Suicide Recognition and Referral

Diagnosis/Condition:	Suicide Recognition and Referral
Discipline:	Integrated
ICD-10 Codes:	
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Suicide is death caused by injuring oneself with the intent to die. A suicide attempt is when someone harms themselves with any intent to end their life, but they do not die because of their actions.[1] Suicide is a compelling personal and public health problem. The emotional and social consequences of attempted or death by suicide are tremendous for the victim, their families, and their care givers. Health care providers who have the skill and confidence to care for at-risk suicides and their family members can contribute to the moderation of what has become to be considered an "epidemic" of suicide.

Suicide rates increased approximately 36% between 2000–2021. Suicide was responsible for 48,183 deaths in 2021, which is about one death every 11 minutes.[2] 2022 showed an increase of 2.6% to 49,449, the highest number ever recorded, according to provisional numbers released by the CDC. The number of people who think about or attempt suicide is even higher. In 2021, an estimated 12.3 million American adults seriously thought about suicide, 3.5 million planned a suicide attempt, and 1.7 million attempted suicide.[3] Suicide is the 11th leading cause of death overall in the US and it affects all age groups. Some age groups are more at risk. It is the second leading cause of death for the 10-14 and 25-34 age group, the 3rd leading cause for the 15-24 year-old group, and it remains in the top 10 for all other age groups.[4] The highest overall numbers continue to be in the 25-44 age group followed by the 45-64 age group. The CDC provisional data shows firearms were involved in more than half of all suicides in 2022.

Historically, suicide attempts have been seen as a moral failure, and was formerly considered criminal behavior. While most countries now view it as a personal and public health crisis that is worthy of clinical intervention, resources devoted to research and evidence-based approaches to suicide prevention and treatment are sparse.[5]

The close therapeutic relationship that integrative health (IH) providers cultivate with their patients can be the setting in which at-risk persons or their family members may raise this most disturbing condition. While the purpose of this clinical pathway is not to encourage providers to offer mental health services, it is intended to alert clinicians and their staff to this

urgent problem and to give direction as to how to recognize at-risk persons and the steps that an informed clinician can take to intervene successfully.

Subjective Findings and History

Knowing the prominent factors that are associated with suicide risk may be crucial in assisting a patient or the family to access appropriate services.

- A number of risk factors are associated with suicide.[6,7] These include:
  - Family history of suicide and child maltreatment.
  - Previous suicide attempt(s).
  - History of mental disorders, particularly clinical depression.
  - Evidence of psychosis (e.g., hearing voices, paranoid delusions or thoughts so disorganized it's hard to follow the conversation and agitation).
  - History of alcohol and substance abuse.
  - Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma).
  - Barriers to accessing mental health treatment.
  - Loss (relational, social, work, or financial).
  - Easy access to lethal methods.
  - Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts.

The key suicide risk factors are:

- Prior suicide attempt
- Major depression
- Substance use disorders

- Demographic risk factors
  - Men in the US are over 4 times more likely to commit suicide.
  - White and Native Americans.
  - Single men, divorced or widowed women.
  - Young people who identify as lesbian, gay, or bisexual.[8]
  - A history of abuse, sexual violence, and bullying.[9]
  - Veterans, people who live in rural areas, and workers in certain industries and occupations like mining and construction.[10,11]
- Protective factors have also been identified that reduce the tendency to suicidal thoughts and actions. These include:
  - Effective clinical care for mental, physical, and substance abuse disorders.
  - Easy access to a variety of clinical interventions and support for help seeking.
  - Family and community support (connectedness).
  - Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes.
  - Cultural and religious beliefs that discourage suicide and support instincts for self-preservation.

Objective Findings

Outward warning signs of suicide may be present as observed by the individual, the family or the IH clinician. How a person talks, behaves, displays their mood, can indicate increased risk of suicide.[12]

- Talk: If a person talks about:
  - Killing themselves.
  - Having no reason to live.
  - Being a burden to others.
  - Feeling trapped.
  - Unbearable pain.
- Behavior: A person's suicide risk is greater if a behavior is new or has increased, especially if it's related to a painful event, loss, or change.
  - Increased use of alcohol or drugs.
  - Looking for a way to kill themselves, such as searching online for materials or means.
  - Acting recklessly.
  - Withdrawing from activities, family, and friends.
  - Sleeping too much or too little.
  - Visiting or calling people to say goodbye.
  - Giving away prized possessions.
  - Aggression.
- Mood: People who are considering suicide often display one or more of the following moods.
  - Depression.
  - Loss of interest.
  - Rage.
  - Irritability.
  - Humiliation.
  - Anxiety.

Assessment/Recognition

Assessment of risk for suicide includes gathering information about the risk and protective factors noted above and being able to probe effectively with appropriate questioning of the individual.

Assessment of suicide risk is in the domain of mental health professionals. IH clinicians, while not trained to perform a formal suicide risk assessment, can develop the sensitivity, skills, and confidence to recognize at-risk individuals and take appropriate steps including an appropriate referral.

Several suicide risk screening tools are available that are appropriate for use in most IH clinical settings. The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) lists 3 suicide risk screening tools:

- The Columbia-Suicide Severity Rating Scale (C-SSRS) is a questionnaire used for suicide assessment. It is available in 114 country-specific languages. Mental health training is not required to administer the C-SSRS. Learn more about the C-SSRS and how it can be used.
- SAFE-T (Suicide Assessment Five-Step Evaluation and Triage) was developed in collaboration with the Suicide Prevention Resource Center and Screening for Mental Health.
- Suicide Behaviors Questionnaire (SBQ-R) assesses suicide-related thoughts and behavior.

Plan

To reiterate, the intent of this Clinical Pathway is not to facilitate IH clinicians' direct provision of mental health interventions, but to provide the necessary information and insights on how to respond to IH patients or their family members.

How to make a connection with someone at risk of suicide.

> Studies show that people do not start thinking about suicide just because someone asks them about it.

Asking about suicide is difficult for many clinicians. Asking direct questions of patients who display any of the above "objective findings" in a manner consistent with their current clinical situation can be the first step in getting them help and preventing suicide. If you have enough information to suspect a person is suicidal, ask the question that is natural and flows normally with the conversation.[13]

The American Foundation for Suicide Prevention (AFSP) states:
Studies show people do not start thinking about suicide just because someone asks them about it. If you suspect a friend or loved one [or your patient] is suicidal, tell them you are worried and want to help them. Don't be afraid to ask whether they are considering suicide, and if they have a specific plan in mind. Having a plan may indicate they are farther along and need help right away. Sometimes people who are thinking about suicide won't tell you because they don't want you to stop them. Your direct, non-judgmental questions can encourage them to share their thoughts and feelings.[14]

> Scenario: You are treating Mr. S. for chronic pain and he has stated, "My life is just not worth living." Expressing concern and endorsing his feelings by asking, "I know you have a serious problem. We have been trying to help you with this since you have been coming here. Some people in your situation get so desperate they want to kill themselves. Are you thinking of killing yourself?"

How to recognize and manage your own emotional responses when talking with suicidal patients.[15]

> Suicide is a highly charged clinical situation. Regardless of your personal convictions, moral, or religious view of suicide, keeping the focus on the health of the individual is, of course, of primary importance.

Examine your own experience and attitude toward suicide. Attitudes about suicide are strongly influenced by life experiences with suicide and similar events. Responses to suicide and to people who are suicidal are highly susceptible to attitudinal influence, and these attitudes play a critical role in working with people who are suicidal. An empathic attitude can assist you in engaging and understanding people in a suicidal crisis. A negative attitude can cause you to miss opportunities to offer hope and help or to overreact to people in a suicidal crisis.

- Suggestions for effective communication with suicidal patients include:
    - **Be Direct.** Discomfort about suicide can lead one to avoid asking directly about suicide, which may convey uneasiness to the patient, imply the topic is taboo, or result in confusion or lack of clarity. Instead, you can learn to ask directly, "Are you thinking about killing yourself?"
    - **Increase Your Knowledge About Suicide.** One of the best ways to become more comfortable with any topic is to learn more about it.
    - **Do What You Already Do Well.** IH clinicians typically are empathic, warm, and supportive. Trust your experience and intuition and leverage your existing therapeutic alliance with the patient.
    - **Recognize and communicate your limitations.** Plan collaboratively with the patient on the next steps.
- Overcoming common problems that arise when referring suicidal patients.
    - Do not make a judgment about the seriousness of suicide risk or try to manage suicide risk on your own.
    - Positive, empathic attitudes toward patients experiencing suicidal thoughts and behaviors do not, by themselves, mean they will initiate or receive appropriate services.
    - Engage the patient in the same way with other treatment planning such as presenting alternatives and assisting the patient in decision making.
- How to confidently refer patients to mental health professionals.
    - Be aware of community resources available to assist suicidal patients such as suicide and mental health hot lines, hospital, and mental health facility emergency services, and 911.

Referral Resources

There are local community and national resources for patients in crisis. Local mental health crisis lines sponsored by state and county mental health agencies are often staffed 24 hours a day, seven days a week by a highly educated, well-trained staff. The call centers may have a variety of resources for professionals, their patients and families including:

- Crisis Counseling by phone, with translation services for non-English speakers.
- 24/7 mobile crisis outreach for in-person assessment.
- Referral to low-cost or sliding-scale agencies.
- Help finding mental health providers, including those who have culturally linguistically specific services.
- Information about non-crisis community resources.

2022 marked the launch of the 988 Suicide and Crisis Lifeline, a transition from the National Suicide Prevention Lifeline to a simpler, three-digit dial code – 988 – that's intended to be easier to remember, like 911 for emergency medical services. This provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week, across the United States. The Lifeline is comprised of a national network of over 200 local crisis centers, combining custom local care and resources with national standards and best practices.

- Call or text 988
- Chat at 988lifeline.org
- Connect with a trained crisis counselor. 988 is confidential, free, and available 24/7/365.

Crisis Text Line: Text HOME to 741741

If a Suicide Occurs

In the event a suicide occurs, there needs to be a review with the clinician and an expert to figure out how to talk to the family if that arises, how to support the clinician, and how to learn non-judgmentally. This would be considered a sentinel event just like harm to a clinician or harm to a patient and these quality related notes are not discoverable in a legal setting.

Clinicians Resources

Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 50. Center for Substance Abuse Treatment.
Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2009.
This free guide is directed toward substance abuse professionals. It contains extensive evidence-based recommendations relevant to IH clinicians in practice settings.

Suicide Prevention Community Edition - shortened version
http://www.vdf.virginia.gov/VDF/Chaplins/Training/VDF--CH019/Operation_SAVE_Suicide_Prevention_DeptOfVA.pdf (unable to open)
This slide set is a short summary of information and practical advice for clinicians. It may also be useful for the lay public.

Suicide Prevention Resource Center. http://www.sprc.org/

From SPRC website: SPRC is the nation's only federally supported resource center devoted to advancing the National Strategy for Suicide Prevention. They provide technical assistance, training, and materials to increase the knowledge and expertise of suicide prevention practitioners and other professionals serving people at risk for suicide.

Screening Tools for Clinicians

Columbia Suicide Severity Rating Scale http://www.cssrs.columbia.edu/

The C-SSRS is the only screening tool assessing the full range of evidence-based ideation and behavior items, with criteria for next steps (e.g., referral to mental health professionals). The C-SSRS can be exceptionally useful in initial screenings.

SAFE-T http://www.integration.samhsa.gov/images/res/SAFE_T.pdf
SAFE-T drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors.

Suicide Behavior Questionnaire: http://www.integration.samhsa.gov/images/res/SBQ.pdf

The Suicide Behaviors Questionnaire-Revised (SBQ-R) is a psychological self-report questionnaire designed to identify risk factors for suicide in children and adolescents between ages 13 and 18.

Patient Resources

Center for Disease Control and Prevention (CDC). National Center for Injury Prevention & Control. Division of Violence Prevention. http://www.cdc.gov/violenceprevention/suicide/

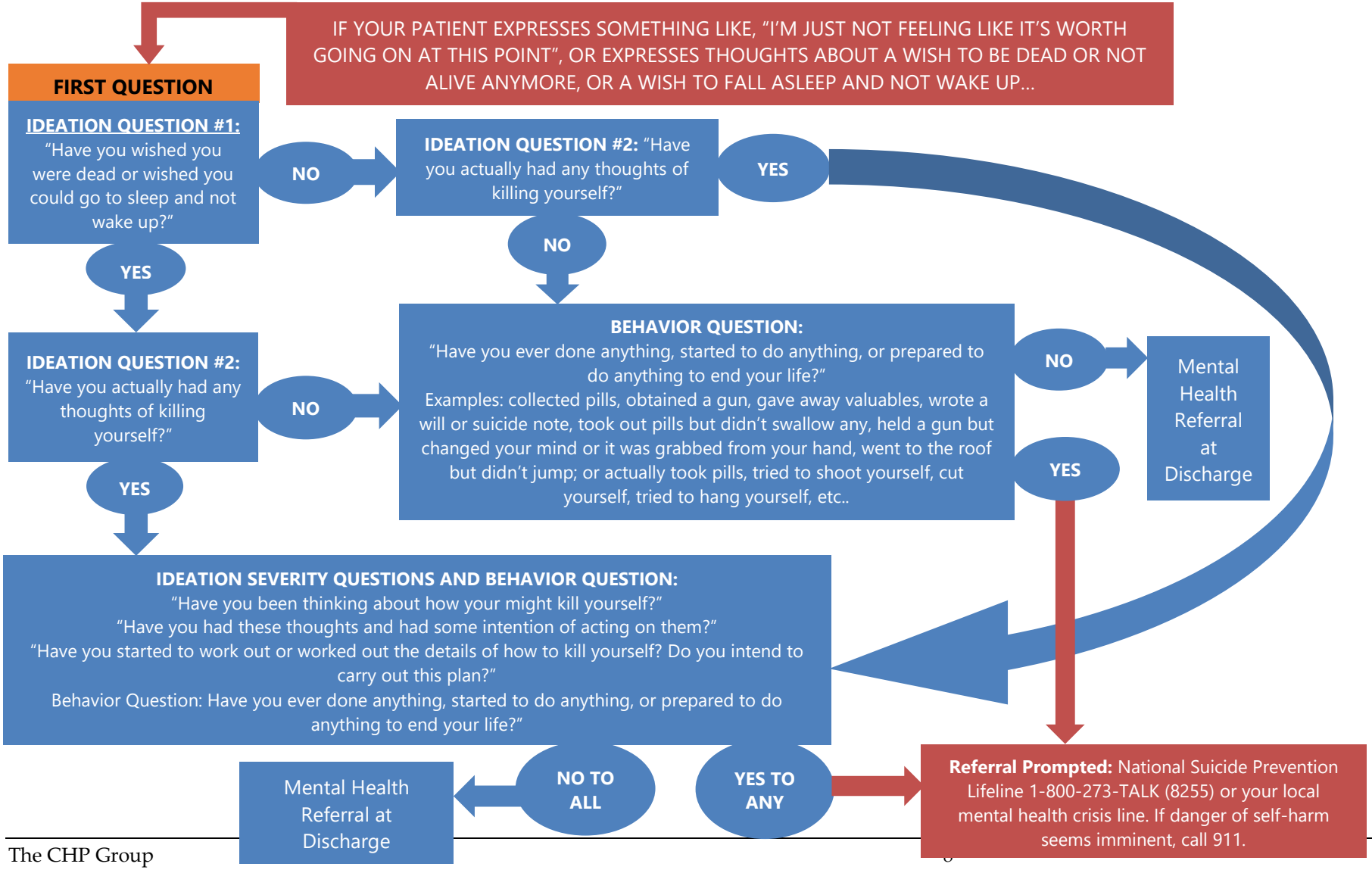
In 1992, CDC established the National Center for Injury Prevention and Control (NCIPC) as the lead federal organization for violence prevention. The Division of Violence Prevention (DVP) is one of three divisions within NCIPC. The Division's mission is to prevent injuries and deaths caused by violence.

Suicide Awareness Voices of Education.
http://www.save.org/index.cfm?fuseaction=home.viewPage&page_id=1

The mission of SAVE is to prevent suicide through public awareness and education, reduce stigma and serve as a resource to those touched by suicide.

Action Points

The following scenario is based on the screening version of the Columbia Suicide Severity Rating Scale. Complete training in the use of this screening tool is available and free at: (**Training is required before using the tool.**) http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/cssrs_web/course.htm.



Clinical Pathway Feedback

CHP desires to keep our clinical pathways customarily updated. If you wish to provide additional input, please use the e-mail address listed below and identify which clinical pathway you are referencing. Thank you for taking the time to give us your comments.

Clinical Services Department: cs@chpgroup.com

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The CHP Group wishes to extend our special thanks to Lauretta Young, MD, (Behavioral Health Director KEPRO Oregon, Quality Health Director Lutheran Family Services NW, board certified in psychiatry and neurology, licensed Oregon and Washington) in the preparation and review of this clinical pathway.

Disclaimer Notice

The CHP Group (CHP) Clinical Pathways are a resource to assist clinicians and are not intended to be nor should they be construed/used as medical advice. The pathways contain information that may be helpful for clinicians and their patients to make informed clinical decisions, but they cannot account for all clinical circumstances. Each patient presents with specific clinical circumstances and values requiring individualized care which may warrant adaptation from the pathway. Treatment decisions are made collaboratively by patients and their practitioner after an assessment of the clinical condition, consideration of options for treatment, any material risk, and an opportunity for the patient to ask any questions.

CHP makes no representation and accepts no liability with respect to the content of any external information cited or relied upon in the pathways. The presence of a particular procedure or treatment modality in a clinical pathway does not constitute a representation or warranty that this service is covered by a patient's benefit plan. The patient's benefit plan determines coverage.

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