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Contact Hours: **1**

Suicide Screening and Prevention

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LEARNING OUTCOME AND OBJECTIVES: Upon completion of this continuing education course, you will demonstrate an understanding of suicide screening and prevention. Specific learning objectives to address potential knowledge gaps include:

- Summarize risk and protective factors for suicide.
- Describe the process of screening for suicide risk.
- Discuss suicide prevention strategies.

INTRODUCTION

Suicide is the culmination of many and varied interactions between biological, social, and psychological factors. Talk of suicide must always be taken seriously, recognizing that people with suicidal ideation are in physical and/or psychological pain and may have a treatable mental disorder. The vast majority of people who talk of suicide do not really want to die. They simply are in pain and want it to stop. Suicide is an attempt to solve this problem of intense pain when problem-solving skills are impaired in some manner, in particular by depression.

Healthcare professionals play a critical role in the recognition and prevention of suicide. However, many express concern that they are ill prepared to deal effectively with a patient with suicidal thoughts. By developing adequate knowledge and skills, these professionals can overcome feelings of inadequacy that may otherwise prevent them from effectively responding to the suicide clues a patient may be sending, thereby allowing them to carry out appropriate screening and referral. They can also develop a better understanding of this choice that ends all choices.

SUICIDE ETIOLOGY AND RISK AND PROTECTIVE FACTORS

Suicide etiology is complex and includes family history, genetics, epigenetics, neurobiology, medication use, and gender.

- **Genetics:** Four genes have been identified as heightening the risk of suicidal thoughts and actions.
- **Epigenetics:** The resulting impact of environmental influences on gene activity and expression has been associated with suicidal behavior.
- **Neurobiology:** Inflammatory mediators have been found to play a critical role in the pathophysiology of suicide.
- **Medications:** Certain antidepressants and anticonvulsant drugs can increase the risk for suicide.
- **Gender:** The rate of completed suicide in men is higher than in women; however, attempted suicide is more common among women than men.

Suicide Risk Factors

Risk factors for suicide may include:

- Family history of suicide or neuropsychiatric conditions
- Previous suicide attempt(s)
- Having a mental health disorder (e.g., depression, substance use disorder, posttraumatic stress disorder, traumatic brain injury)
- Being a divorced or widowed female
- Socioeconomic factors (especially for men), including occupation, education, income
- Personality factors (e.g., paranoid personality features, obsessive-compulsive features)
- Developmental factors (e.g., behavioral disinhibition, negative emotional states)
- Life experiences, including history of trauma or abuse
- Impulsive/aggressive tendencies
- Cultural and religious factors
- Barriers to accessing mental health care
- Lack of or poor supportive social networks

(NV DPBH, 2021)

Suicide Protective Factors

Although there are many risk factors for suicide, there are also factors that protect people from making an attempt or dying by suicide. These protective factors are both personal and environmental.

Personal protective factors include:

- Values, attitudes, and norms that prohibit suicide, such as strong beliefs about the meaning and value of life
- Strong problem-solving skills
- Social skills, including conflict resolution and nonviolent ways of handling disputes
- Good health and access to mental and physical healthcare
- Strong connections to friends and family as well as supportive significant others
- Strong sense of cultural identity
- A healthy fear of risky behaviors and pain
- Optimism about the future and reasons for living
- Sobriety
- Medical compliance and a sense of the importance of health and wellness
- Good impulse control
- A strong sense of self-esteem or self-worth
- A sense of personal control or determination
- Strong coping skills and resiliency
- Being married or a parent

External/environmental protective factors include:

- Opportunities to participate in and contribute to school or community projects and activities
- Strong relationships, particularly with family members
- A reasonably safe and stable environment
- Availability of consistent and high-quality physical and behavioral healthcare
- Financial security
- Responsibilities and duties to others

- Cultural, religious, or moral objections to suicide
- Owning a pet
- Restricted access to lethal means
(WMU, 2023; CDC, 2022b)

Suicide Risk According to Age

Suicide occurs throughout the lifespan, affecting individuals in various age groups differently, and some have higher suicide rates than others.

CHILDREN AND ADOLESCENTS

Suicide is the third leading cause of death among U.S. children and adolescents ages 5–19 years. The number of children ages 5–11 who have died by suicide has increased significantly between 1999 and 2020, most of these being children between 10–11 years old and 75% being male. Younger children who die by suicide are more likely to be of above-average intelligence, which possibly exposes them to the developmental level of stress experienced by older children.

During adolescence, abstract and complex thinking begin to develop, and these youth become more capable of contemplating life circumstances, envisioning a hopeless future, generating suicide as a possible solution, and planning and executing a suicide attempt. The prevalence of depression increases and becomes twice as high among girls than boys, which explains some differences in rates of suicide between boys and girls.

After puberty, the rate of suicide increases with increasing age. Potential reasons for this include an increased access to firearms and potentially lethal drugs; increased rates of psychiatric illness, substance abuse, and other comorbidities; or a history of aggressive, impulsive conduct with a tendency to act out emotions in damaging ways.

The risk of suicide among children and adolescents is increased due to:

- Family tensions
- Emotional and physical abuse
- Violence
- Lack of family connectivity
- Parental mental health problems
- Death of a loved one
- Family homelessness
- History of foster care and adoption
- Bullying

- Sexual orientation
- Substance abuse
  (Kennebeck & Bonin, 2021; Sruthi, 2022; Nationwide Children's Hospital, 2021)

SOCIAL MEDIA AND SUICIDE IN ADOLESCENTS

It has been found that the rise in suicide and suicide attempts by adolescents correlates with the rise in electronic communication and social media. Increased digital media and smartphone use may influence mental health through several mechanisms, including the displacement of time spent in in-person social interactions, disruption of in-person social interactions, interference with sleep time and quality, cyberbullying, toxic online environments, and online information about self-harm (Twenge, 2020).

YOUNG ADULTS

Young adults experience mental health challenges at higher rates than any other age group. Close to half of those ages 18–24 struggle with mental health issues, and in 2021, 25.5% of young adults seriously considered suicide, including 10% of college students, and over 1,000 college students died by suicide. For specific ethnic and cultural groups, rates of suicide are even higher. Among American Indian and Alaska Native young adults, the rate of suicide is 2.5 times higher than that of their peers.

Many young adults continue to deal with the consequences of the COVID-19 pandemic, which has resulted in high levels of depression, loneliness, anxiety, and trauma.

The top reasons for suicide among young adults include the following:

1. Depression, anxiety, and other mental health disorders
2. History of substance abuse
3. Exposure to violence, abuse, or other trauma, either chronic or acute
4. Social isolation and loneliness
5. Losing a family member through death or divorce
6. Financial or job loss
7. Conflict within relationships
8. Starting or changing psychotropic medications
9. Feeling stigmatized
10. Lack of a support system
    (Newport Institute, 2022)

MIDDLE-AGED ADULTS

Middle age (35–64 years) is a time of maximum risk, with suicide rates increasing in both middle-aged men and women, although men are much more likely than women to die by suicide. Middle-aged adults account for 47.2% of all suicides in the United States, and suicide is the ninth leading cause of death for this age group (CDC, 2022c).

Middle age is a period characterized by high familial and social expectations, increased self-confidence, leadership, and community contribution, making midlife a time of well-being and peak functioning as well as a time of high stress. Well-being during this phase of life can vary considerably, from being confident and resilient when meeting changes and difficulties, to being nervous or overanxious in response to stressful events and conflicts.

Suicide rates for middle-aged women have increased more quickly compared to rates for men in recent years. Many of these women are in the "sandwich" generation, those who take care of their children as well as older parents. They are more likely to be very stressed as a result of the responsibilities they carry, increasing their risk for suicide.

Unemployment has been found to be present in 43.2% of those who die by suicide in midlife and is associated with an almost fourfold increased risk of suicide. Separation and divorce increase suicide risk by more than three times. People in this age group, especially men, consider work position, employment, and marital relationship as indicators of their social identity, and problems in these areas can be deeply distressing (AACI, 2020; Qin et al., 2022).

OLDER ADULTS

Adults ages 65 and older comprise just 12% of the population but make up approximately 18% of suicides. Men 65 and older face the highest overall rate of suicide. Older adults tend to plan suicide more carefully and are also more likely to use more lethal methods. Among people who attempt suicide, 1 in 4 older adults will succeed, compared to 1 in 200 youths. Even if an older adult survives a suicide attempt, they are less likely to recover from the effects.

Loneliness has been found to top the list of reasons for suicide among this age group. Many of them are homebound, live on their own, and may lack the social connections needed to thrive. Other reasons may include:

- Grief over the loss of family members and friends, and anxiety about their own death
- Loss of self-sufficiency and independence
- Greater likelihood of illnesses and chronic and/or debilitating diseases such as arthritis, cardiac problems, stroke, or diabetes, which compromise quality of life
- Loss of vision and hearing make it harder to do the things they've always enjoyed doing

- Cognitive impairment and dementia, which can affect a person's decision-making abilities and increase impulsivity
- Financial stress, such as living on a fixed income and/or struggling to pay bills or afford food
- Clinical depression brought on by physical, emotional, and cognitive struggles (NCOA, 2021)

Suicide Risk among Specific Populations

Although suicide affects all groups of the population, the risk and protective factors for suicide may differ. The following summarizes risk and protective factors among specific populations.

PERSONS WITH DEMENTIA

Overall, people with dementia have no higher risk of dying by suicide than the general population, but the risk is significantly increased in three groups of people with dementia: those diagnosed before the age of 65, those in the first three months following diagnosis, and those with dementia and psychiatric comorbidity. In people younger than 65 years and within three months of diagnosis, suicide risk was seven times higher than in those without dementia.

Patients with early dementia may have greater cognition, giving them more insight into their disease and better enabling them to carry out a suicide plan. Severe dementia, however, could protect against suicide by decreasing a person's capacity to implement a suicide plan. Also, impairment in cognition and personal activities of daily living are associated with greater risk of nursing home admission, which in itself is a risk factor for suicide (Alothman et al., 2022; Joshaghani et al., 2022).

CAREGIVERS

More than 21% of the U.S. population serves as caregivers to someone with an illness or disability. They are usually spouses, older children, parents, and family friends. Men and women equally share in the responsibility, which is fulfilled mostly by those ages 38–64. In 2020, 24% of caregivers were looking after more than one person. As a result of their significant social, economic, and personal contributions, caregivers experience high rates of physical and mental illness, social isolation, and financial distress. They are also at high risk for suicide.

In a U.S. study asking hospice and palliative social workers to identify patients and caregivers at risk for suicide in the previous year, 55.4% reported one or more caregivers who exhibited warning signs of suicide, 6.8% reported one caregiver who had attempted suicide, and 4.1% reported one caregiver who died by suicide (Herman & Parmar, 2022; O'Dwyer et al., 2021).

MILITARY SERVICE PERSONNEL

Suicides among military service personnel have been steadily rising during the past 10 years, and suicide is now the second-leading cause of death among this group. Greater than 90% of military suicides are by male personnel who are most often younger than 35 years of age. The most common method used for military personnel to die by suicide is a firearm.

In a study asking a group of active-duty soldiers why they tried to kill themselves, all of the soldiers indicated a desire to end intense emotional distress. Other common reasons included the urge to end chronic sadness, a means of escaping people, or a way to express desperation. In addition, rates of mental health problems have risen 65% in the military since 2000, with nearly one million troops diagnosed with at least one mental health issue. Risk for suicide increases when military personnel experience both depression and posttraumatic stress together (MSRC, 2022; ABCT, 2022).

Experiencing child abuse, being sexually victimized, and exhibiting suicidal behavior before enlistment are significant risk factors for service members and veterans, making them more vulnerable to suicidal behavior when coping with combat and multiple deployments. Military personnel reporting abuse as children have been found to be three to eight times more likely to report suicidal behavior. Sexual trauma of any type increases the risk for suicidal behavior. Men who have experienced sexual trauma are less likely than females to seek mental health care, which they may see as a threat to their masculinity. This is a strong predictor of suicide attempts in military personnel. Service members who attempted suicide before joining the military are six times more likely to attempt suicide post enlistment (APA, 2023).

Suicide among women in the military has increased at twice the rate of male service members. When compared to civilian women, those in the service are two to five times more likely to die by suicide. The primary reason is sexual trauma, particularly incidences of harassment and rape while stationed overseas, resulting from a pervading military culture that is antagonistic toward women in the military (Gorn, 2023).

There is strong evidence that among veterans who experienced combat trauma, the highest suicide risk has been observed in those who were wounded multiple times and/or were hospitalized as a result of being wounded.

Studies that looked specifically at combat-related posttraumatic stress disorder (PTSD) found that the most significant predictor of both suicide attempts and the preoccupation with thoughts of suicide is combat-related guilt about acts committed during times of war. Those with only some PTSD symptoms have been found to report hopelessness or suicidal ideation three times more often than those without PTSD (VA, 2022a).

SUICIDE SCREENING

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

Suicide prevention **screening** refers to a quick procedure in which a standardized instrument or tool is used to identify individuals who may be at risk for suicide and in need of assessment. It can be done independently or as part of a more comprehensive health or behavioral health screening. Suicide **assessment**, as opposed to screening, refers to a more comprehensive evaluation done by a clinician to confirm a suspected suicide risk, to estimate imminent danger, and to decide on a course of treatment.

Screening Recommendations

There is debate about the benefits of screening all patients (**universal screening**) for suicide risk factors and whether screening actually reduces suicide deaths. The general view, however, is that such screening should only be undertaken if there is a strong commitment to provide treatment and follow-up, since there is some evidence that screening improves outcomes when it is associated with close follow-up and treatment. Instead of universal screening, some recommend that screening be done only for those presenting with known risk factors (**selective** or **targeted screening**). Despite this lack of uniform guidance, health systems are implementing suicide screening protocols, and screening tools are already widely used in primary care settings (O'Rourke et al., 2022).

U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATIONS

Previously the U.S. Preventive Services Task Force (USPSTF) concluded that there was insufficient evidence to assess the balance of benefits and harms of screening for suicide risk in adolescents, adults, and older adults in primary care. The USPSTF, however, recommended screening for major depressive disorder in adolescents ages 12–18 years and in the general adult population, including pregnant and postpartum persons, noting that screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow up. The 2022 draft recommendation statements are consistent with these previous recommendations (USPSTF, 2022).

JOINT COMMISSION RECOMMENDATIONS

The Joint Commission requires that all individuals from age 12 and above in all medical settings be screened for suicidal ideation using a validated tool. Patients who are screened and found positive for suicide risk on the screening tool should receive a brief suicide safety assessment conducted by a trained clinician to determine whether a more comprehensive mental health evaluation is required (TJC, 2023).

AMERICAN ACADEMY OF PEDIATRICS

The American Academy of Pediatrics' age recommendations for screening state:

- Youth ages 12 and over: Universal screening
- Youth ages 8–11: Screen when clinically indicated

- Youths under age 8: Screening not indicated; assess for suicidal thoughts/behaviors if warning signs are present

Young people require screening more frequently than adults, as adolescence and young adulthood are times of rapid developmental change, and circumstances can shift frequently (AAP, 2022).

Screening Tools

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

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

Recognizing Suicide Warning Signs

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

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

- Killing oneself
- Feeling hopeless
- Having no reason to live
- Being a burden to others
- Feeling trapped

- Having unbearable pain

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

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

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

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

SUICIDE PREVENTION STRATEGIES

Effective suicide prevention is a comprehensive undertaking requiring the combined efforts of every healthcare provider and addressing different aspects of the problem. A model of this comprehensive approach includes:

- Identifying and assisting persons at risk. This may include suicide screening, teaching the warning signs of suicide, and providing gatekeeper training (see below).

- Ensuring access to effective mental health and suicide care and treatment in a timely manner and coordinating systems of care by reducing financial, cultural, and logistical barriers to care.
- Supporting safe transitions of care by formal referral protocols, interagency agreements, cross-training, follow-up contacts, rapid referrals, and patient and family education.
- Responding effectively to persons in crisis by ensuring crisis services are available that provide evaluation, stabilization, and referrals to ongoing care.
- Providing for immediate and long-term postvention to help respond effectively and compassionately to a suicide death, including intermediate and long-term supports for people bereaved by suicide.
- Reducing access to lethal means by educating families of those in crisis about safe storage of medications and firearms, distributing gun safety locks, changing medication packaging, and installing barriers on bridges.
- Enhancing life skills and resilience to prepare people to safely deal with challenges such as economic stress, divorce, physical illness, and aging. Skill training, mobile apps, and self-help materials can be considered.
- Promoting social connectedness and support to help protect people from suicide despite their risk factors. This can be accomplished through social programs and other activities that reduce isolation, promote a sense of belonging, and foster emotionally supportive relationships.
  (SPRC, 2020a)

Gatekeeper Training Programs

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

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

Reducing Access to Lethal Means

When a person is at risk for suicide, actions are required to removal lethal means. There are many actions that can be taken by families, organizations, healthcare providers, and policymakers to reduce access to lethal means of self-harm. Examples include:

- Responsible **firearm storage** involves keeping them locked and preferably unloaded, and separating firearms and ammunition when not in use.

- Reducing **means of suffocation** includes taking measures to reduce suicide by hanging in controlled environments including hospitals, prisons, and police custody.
- Safe **storage and disposal of prescription and nonprescription drugs** includes drug lockboxes, drug buyback programs, and confidential drug return programs.
(NAASP, 2020)

CONCLUSION

Suicide—the deliberate ending of one's own life—is an important public health concern. One important thing to consider is that most people are ambivalent about dying by suicide. They are caught in a situation from which they see no way out but to end their lives. This ambivalence is important, as it is the starting point at which an effective intervention can occur.

It is imperative that healthcare professionals understand the ways in which they can screen individuals at risk of suicide. This includes recognizing who is at risk, especially those who may be at high risk in the near future. Reducing suicide also depends on a comprehensive approach to prevention.

RESOURCES

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

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

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

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

Suicide & Crisis Lifeline
https://988lifeline.org
988 (call or text)
800-273-TALK (8255)

Suicide prevention (National Institute of Mental Health)
https://www.nimh.nih.gov/health/topics/suicide-prevention

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

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

REFERENCES

AACI. (2020). *Healthy living blog-mental health and suicide rates in middle-aged adults*. https://aaci.org/healthy-living-blog-mental-health-and-suicide-rates-in-middle-aged-adults/

Alothman D, Card T, Lewis S, et al. (2022). Risk of suicide after dementia diagnosis. *JAMA, 79*(11), 1148–54. doi:10.1001/jamaneurol.2022.3094

American Academia of Pediatrics (AAP). (2022). *Screening for suicide risk in clinical practice*. https://www.aap.org/en/patient-care/blueprint-for-youth-siuicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/screening-for-suicide-risk-in-clinical-practice/

American Foundation for Suicide Prevention (AFSP). (2023). *Risk factors, protective factors and warning signs*. https://afsp.org/risk-factors-protective-factors-and-warning-signs

American Psychological Association (APA). (2023). *Trauma before enlistment linked to high suicide rates among military personnel, veterans.* https://www.socialworktoday.com/news/dn_081314.shtml

Association for Behavioral and Cognitive Therapies. (ABCT). (2022). *Military suicide.* https://www.abct.org/fact-sheets/military-suicide/

California Evidence-Based Clearinghouse for Child Welfare (CEBC). (2020). *Suicide behaviors questionnaire–revised (SBQ-R).* https://www.cebc4cw.org/assessment-tool/suicide-behaviors-questionnaire-revised

Centers for Disease Control and Prevention (CDC). (2022b). *Suicide data and statistics.* https://www.cdc.gov/suicide/suicide-data-statistics.html

Centers for Disease Control and Prevention (CDC). (2022c). *Suicide and occupation.* https://www.cdc.gov/niosh/topics/stress/suicide.html

Columbia University. (2021). *A simple set of 6 questions to screen for suicide.* https://www.columbiapsychiatry.org/news/simple-set-6-questions-screen-suicide

Gorn D. (2023). *Veterans in America.* RAND Corporation. https://www.rand.org/multimedia/podcasts/veterans-in-america/why-so-many-military-women-think-about-suicide.html

Hawgood J, Woodward A, Quinnett P, & De Leo D. (2022). Gatekeeper training and minimum standards of competency: Essentials for the suicide prevention workforce. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 43*(6), 516–22.

Herman E & Parmar R. (2022). Taking care of caregivers. *Psychiatric Times.* https://www.psychiatrictimes.com/view/taking-care-of-caregivers

Joshaghani N, Villa N, Badla O, et al. (2022). How residing in a long-term care facility affects suicidal risk in patients with dementia: A systematic review. *Cureus, 14*(8), e27858.

Kennebeck S & Bonin L. (2021). Suicidal behavior in children and adolescents: Epidemiology and risk factors. *UpToDate.* https://www.uptodate.com/contents/suicidal-behavior-in-children-and-adolescents-epidemiology-and-risk-factors

Military Suicide Research Consortium. (MSRC). (2022). *Study reveals top reason behind soldiers' suicides*. https://msrc.fsu.edu/news/study-reveals-top-reason-behind-soldiers-suicides

National Action Alliance for Suicide Prevention Lethal Means Stakeholder Group (NAASP). (2020). *Lethal means & suicide prevention: A guide for community & industry leaders.* https://theactionalliance.org/resource/lethal-means-suicide-prevention-guide-community-industry-leaders

National Council on Aging (NCOA). (2021). *Suicide and older adults: What you should know*. https://ncoa.org/article/suicide-and-older-adults-what-you-should-know

National Institute of Mental Health (NIMH). (2022). *Ask suicide-screening questions (ASQ) toolkit.* https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

Nationwide Children's Hospital. (2021). *Understanding why kids die by suicide.* https://www.nationwidechildrens.org/family-resources-education/700childrens/2021/09/understanding-why-kids-die-by-suicide

Nevada Division of Public and Behavioral Health (NV DPBH). (2021). *Risk and protective factors.* https://suicideprevention.nv.gov/Adult/Risk/

Newport Institute. (2022). *Preventing suicide among young adults: Statistics and strategies.* https://www.newportinstitute.com/resources/mental-health/suicide-among-young-adults/

O'Dwyer S, Janssens A, Sansom A, Biddle L, et al. (2021). Suicidality in family caregivers of people with long-term illnesses and disabilities: A coping review. *Comprehensive Psychiatry,* 110, 152261.

O'Rourke M, Jamal R, & Siddiqui W. (2022). *Suicide screening and prevention.* StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK531453/

Purdue University. (2022). *QPR suicide prevention gatekeeper training available this fall.* https://www.purdue.edu/newsroom/purduetoday/releases/2022/Q3/qpr-suicide-prevention-gatekeeper-training-available-this-fall.html

Qin P, Syeda S, Canetto S, Arya V, et al. (2022). Midlife suicide: A systematic review and meta-analysis of socioeconomic, psychiatric and physical health risk factors. *Journal of Psychiatric Research, 154,* 233–41.

Sruthi M. (2022). *What age group is the most suicidal?* MedicineNet. https://www.medicinenet.com/what_age_group_is_the_most_suicidal/article.htm

Suicide Prevention Resource Center (SPRC). (2020a). *A comprehensive approach to suicide prevention*. https://www.sprc.org/effective-prevention/comprehensive-approach

The Joint Commission (TJC). (2023). *Suicide prevention.* https://www.jointcommission.org/resources/patient-safety-topics/suicide-prevention/

Twenge J. (2020). *Increases in depression, self-harm, and suicide among U.S. adolescents after 2012 and links to technology use: Possible mechanism*. https://prcp.psychiatryonline.org/doi/full/10.1176/appi.prcp.20190015

U.S. Department of Veterans Affairs (VA). (2022a). *The relationships between PTSD and suicide*. https://www.ptsd.va.gov/professional/treat/cooccurring/suicide_ptsd.asp

U.S. Preventive Services Task Force (USPSTF). (2022). *Suicide risk in adolescents, adults, and other adults: Screening.* https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/suicide-risk-in-adolescents-adults-and-older-adults-screening

Western Michigan University (WMU). (2023). *Protective factors.* https://wmich.edu/suicideprevention/basics/protective

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TEST

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

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

2. Which person is considered at risk for suicide?

a. A 55-year-old male who started employment at age 18
b. A 60-year-old female whose spouse died six months ago
c. A 23-year-old female who attends religious services on holidays
d. A 70-year-old male whose grandson helps with the garden

3. Which statement describes the Joint Commission recommendation for suicide screening?

a. For adolescent patients in primary care settings
b. For adult patients in acute care settings
c. For older adult patients in primary care settings
d. For all individuals ages 12 and over in all medical settings

4. For which patient would the Ask (ASQ) Suicide Screening tool be appropriate?

a. An 80-year-old male who naps several times during the day
b. A 50-year-old female who asks for help with smoking cessation techniques
c. A 9-year-old girl who asks a parent to donate favorite dolls to an orphanage
d. A 30-year-old male whose work schedule prevents socializing with friends on weekends

5. Which statement by a patient at risk for suicide indicates the need for prevention intervention in the home environment?

a. “I turn in my old, unused medications to the pharmacy.”
b. “I attend job retraining courses online at home.”
c. “I keep a gun under my bed to feel safer at night.”
d. “I play cards at the community center two afternoons a week.”