Assessing suicide

risk

CE
2.0
ANCC/AACN
CONTACT HOURS

Would you recognize suicidal behavior in one of your patients and know how to intervene? We'll give you practical, potentially lifesaving guidelines you can follow.

CONSTANCE CAPTAIN, RN, PHD
Clinical Nurse Specialist • Behavioral Health
North Broward Hospital District Service • Fort Lauderdale, Fla.

The author has disclosed that she has no significant relationships with or financial interest in any commercial companies that pertain to this educational activity.

JOESEPH GAINES, a single, 36-year-old teacher, came to the emergency department (ED) by ambulance after his neighbor called 911. He suffered a near-fatal overdose—a failed suicide attempt. He was transferred to your medical-surgical unit after being in the intensive care unit (ICU) for 2 days. According to the ICU nurse, when Mr. Gaines regained consciousness, he was angry about being rescued.

Nearly 500,000 ED admissions for suicide-related injuries are reported annually, so sooner or later you're likely to care for a patient like Mr. Gaines (see *Suicide in the United States: By the numbers*). After a patient attempts suicide, hospital policy defines the nursing interventions needed. More difficult, however, is identifying suicide risk in a patient who's admitted for an illness or injury unrelated to a suicide attempt.

In this article, I'll provide an overview of suicide and suicide prevention in a medical-surgical setting and discuss risk factors, elements of an effective suicide assessment, and nursing interventions you can apply to your everyday practice.

Overcoming barriers

Patients rarely attempt suicide when admitted for a specific physical problem, probably because these patients are generally treated and discharged as quickly as possible. If a hospitalized patient attempts suicide, with or without a permanent loss of function such as brain damage, or commits suicide, it's a sentinel event according to The Joint Commission.

Admission patient-assessment forms seldom include questions about suicide, and most nurses don't routinely screen patients for suicide risk, even though patients aren't likely to volunteer information about suicidal thoughts. One study indicated that two of every three people who commit suicide may have seen a primary care provider in the month before their death, suggesting that health care professionals are missing opportunities to intervene. In hospitals, shorter stays hinder the development of nurse/patient relationships, so patients may not feel comfortable enough to disclose suicidal thoughts to caregivers.

Like many nurses, you may feel uncomfortable with the topic too. For instance, you may be afraid that asking a patient about suicidal intentions may trigger suicidal thinking or behavior. Or you may not know what to say or do if he admits to having suicidal thoughts. To save lives, we need to

overcome these barriers by making suicide assessment part of routine nursing assessment.

Let's consider some basic information you need to know before you can assess a patient's risk and intervene effectively.

Along the continuum

Most suicide attempts are expressions of extreme distress, not bids for attention. Suicidal behavior develops along this continuum:

- ***ideation.*** This is the process of contemplating suicide or the methods used without taking action. At this point, the person might not talk about these thoughts unless he's pressed.
- ***suicidal gestures.*** These are actions that aren't likely to be lethal, such as taking a few pills or making superficial cuts on the wrist. They suggest that the person is ambivalent about dying or hasn't planned to die. He has the will to survive, wants to be rescued, and is experiencing a mental conflict. A suicidal gesture is often called a cry for help because the person is struggling with unmanageable stress.
- ***suicide attempts.*** An attempt, such as taking a potentially lethal dose of medication, indicates that the person wants to die and has no wish to be rescued.
- ***suicide.*** The act of intentionally killing oneself may follow previous attempts, but about 30% of those who commit suicide are believed to have done so on their first attempt. Suicide results when the person can see no other option for relief from unbearable emotional or physical pain.

Physiologically speaking

Research is beginning to unravel some of the physiologic reasons for suicidal behavior. For example, psychological autopsy studies suggest that in 90% of completed suicides, the person had one or more mental disorders, usually major depression and substance abuse, particularly alcoholism. A psychological autopsy, which is a technique used to discover a suicide victim's state of mind before his death, is often used for legal purposes.

Researchers are also investigating how alterations in neurotransmitters such as serotonin negatively affect mood and judgment. Diminished levels of this brain chemical have been found in people with depression, impulsive disorders, or a history of suicide attempts and also in suicide victims (see *The role of neurotransmitters*).

Understanding the motivation behind suicidal behavior is difficult not only for nurses, who are dedicated to saving lives, but also for suicidal patients themselves. Those who've attempted suicide most commonly express their need to escape from an unbearable situation, usually one involving despair and mental or physical pain. Many

Suicide in the United States: By the numbers

- Over 30,000 suicides occur each year.
- Suicide is the 11th leading cause of death overall.
- Over 60% of all people who die by suicide suffer from major depression; alcoholism is a factor in about 30% of all completed suicides.

By age

- Suicide is the third leading cause of death for young adults between the ages of 15 and 24.
- It's the fourth leading cause of death in adults between the ages of 18 and 65.
- It's the fifth leading cause of death in children and adolescents between the ages of 5 and 14.

By gender

- Four men commit suicide for every one woman, but twice as many women attempt suicide than men.
- Seven times the number of men than women over age 65 commit suicide.
- The suicide rate for men increases after age 65; the rate for women peaks between the ages of 45 and 54 and again after age 75.

By method

- Firearms account for 52% of all suicides.

Adapted from American Foundation for Suicide Prevention, Facts and figures: National statistics. **http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=050FEA9F-B064-4092-B1135C3A70DE1FDA**. Accessed January 15, 2008.

patients describe their emotional pain as a constant, intolerable, inescapable heaviness. Depression and despair often accompany medical conditions that are characterized by physical pain, disfigurement, limited function, and loss of independence.

But how do you know if your patient is at risk for suicide? Let's take a closer look.

Recognizing risks

To prevent suicide, the first steps are identifying and understanding risk factors. A risk factor is anything that increases the likelihood that a person will harm himself, and it should alert you to the need to assess him further for suicidal ideation.

Consider why your patient is currently in the hospital; this may be the first indication of increased risk. For many patients, hospitalization is likely to mean bad news: a confirmed diagnosis, troubling test results, a decline in health, or difficult medical decisions. You'll need to evaluate your patient's emotional response to his medical condition, not just his physical status.

Don't be afraid to ask about suicidal thoughts (see *Interview do's and don'ts*). Most patients who are suicidal are relieved to talk about their feelings and to be assured that they aren't crazy for thinking this way. First, assess your patient for depression by asking a question like this: Are you feeling depressed (or sad or discouraged)? If the answer is yes, then ask these standard suicide assessment questions:

- How long have you felt like this?
- Do you feel that your life is no longer worth living?
- Are you thinking of acting on that feeling by hurting yourself or taking your own life?
- Do you have a suicide plan?
- Can you tell me about your plan?

You should ask for detailed information if your patient has a suicide plan. A plan is more likely to be lethal if he can articulate specifics, such as method and place; believes the plan can succeed; and has devised precautions to avoid interruption or discovery. Ask whether he has made final arrangements, such as a will or other instructions, or has given away treasured items. His responses will provide you with a sense of the seriousness of his suicidal intentions. If you determine that he's at risk for suicide, never leave him alone even if he can't carry out his plan in the hospital. You'll also need to implement suicide precautions.

Now let's take a look at what you need to do if your patient is suicidal.

One on one

Because a nonpsychiatric hospital environment is loaded with potentially dangerous items, you can't make it completely safe for a patient at risk for suicide. Initiate one-to-one observation status according to your

Interview do's and don'ts

When interviewing a patient at risk for suicide, follow these guidelines.

Do set clear goals

The assessment interview isn't meant to be a random discussion. Make sure you have clearly set goals, such as investigating for depression or suicidal thoughts.

Do heed unspoken signals

Listen carefully for indications of anxiety or distress. What topics does the patient ignore or pass over vaguely? You may find important clues in his method of self-expression and in the subjects he avoids.

Do check yourself

Monitor your own reactions. The patient may provoke an emotional response strong enough to interfere with your professional judgment.

Don't rush

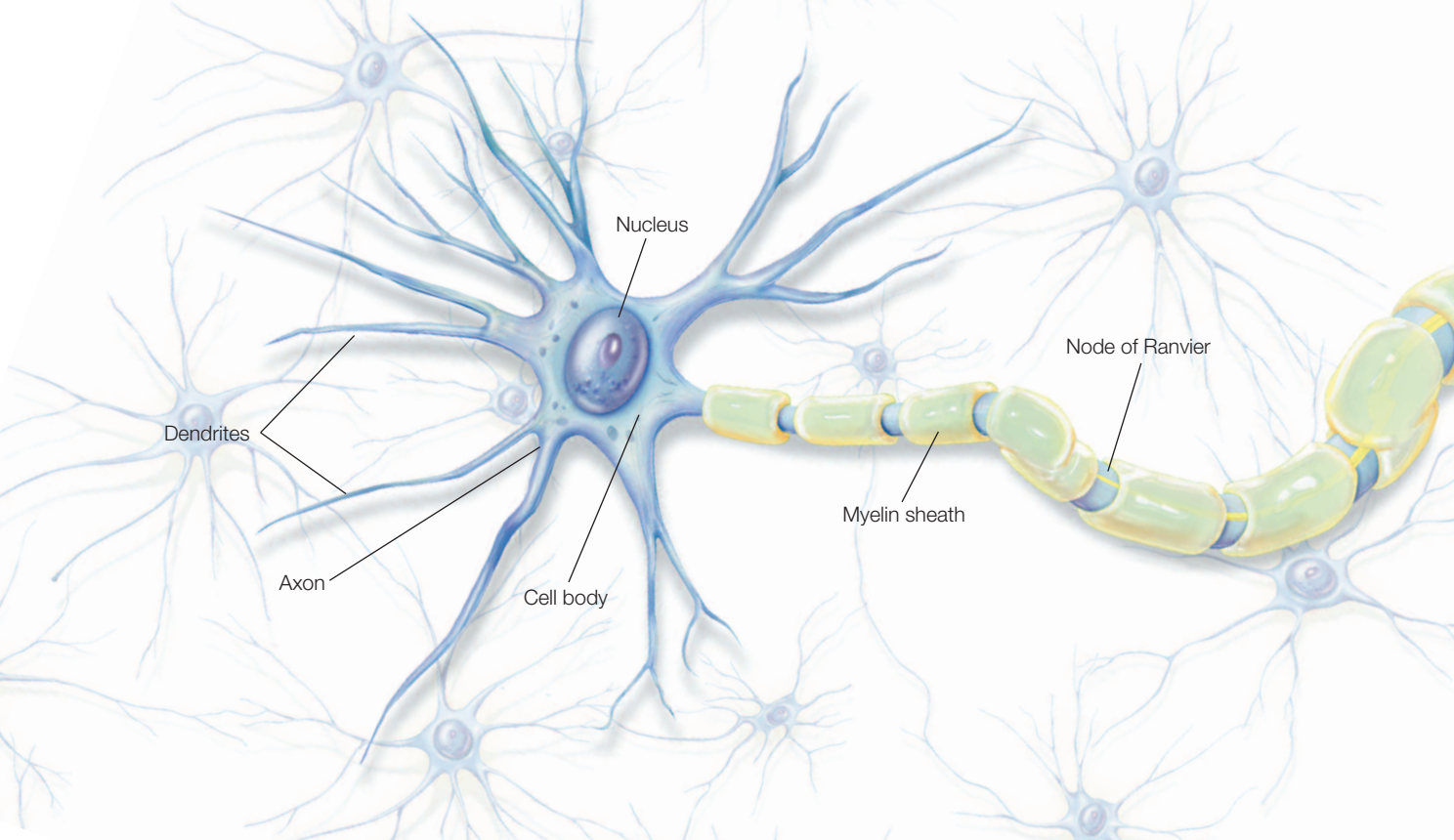
Don't rush through the interview. Remember, building a trusting therapeutic relationship takes time.

Don't make assumptions

Don't make assumptions about how past events affected the patient emotionally. Try to discover what each event meant to him. For example, if he says one of his parents died, don't assume that the death provoked sadness. A death by itself doesn't cause sadness, guilt, or anger. What matters is how the patient perceives the loss.

Don't judge

Don't let personal values cloud your professional judgment.



The role of neurotransmitters

Affecting behavior, mood, and thought, neurotransmitters are chemical messengers released into the synapses (gaps) between neurons (nerve cells) that carry messages from one neuron to another. If a person has low levels of the neurotransmitters norepinephrine and serotonin in areas of the brain that control mood and emotion, depression may result.

facility's policy, notify his primary care provider, and explain to him why you're taking precautions. Assure him that you want to keep him safe until he's feeling less despondent and more in control. Most hospitals have a written policy on caring for a suicidal patient who has already attempted suicide like Mr. Gaines. Follow your facility's policy; obtain a copy and use it as a guide.

Risk factors for suicide

cheat sheet

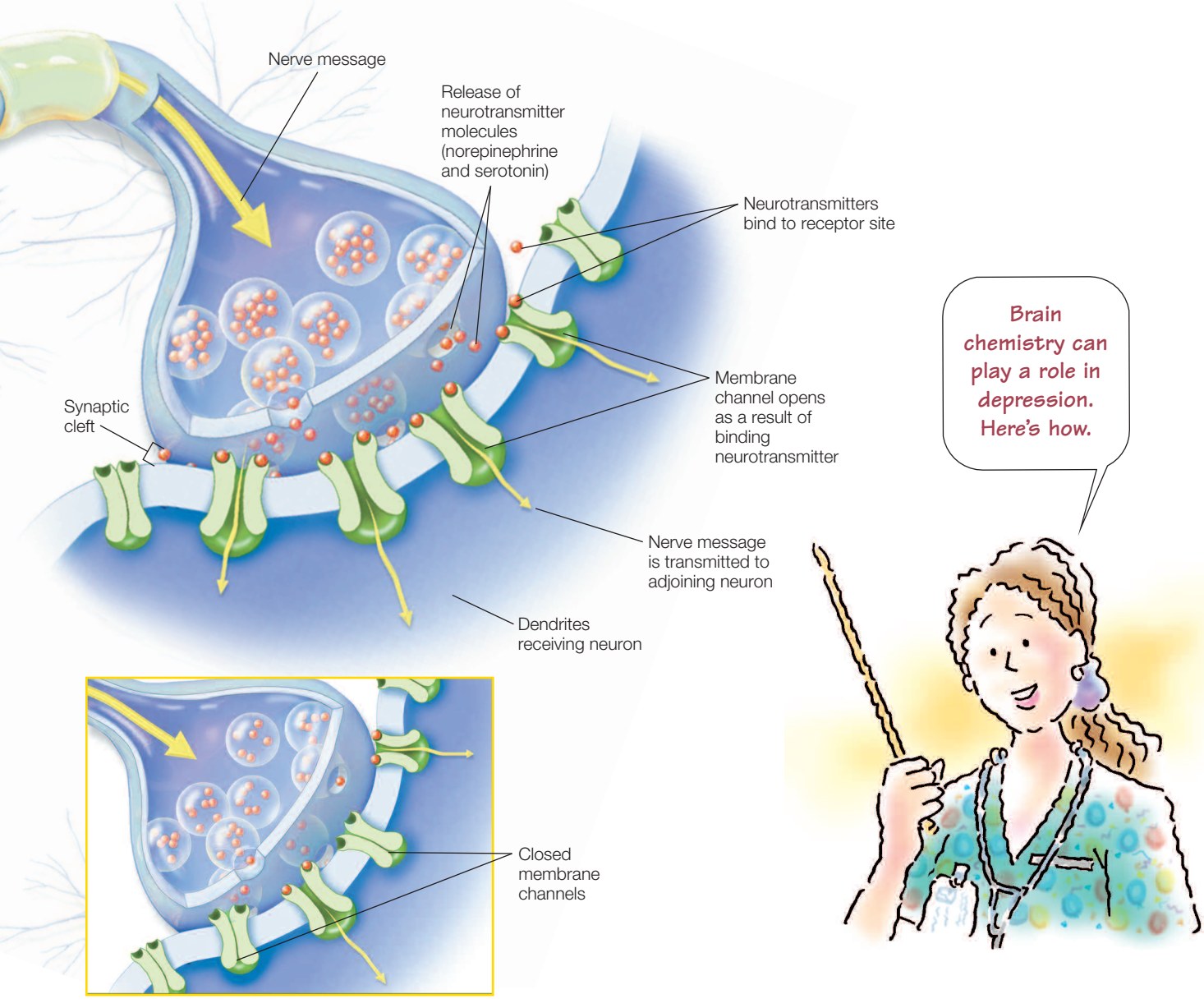
Consider your patient at risk if he:

- verbalizes suicidal thoughts, wishes, or a plan
- has a history of one or more suicide attempts
- has a family history of suicide
- feels depressed or anxious or expresses feelings of hopelessness
- has a chronic mental illness or history of mental illness
- abuses alcohol or another substance
- has a physical illness with a poor prognosis
- has impulsive or aggressive tendencies
- has suffered a significant loss or multiple losses (such as the death of a spouse, job loss, or financial setback)
- has access to lethal methods, such as firearms or medications
- feels ambivalent about treatment or doesn't cooperate with treatment
- suffers from loneliness and lacks a social network.

If you initiate one-to-one observation, instruct the observer to stay at least an arm's length away from the patient at all times. An appropriate observer is a staff nurse who's been trained on how to observe and how to respond. Although family members may ask to fill this role, it isn't appropriate for them to do so because they may not know how to respond. Using them could also present liability issues.

Other common safety measures include:

- removing all sharp or hazardous objects (including plastic bags and metal coat hangers) from the patient's room
- requesting that food be served with paper plates and cups and plastic eating utensils
- taking away potentially hazardous personal items, such as shoelaces, belts, glass objects, and lighters
- performing a contraband check of all personal belongings
- telling visitors not to leave anything with the patient unless the nurse approves
- observing the patient to make sure he swallows medications
- restricting him to the unit
- locating him near the nurses' station



■ placing him in a room with another patient.

I find that having the patient write and sign a no-harm contract is a good way to encourage him to start taking charge of his own behavior and become an active partner in his treatment. It might include statements such as "I won't harm myself while I'm in the hospital. I'll tell the nurse if I have thoughts of harming myself." Another early intervention is to involve the family, if your patient consents. Ask him if he has a family member or friend whom he wants to involve in his care.

Comprehensive documentation for your patient should include risk factor data, direct quotes that capture his suicidal thoughts or plans, actions you took to keep him safe, who you notified about his suicidal behavior, and precautions taken.

Working through it

Reassess your patient at least once per shift to determine his current level of suicidal intent and whether one-to-one observation should continue. Ask him to rate his level of suicidal intent on a 0-to-10 scale, with 0 meaning no thoughts of suicide and 10

meaning constant thoughts of suicide. Document the score during each shift so staff members can track trends.

You can also use the comparisons to help your patient understand what factors may or may not be decreasing his suicidal thoughts or underlying depression. For instance, did he have visitors, receive cards or flowers, sleep well, or participate in self-care? This will give him some insight into factors contributing to his improved mood or sense of hope.

You can help your patient by talking about his experience in a sincere and supportive way. You'll want to spend uninterrupted, but not necessarily long, periods with him. One approach is to relieve the observer for breaks and meals. Focus your interactions on your patient's present crisis. For example, you might say, "Help me understand. Can you tell me what's going on in your life that's unbearable?" This approach encourages him to talk about his circumstances and perceptions. To assess his emotional status, focus on how he feels. After a suicide attempt, some patients are embarrassed and some are relieved that they were rescued. Others, like Mr. Gaines, are disappointed and angry.

As his nurse, show empathy by listening as your patient expresses his frustration. If he says he's feeling discouraged or depressed, explain that, until it lifts, depression limits a person's ability to see other options. Suicidal behaviors are often transient and time limited and can be precipitated by a personal crisis. Focus on the precipitating factors and events leading up to the attempt and look for an opportunity to talk about alternative problem-solving approaches he could have used. For example, you might ask, "Have you ever been in a similar situation? How did you handle that?" Ask open-ended questions, listen, and reinforce his efforts to work through his feelings and concerns. Don't try to resolve his problems, give advice, or point out how much better off he is than someone who's less fortunate.

Ultimately, you want your patient to regain a sense of hope. This process begins with helping him identify personal strengths and setting small achievable goals. Listen for and pick up on any reference to the future, which is a positive sign suggesting improvement.

What are the treatments available for a patient who's suicidal as a result of depression? That's up next.

Looking to the future

Standard treatment for a patient with major depression is antidepressant medication

Mental health assessment review

cheat sheet

Obtaining a mental health history

- Establish a trusting, therapeutic relationship.
- Choose a quiet, private setting.
- Maintain a calm, nonthreatening tone of voice to encourage open communication.
- Determine your patient's chief complaint, using his own words to document it.
- Discuss past psychiatric disturbances and previous psychiatric treatment, if any.
- Obtain his demographic and socioeconomic data.
- Discuss his cultural and religious beliefs.
- Obtain a medication history.
- Ask about a history of medical disorders; some conditions may adversely affect his mental health.

Mental status checklist

- Appearance
- Demeanor and overall attitude
- Extraordinary behavior
- Inconsistencies between body language and mood
- Orientation to time, place, and person
- Confusion or disorientation
- Attention span
- Ability to recall events
- Intellectual function
- Speech characteristics that indicate altered thought processes
- Insight
- Coping or defense mechanisms
- Self-destructive behavior
- Psychological and mental status test results

combined with counseling or other talk therapy. Teach your patient about his medications and explain that these drugs may not be fully effective for weeks. In addition, prepare him for follow-up psychiatric care. He may have a psychiatric consult while he's in your unit or he may be transferred to a psychiatric facility or the psychiatric unit within your facility. Informing him of this in advance will help him accept and cooperate with this routine practice.

If your patient is discharged home, ask his permission to have a family member ensure that the home environment is safe and free from weapons, potentially dangerous medications, and other hazards.

Assess and act

By knowing how to assess a patient's risk of suicide and taking appropriate nursing actions, you may prevent a suicide attempt. You don't need to be a psychiatric nurse to recognize a vulnerable patient and initiate interventions that may save his life. ■

Learn more about it

Assessment Made Incredibly Easy!, 3rd edition. Philadelphia, Pa., Lippincott Williams & Wilkins, 2005:67.

Captain C. Is your patient a suicide risk? *Nursing2006.* 36(8):43-47, August 2006.

Pathophysiology Made Incredibly Visual! Philadelphia, Pa., Lippincott Williams & Wilkins, 2008:80-81.

Psychiatric Nursing Made Incredibly Easy! Philadelphia, Pa., Lippincott Williams & Wilkins, 2004:20.

On the Web

These online resources may be helpful to your patients and their families:
American Foundation for Suicide Prevention: **http://www.afsp.org**
Centers for Disease Control and Prevention: **http://www.cdc.gov/ncipc/factsheets/suifacts.htm**
National Institute of Mental Health: **http://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml**
Suicide Prevention Resource Center: **http://www.sprc.org**
World Health Organization: **http://www.who.int/mental_health/prevention/suicide/suicideprevent/en**.

CE Connection

Earn CE credit online:
Go to http://www.nursingcenter.com/CE/nmie and receive a certificate *within minutes*.

INSTRUCTIONS

Assessing suicide risk

TEST INSTRUCTIONS

- To take the test online, go to our secure Web site at **www.nursingcenter.com/ce/nmie**.
- On the print form, record your answers in the test answer section of the CE enrollment form on page 55. Each question has only one correct answer. You may make copies of these forms.
- Complete the registration information and course evaluation. Mail the completed form and registration fee of $21.95 to: **Lippincott Williams & Wilkins, CE Group**, 2710 Yorktowne Blvd., Brick, NJ 08723. We will mail your certificate in 4 to 6 weeks. For faster service, include a fax number and we will fax your certificate within 2 business days of receiving your enrollment form. Deadline is June 30, 2010.
- You will receive your CE certificate of earned contact hours and an answer key to review your results. There is no minimum passing grade.

DISCOUNTS and CUSTOMER SERVICE

- Send two or more tests in any nursing journal published by Lippincott Williams & Wilkins together and deduct $0.95 from the price of each test.
- We also offer CE accounts for hospitals and other health care facilities on nursingcenter.com. Call **1-800-787-8985** for details.

PROVIDER ACCREDITATION

Lippincott Williams & Wilkins, publisher of *Nursing made Incredibly Easy!*, will award 2.0 contact hours for this continuing nursing education activity.

LWW is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

LWW is also an approved provider of continuing nursing education by the American Association of Critical-Care Nurses #00012278 (CERP Category A), District of Columbia, Florida #FBN2454, and Iowa #75. LWW home study activities are classified for Texas nursing continuing education requirements as Type 1. This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749, for 2.0 contact hours. Your certificate is valid in all states.