treatment, get release of information. If not, refer to mental health provider for further assessment (within one week). Consider pharmacological treatment. Provide education on safe fire arms storage, suicide warning signs and 1-800-273-TALK (8255) and local contacts.
Low Risk Wish to die (C-SSRS Suicidal Ideation #1) without plan, intent or behavior ***or*** Suicidal ideation more than one month ago WITHOUT plan, intent or behavior (C-SSRS screen #2 or #3)	Assess for any other mental health or substance use conditions and consider behavioral health and/or pharmacological treatment. Provide education on safe fire arms storage, suicide warning signs and 1-800-273-TALK (8255) and local contacts.

If an individual is identified as having suicidal ideation, then the SAFE-T (Suicide Assessment Five-step Evaluation and Triage) can serve as a guide.

This tool is based the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behavior.

The SAFE-T program has incorporated the Columbia-Suicide Severity Rating Scale (risk assessment version) as an evidence-based suicide risk assessment process. https://www.psychiatry.org/patients-families/suicide-prevention
This version of the C-SSR assesses both risks and protective factors and is recommended by the Joint Commission.

In addition to the initial C-SSR screening (above, step 1), this version of the C-SSR assesses additional information to give a more detailed picture of the individual's suicidal ideation.

Activating Events: □ Recent losses or other significant negative event(s) (legal, financial, relationship, etc.) □ Pending incarceration or homelessness □ Current or pending isolation or feeling alone **Treatment History:** □ Previous psychiatric diagnosis and treatments □ Hopeless or dissatisfied with treatment □ Non-compliant with treatment □ Not receiving treatment □ Insomnia **Other:** □ _____ □ _____ □ _____	**Clinical Status:** □ Hopelessness □ Major depressive episode □ Mixed affect episode (e.g. Bipolar) □ Command Hallucinations to hurt self □ Chronic physical pain or other acute medical problem (e.g. CNS disorders) □ Highly impulsive behavior □ Substance abuse or dependence □ Agitation or severe anxiety □ Perceived burden on family or others □ Homicidal Ideation □ Aggressive behavior towards others □ Refuses or feels unable to agree to safety plan □ Sexual abuse (lifetime) □ Family history of suicide

The SAFE-T C-SSR also includes questions about protective factors and suicidal intent:

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)	
Internal: □ Fear of death or dying due to pain and suffering □ Identifies reasons for living □ _____ □ _____	**External:** □ Belief that suicide is immoral; high spirituality □ Responsibility to family or others; living with family □ Supportive social network of family or friends

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	□ Engaged in work or school

It's important to remember that if an individual is at acute risk of suicide, protective factors may not prevent the person from carrying out a suicide attempt. Priests, for example, who believe that suicide is a mortal sin, still commit suicide.

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent	
C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)	**Month**
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous (0) Does not apply.	

Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	

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Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others and to end/stop the pain (3) Equally to get attention, revenge or a reaction from others (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	

When assessing individual for suicidal ideation, the person conducting the interview should express empathy and support and recognize that patients often feel ambivalent about suicide prevention if they feel that death is preferable to a life with some type of emotional or physical suffering. It's important to reassure the patient that there is an alternative and that services are available to help. The interviewer should conduct the interview as a collaborative conversation rather than simply reading off a checklist.

Information about hotlines and crisis services should be posted where it is easily seen, such as in waiting rooms, bathrooms, treatment rooms, and community bulletin boards. These services are available 24 hours a day and provide confidential support. Additionally, one can call 9-1-1 for emergency assistance.

- Veterans Crisis Line: 1-800-273-8255 (press 1) or send text message to 328255
- Veteran's Crisis Chat: <https://www.veteranscrisisline.net/get-help-now/chat/>
- Crisis Text Line: 741741 (text HELLO)
- Suicide and Crisis Lifeline: 988 (Call or text)
- Emergency services: 9-1-1

Hotlines and crisis services

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Safety planenvironments/Gun Safety

Since half of all suicides result from firearms, reducing access to guns is a critical element in suicide prevention. However, state laws regarding guns vary widely with some states having few regulations at all. There is an estimate of 300 million guns in the United States, and many are stored loaded. In fact, a national survey found that only 46% of gun owners store their guns safely, and only 55% of those with children under age 18 do so.

Regardless of states laws, all guns should be stored unloaded in a securely locked container with the ammunition stored separately. Studies show that 75% of children know where their families' "hidden" guns are stored. Various types of safety locks are available, and providing these devices to gun owners—or at least providing information about them—can help to reduce access.

In the United States, firearms are the number one cause of death among children, and 30% of those deaths are attributed to suicide. Death by firearm suicide among children increased 89% from 2010 to 2022. In 2020, 1.7 per 100,000 children died by firearm suicide compared to a rate of 0.2 per 100,000 children in comparable countries. Adolescents, who often act impulsively, are at a higher risk for suicide if there is a gun in the home.

When people are identified as being at risk of suicide, it's good to develop a safety plan together with the individuals. This may include:

- Identifying a support person: This should be someone that people can contact if they feel suicidal. Some people may have difficulty identifying someone, especially if they have no close family or friends,

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so explore this. In some cases, even a neighbor or co-worker may serve in this role.

Keep in mind that simply providing a name doesn't mean that people will follow through, so it's good to urge them to call the person they've identified in your presence and ask if the person is willing to serve as a support.

- Limiting access to the means of suicide: This may mean to ensure that someone removes weapons, poisons, and pills from the home or secures them so they are not accessible.

- Coping strategies: The plan should include strategies people can use if they are in crisis. These might include visualization, relaxation exercises, exercise, positive self-talk as well as contacting a support person or mental health professional to talk about feelings. People should be urged to focus on just getting through the day rather than focusing on the future.

- Safe place: The plan should identify those places in which people feel safe and more at ease, such as their bedroom, a spiritual center, a therapy center, a library, or a friend's house.

- Trigger identification: This may include any variety of things that make people feel worse. The plan should include a list of those things, and people should try to avoid them. Because alcohol and drugs can be depressants, people should be cautioned to avoid use of both if they are feeling depressed or suicidal.

- Crisis box: This is a personal box filled with items that make people feel better, such as a favorite CD, photographs of family or friends, a copy of the safety plan, a list of coping strategies, a favorite game or something to help to distract from negative thoughts.

- Contract: People may fill out a contract in which they agree to notify someone, such as the doctor or nurse, if contemplating suicide or self-harm and agree to carry out no such plans. However, there is little evidence that they decrease the risk of suicide and may make healthcare providers complacent.

A simple template for a safety plan is available from Staying Safe: https://stayingsafe.net/sites/default/files/BlankSafetyPlan.pdf

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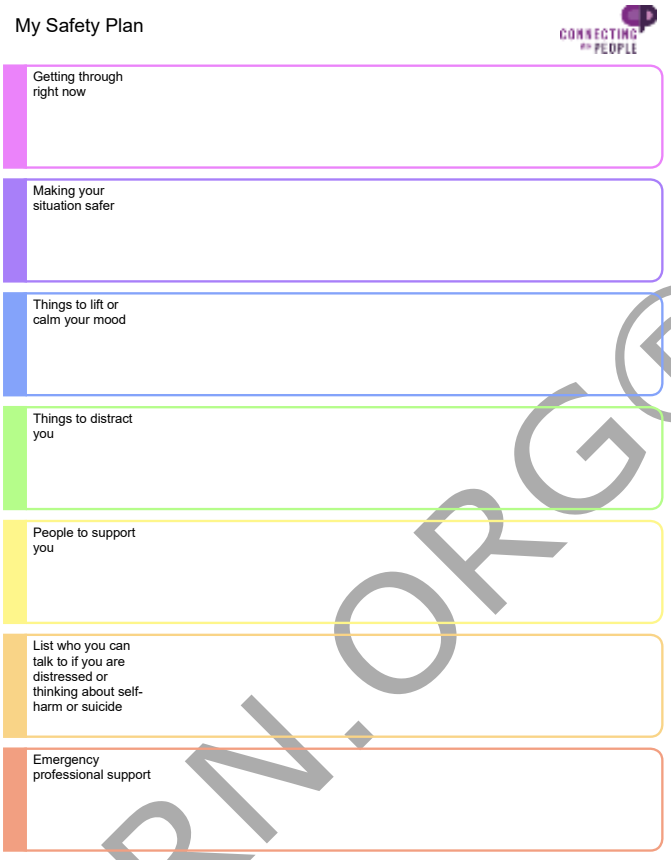
Treatment/Therapy


My Safety Plan

CONNECTING PEOPLE

Getting through right now

Making your situation safer

Things to lift or calm your mood

Things to distract you

People to support you

List who you can talk to if you are distressed or thinking about self-harm or suicide

Emergency professional support

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People who are at risk of suicide may benefit from a variety of different treatment and therapies:

- **Medications:** Some people may benefit from medications to reduce anxiety or depression, such as antidepressants although SSRIs have been shown to increase the risk of suicidal ideation among adolescents, so SSRIs should be monitored carefully.

  Clozapine is FDA approved for treatment of suicidal ideation in people with schizophrenia or schizoaffective disorder. Lithium may reduce suicidal ideation in those being treated for bipolar disorder.

- **Psychotherapy:** Cognitive behavioral therapy (CBT) is one of the most common approaches to therapy for people who are suicidal and can teach people to develop coping skills and to recognize their thought patterns so they can consider alternatives to suicide.

  Dialectical behavior therapy may be used to decrease suicidal ideation in adolescents and in people with borderline personality disorder.

Toxic stress

Mentalization based treatment (MBT) may also be used for people with borderline personality disorder. MBT encourages patients to mentalize and arrive at strategies to manage their behavior and distress.

Collaborative care is a team-based approach to mental health treatment in which a case manager works with the patient, mental health specialists, and the patient's primary care physician to develop a plan of treatement.

Nurses of both genders are especially at risk for suicidal ideation and have rates of suicide higher than that of the general population.

According to a study in the *American Journal of Nursing,* a survey of 7378 nurses showed that 5.5% had considered suicide in the previous 12 months. Nurses are vulnerable to toxic stress and burnout, and these can lead to suicidal ideation.

Toxic stress is chronic recurring stress that persists without an adequate support system to help to alleviate the stress. Toxic stress may occur in response to persistent exposure to adversity. While stress is a normal response, it is typically temporary in nature. In some cases, the onset of toxic stress can be traced to a single traumatic event, such as a sexual assault, but in many cases, the cause is more insidious and can occur in response to the workplace.

Workplace issues may include:

- Nursing is mentally challenging and requires high-level skills and continual learning.
- Conflicts may arise among team members.
- Nurses often work 12-hour shifts or over-time and become exhausted.
- Dealing with severely ill patients and family members can be taxing and demanding.

Suicide in nursing is often directly associated with burnout, and the recent coronavirus pandemic has taken a terrible toll on nurses who have been asked to not only work long exhausting hours and stand by while patient after patient dies but also to contend with those who deny the reality of the pandemic.

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Secondary traumatic stress

A study of stress in nursing found that about 50% of nurses report moderate to high levels of stress and over 60% report feeling emotionally exhausted. Unresolved or toxic stress can have lasting effects, both emotional and physical. Stress can increase cortisol (the "stress hormone") levels, which in turn can lead to fatigue, anxiety, weight gain, hypertension and decreased libido.

Common indications of toxic stress may include:

- Physical complaints: abdominal pain, headache, diarrhea, constipation.
- Nightmares and other sleep disturbances.
- Labile emotional responses.
- Substance abuse.
- Constant anxiety.
- Difficulty focusing attention, remembering.
- Social withdrawal and isolation.
- Suicidal ideation.
- Difficulty balancing the demands of the workplace with those of home and family.

Nurses suffering from toxic stress may need to take a break from nursing, make a change, or seek professional help. In some cases, stress in the workplace can be managed by taking steps to reduce the stress:

- **Identify stress triggers:** These are often very individual, but the nurse should try to determine those things that increase stress and develop a plan to better cope with them or, if possible, to avoid them.

- **Establish boundaries:** This is important in both the nurse's personal and professional roles. Professionally, the nurse may need to limit overtime and turn off work-related emails, calls, or messaging.

- **Take personal relaxation time:** The nurse should plan for free time and use that time to rest or engage in relaxing activities.

- **Exercise and eat a healthy diet:** The nurse should avoid using caffeinated beverages to stay alert and should avoid fast foods.

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Nurses are also vulnerable to secondary traumatic stress (AKA compassion fatigue). Secondary traumatic stress results from repeatedly working with people who are traumatized, such as patients and their families or from the

trauma associated with one event, such as making a serious error. During the COVID-19 outbreak, for example, the prevalence of secondary traumatic stress among nurses was 5.11%. Nurses who experience secondary traumatic stress tend to have higher rates of depression, anxiety, and suicidal ideation that those without secondary traumatic stress.

Secondary traumatic stress is not limited to just periods of outbreaks but is a constant concern. It is more common in nurses who work ICU-CCU than other types of hospital units because of the severity of illness these nurses encounter on a daily basis. Secondary traumatic stress is also common in oncology and hospice nurses because of frequent deaths of patients.

Nurses experiencing secondary traumatic stress often exhibit signs and symptoms that in many ways mirror those of post-traumatic stress disorder (PTSD), including cognitive, emotional, behavioral, and physical symptoms:

- Cognitive: Impaired concentration, rigid thinking, perfectionism, apathy, preoccupation with trauma.
- Emotional: Feelings of guilt, anger, numbness, sadness, and helplessness.
- Behavioral: Hypervigilance, elevated startle response, sleep and appetite disturbance, withdrawal and isolation.
- Physical: Tachycardia, dyspnea, myopathy, arthropathy, immunocompromise,

As with toxic stress, nurses experiencing secondary traumatic stress may need to take a break from nursing, make a change, or seek professional help. It's important to reach out for help for oneself before becoming overwhelmed but also to be alert to the signs that a coworker may need help as well.

Interventions to relieve secondary traumatic stress are similar to those for toxic stress but may also include:

- Journaling: Writing about feelings and experiences can help the nurse to deal with negative experiences and to acknowledge how these experiences are making the nurse feel and respond.

- Support group: Talking with others who share the same experiences can help to reduce the stigma nurses sometimes associate with seeking help and can help the nurse to express feelings and learn and share coping strategies with others.

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Screening for nurses at risk

- Plan for coping: Making a plan for strategies to cope with different types of circumstances can help to reduce stress because the nurse has already decided what steps to take: "If this happens, then I will do this."

Each organization should develop a pathway to care in collaboration with the nursing staff. It's imperative that the program remain confidential and that participating nurses are protected from punitive actions. The Suicide Prevention in Nursing model presents a guide that stresses the importance of screening for risk factors, assessing, referrals, education, and debriefing.

It's also important to work to remove the stigma attached to nurses and other medical professionals seeking mental health help. A suicide prevention program needs to be explained, talked about, written about, and posted about with a clear message: "We understand, and we are here to help."

Different factors may increase the risk of suicide in nurses:

- Repeated exposure to trauma
- Overwork, long hours, overtime
- Lateral bullying, violence
- Isolation, feeling of not belonging
- Conflicts with management, lack of support.
- Lack of balance between personal life and work.
- Lack of confidence in abilities
- Depression
- Substance abuse and investigation of substance abuse (nurses are often afraid of losing their jobs and/or nursing licenses and ability to work)
- Fear for safety
- Financial stressors

A number of different screening tools are available for self-assessment of professionals working in health and human services. These tools should be readily available to nursing and other staff members at a medical institution, and staff members should be encouraged to carry out self-screening to monitor their own sense of wellbeing.

- **Professional Quality of Life Scale 5.0 (ProQOL 5.0):** This tool is available for free in 28 languages and can be accessed online at https://proqol.org/proqol-measure. This tool assesses compassion

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satisfaction and compassion fatigue. The tool comprises 30 statements to which the person responds with a number from a scale of 1 (never) to 5 (very often).

- **Malach Burnout Inventory:** This tool is available for purchase. The form intended for medical personal addresses emotional exhaustion, depersonalization, and personal accomplishment.

- **Copenhagen Burnout Inventory:** This tool can be accessed online at file:///Users/wanda/Desktop/CBI-scales.pdf The tool assesses personal burnout, work-related burnout, and client-related burnout.

- **Secondary Traumatic Stress** Scale (STSS): This 17-item tool measures intrusion, avoidance, and arousal symptoms associated with secondary traumatic stress. The nurse scores each statement on a scale of 1 (never) to 5 (very often). https://www.stsconsortium.com/_files/ugd/72c6ae_96666786a8514dd9a9c8850c35e76598.pdf

- **Interactive Screening Program (ISP):** This online tool is available by license and provides a confidential method for individuals to take a brief screening and receive a personal one-to-one response from a counselor with the program. This counselor can provide information, recommendations, and referrals to mental health services.

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Assessing: A nurse may access a suicide prevention program after carrying out self-screening or without doing so. This first contact is very important in establishing a relationship of trust. Individuals should be assured that they can remain anonymous if they wish, that anything they say will be held in confidence, and that assuring their safety is a primary concern. A counselor or trained volunteer should do this initial contact and assessment.

Contact should be simple and straightforward and provided in various ways, such as by telephoning, visiting a designated counselor, video chatting, using a chat, or texting. However, whenever possible, voice to voice communication is better than written because it allows the counselor/volunteer to assess tone of voice and allows for more spontaneous exchange.

It's imperative to assess safety at the first contact by asking individuals directly if they have considered suicide, have made a plan, and have access to the means of committing suicide. Utilizing a script and asking the same questions to all individuals can ensure consistency:

- "Have you thought about ending your life in the last 3 months?"
- "Have you made a specific plan for how you might end your life?" "Can you tell me about that?"
- "Have you done anything to prepare to end your life, such as obtaining a gun, writing a suicide note, or collecting pills?" "Can you tell me about that?"

If the answer to these questions is "yes," then the contact should be continued, and the counselor/volunteer should try to keep the individuals engaged and talking and to find out their locations. The counselor/volunteer should call for emergency assistance when appropriate.

Safety planning: Safety planning for nurses with suicidal ideation is similar to safety planning for other individual, so nurses should be assisted to develop a personal safety plan. However, because suicidal ideation is often related to stresses of the workplace, special preventive considerations may be indicated:

- Scheduling accommodations: Nurses should be able to receive changes to their schedules for mental health reasons. For example, they may need to switch from 12-hour schedules to 8-hour schedules or be excused from working mandatory overtime. If nurses are experiencing toxic stress or secondary traumatic stress related specifically to a high-stress environment, such as ICU, then they may need a transfer to a different unit.

- Debriefing sessions: Group meetings should be held when traumatic events occur, such as a high rate of patient death or mass casualty events. Nurses need to be able to talk openly about their emotional response and know that the administration is supportive and understands the stress associated with these events.

Referrals: A suicide prevention program should include a list of mental health professionals to whom nurses can be referred when warranted. In addition to mental health professionals, nurses may be referred to support groups, such as Alcoholics Anonymous or bereavement support when indicated. Crisis support services may vary from one region to another, so it's essential to be knowledgeable about services offered.

Other referrals may include:

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Best practices: NIMH 5-Step Prevention

- Substance use disorder program: substance use disorder is not uncommon among nursing personnel and is often a precipitating factor in suicidal ideation. Nurses with substance use disorder are often fearful of being caught and of losing their jobs and their nursing licenses, so any substance use program should begin an open-door confidential policy and education that includes:
    - Warning signs of substance use disorder.
    - Ethical/legal responsibilities regarding investigating/reporting a nurse with substance use disorder.
    - State's Nurse Practice Act and regulations regarding substance use disorder, including the difference between being reported for substance use disorder and self-reporting.
    - Policies regarding organizational response to substance use disorder, including time away from patient care, rehabilitation responsibilities, and transition back to work

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There is no one best practice for suicide prevention because comprehensive interventions and multiple strategies may be necessary. These following steps are designed by the National Institute of Mental Health for use with people who are in crisis and appear to be at risk of suicide.

Ethical and legal considerations

- **Ask:** Asking people if they are thinking about killing themselves does not increase the risk that they will do so, and they may take the opportunity to share their feelings. Actually talking with people about suicide may help to reduce suicidal thoughts. Many people do not seek help on their own without intervention, such as questioning.
- **Keep them safe:** This means to reduce access the means of suicide—guns, knives, medications, dangerous places. People are more likely to be safe if they have uninterrupted care transitions and good continuity of care.
- **Be there:** It's important to remain supportive and stay with those who are suicidal if necessary to ensure they are safe and can explore their feelings. Help people to develop coping and life skills.
- **Help them connect:** Assist them to connect with someone from their support system, such as a family member or mental health professional and provide crisis and hotline numbers and resources.
- **Stay connected:** Remain in touch and followup with visits or telephone calls. A postvention plan should be in place and should include long-term supports.

When a healthcare provider identifies an individual as a suicide risk, the healthcare provider has a responsibility of care for that individual, and a number of ethical and legal considerations may arise:

- **Liability**: If a healthcare providers falls below the standard of care, resulting in increased risk of harm to the patient, such as by the healthcare provider failing to foresee that the patient was likely to try to commit suicide, the healthcare provider may be found negligent.

- **Documentation**: All suicide assessments and observations must be carefully documented because failing to do so suggests that they were not carried out, and this can result in a charge of negligence.

- **Involuntary hospitalization**: While states laws vary somewhat, generally people who are suicidal may be subject to short-term commitment or involuntary hospitalization. Anybody can contact emergency services and make a request that someone be committed, but most states require that the individual undergo medical evaluation or court approval before involuntary hospitalization.

  Caring for a patient who is involuntarily hospitalized may pose challenges because the patient may be resistive to hospitalization and

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treatment, and patients usually have the right, by law, to refuse both. In fact, even patients with involuntary hospitalization retain the right to refuse treatment unless they have been found incompetent by a court and a surrogate decision-maker identified to make decisions. However, the patient may be administered medications on an emergency basis to calm a patient although not medications specifically intended to treat mental illness.

- **Breach of confidentiality**: If a patient's suicide screen is positive and the patient refuses treatment or denies being suicidal and the healthcare provider believes the patient is a risk to self or others, HIPAA allows the healthcare provider to make contact with others and provide this information, such as to a close family member, without consent of the patient. When a patient identifies a support person, it's good practice to ask the patient to sign a release form so that the person can be notified if the patient appears to pose a risk to self.

  However, breach of confidentiality is sometimes a gray area because it's not always possible to discern suicidal ideation and the degree of danger, especially if the patient is not truthful on screening. Studies show that the majority of patients who commit suicide deny suicidal thoughts when last asked before their death.

- **Right-to-die/Physician-assisted death**: Currently, 10 states (Colorado, Hawaii, Main, New Jersey, New Mexico, Oregon, Vermont, Montana, and California) and the District of Columbia allow physician-assisted death if the patient has a terminal illness and is expected to live no more than 6 months. State laws vary somewhat but generally require that the patient be able to self-administer the prescribed drugs. These laws are an ethical issue for healthcare providers, especially if their personal or religious beliefs view physician-assisted death as suicide.

  While patients always have the right to refuse life-sustaining treatments, in other states, patients who want to end their lives because of terminal disease do not have the option of receiving a prescription for drugs to do so. However, patients with a terminal illness may express the desire to die, and it can be difficult to decide if the patient is suicidal or is making a considered decision about the quality of life.

  If this occurs, the nurse should ask the patient the reason for wanting to die, because there is often a reason for which the nurse can assist the patient. For example, if the patient's pain is becoming unbearable,

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Conclusion

then different pain control options can be explored. Even in states that allow physician-assisted death, few patients choose that option, and some patients ask for prescriptions but do not fill them. Therefore, it's important to always discuss other options with patients.

- **Inadequate resources:** It is a fact that people with insurance and adequate income have more options for care and treatment than people without. Free mental health services are often limited, unavailable, or have long waiting lists. It can be ethically challenging when people need services that are simply not available to them. People who are homeless are often lost in the cracks of mental health care.

Suicide is preventable, but a comprehensive approach is necessary, and a lack of adequate resources and the stigma that is still associated with mental health problems are barriers to progress. Suicide prevention requires input and cooperation among community members, individuals from populations most affected by suicide, community-based organizations, educational systems, government (state, local, and federal), social services, healthcare providers, businesses, media, first responders, and policymakers.

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