FLEX CEUs

Suicide Prevention

Introduction [1]

Suicide affects around thirteen people per 100,000 in the United States each year. This means that just under 46,000 individuals commit suicide each year in the US. Nearly everyone likely knows someone who is affected by suicide. Healthcare professionals who interact with patients as clinicians should be aware of the crisis of suicide and have strategies through training to help. The state of Washington recognizes that requiring the training of all patient-facing clinicians is a great opportunity to prevent and manage the problem of suicide in the state. This course will educate both Physical Therapists and Physical Therapist Assistants on important information regarding epidemiology, etiology, screening, identification, response, and referral resources to help patients at risk of suicide.

Overview and Background

Physical therapists and physical therapist assistants need to know the history, background, definitions, epidemiology, and etiology of suicide. It is difficult to respond appropriately to a patient at risk of suicide without having general knowledge about suicide, how many people it impacts, and the reasons someone may commit suicide. Every provider who does not specialize in mental health has a responsibility to screen for mental health disorders that may lead to suicide risk and for suicide risk itself. This strategy promotes comprehensive, patient-centered care to patients with mental health care needs. It also promotes prevention based on referrals for patients who are at low risk of suicide but who may be at risk later based on risk factors and mental health status. This section will detail pertinent background information so PTs and PTAs have knowledge of the scope of the issue of suicide, which will prepare them to act appropriately when screening their patients for suicide risk.

Washington State Suicide Prevention Plan [2]

Washington state is among the most progressive states in the country in suicide prevention efforts. The state has laid out a state suicide prevention plan which consolidates resources and efforts to prevent suicide in as many people as possible. The principles of the Washington state suicide prevention plan apply to everyone residing in the state, not just healthcare providers. The principles are as follows and adopted directly from the plan:

“Suicide is a preventable public health problem, not a personal weakness or family failure.

Everyone in Washington has a role in suicide prevention. Suicide prevention is not the responsibility of the health system alone.

Many people avoid discussing suicide. Silence and stigma about suicide harm individuals, families, and communities.

To prevent suicide in Washington, we must change the factors we know contribute to suicide risks, such as childhood trauma, isolation in our communities, access to lethal means, and lack of access to appropriate behavioral healthcare.

Suicide does not affect all communities equally or in the same way. Suicide prevention programs should be based on the best available research and best practices while reflecting community needs and local cultures.

People experiencing mental illness, substance use disorders, trauma, loss, and suicidal thinking and behavior deserve dignity, respect, and the right to make decisions about their care.” [3]

These principles guide the state’s goal of reducing suicide attempts, preventing suicide by triaging those in need of mental health resources, and reducing stigma around the topic of suicide. The strategy relies on education to the public, healthcare providers, and other fields who may identify suicide risk, such as teachers.

Washington State Suicide Prevention Requirements for Training [2,4]

The state of Washington has required suicide prevention and response training for healthcare professionals since the mid-2010s. Washington is the first state to implement widespread suicide prevention training for healthcare providers. The state implemented this requirement as a response to the state’s elevated suicide rates compared to the United States average. The state of Washington believes that healthcare providers of any type play a large role in suicide prevention. There is an estimate that about forty percent of those who attempted suicide visited a healthcare provider within seven days before their attempt. Healthcare providers of any type who are trained in the recognition and screening of suicide risk should be able to detect risk at an initial visit and refer to the correct resources.

According to code WAC 246-12-630, several components of the training are necessary to meet the state requirement. It must be evidence-based, reflect cultural sensitivity, how to gain insight on warning signs for suicide, how to document suicide risk, how to refer and act when discovering someone at risk of suicide, and what psychiatric and psychological interventions are available. Physical therapists and physical therapist assistants must take three hours of appropriate training every continuing education (two-year) cycle of license renewal.

Background and Definitions [5–12]

Suicide is a critical health event that causes around two percent of total human deaths across the world. It is important to clarify definitions regarding suicide including defining suicide, suicide attempt, suicide ideation, and suicidal planning. Healthcare providers must "speak the same language" with agreed-upon definitions to communicate the severity of their patient's situation. This helps to facilitate standardized documentation efforts that all providers will understand based on measurable components such as severity, frequency of suicidal ideation, and risk factors for suicide.

Suicide is defined as "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 as a result of their actions".[6] *Suicide ideation* describes a range of persistent contemplations and thoughts of committing suicide. This is also termed suicidal thoughts. There is some disagreement about what is considered suicidal ideation due to the broad definition. Some definitions include suicidal planning and others consider this to be a different stage. Either way as an element of suicidal ideation or an independent concept, *suicidal planning* is having a distinct and thought-out plan on how to carry out suicide and when.

Certain factors may increase someone's risk for suicide, like comorbid mental health illness, people who have endured violence such as abuse or sexual violence, and bullying. This is what we think of in modern times, and historical societies have not always considered suicide a mental illness. Elements of religion, understanding of mental health, and things like hierarchal societies shaped a negative view of suicide in ancient times.

Suicide diagnosis, prevention, and treatments have been reported dating back to 460 BC. Religious beliefs played an important role in the ideas surrounding suicide in Medieval Europe, where it was considered sinful and prohibited. The bodies of victims

were abandoned in forests when people were suspected or known to have committed suicide. However, in some circumstances, the act of suicide was considered necessary and even noble. An example of this is committing suicide to avoid being killed by enemies in war. In most cases in these times, suicide was considered murder. In Christianity, this was influenced by the writings of Augustine of Hippo, who elaborated that suicide was murder and a forbidden act based on the Sixth Commandment “You shall not murder”. The Catholic church forbade the right to burial and funeral from the sixth century to the sixteenth to seventeenth centuries when mental health became a recognizable cause. Societies in the twelfth century even considered suicide a felony, and there was a widespread belief that the bodies of those who died by suicide should be tortured. This was to create fear for others to commit the act and the belief that those who died by suicide had restless souls.

In the Middle Ages, societies believed that suicide was caused by delusion. By the seventeenth century, there was a clinical diagnosis and documentation of abnormal behavior. The condition was first recognized as an illness in 1642 in the United Kingdom. By the eighteenth and nineteenth centuries, the nervous system was suspected to be involved, along with psychiatric symptoms. By the twentieth century, suicide became recognized as a mood disorder. Globally, suicide is still considered a crime in twenty countries. For example, as of 2022 in Nigeria, people from the age of seven and beyond can still be prosecuted for attempted suicide. This remains a standard in third-world, low-income countries.

In first-world countries, suicide is now considered a mental health crisis. In 1961, the United Kingdom made suicide legal under the Suicide Act of 1961. In the United States, the Suicide Prevention Act, most recently updated in 2022, aims to create funding for the prevention of self-harm and suicide. These grants will be distributed to state, local, and tribal health centers to expand awareness and treatment to those at risk of suicide. The National Suicide Prevention Hotline (800-273-TALK) was established in 2001 in the United States, to connect those with a plan of committing suicide to trained mental health professionals. The hotline is now accessed by dialing just 988. The hotline is available every day and hour of the year to help those in need. Two other federal policies on suicide were the Garrett Lee Smith Memorial Act (2004), which created a grant program for preventing suicide in youth and college-aged citizens. In addition, the Joshua Omvig Veteran Suicide Prevention Act was passed in 2007, which has helped in the development of several programs to reduce suicide among veterans.

With historical and modern context, it is clear that the best strategies for addressing suicide are recognition and prevention. The state of Washington requires all healthcare professionals to be educated on just that – the recognition and response that can best serve patients at risk of suicide. RCW 43.70.442 is a Washington state code that requires "Suicide assessment, treatment, and management training" for most patient-facing clinicians. It is required for physical therapists and assistants to complete a one-time training in suicide assessment, treatment, and management as a profession licensed under Washington statute 18.74 RCW.

Epidemiology [1,3]

To understand the health crisis of suicide, it is important to describe the characteristics of victims and the number of people who are impacted. In 2020 in the United States 45,979 people died by suicide. Meanwhile, around twelve million adults thought extensively about suicide, around three million had a plan, and around one million attempted suicide. In 2020, men had a rate of suicide four times higher than women. The highest rate of suicide per age group is those older than eighty-five, followed by seventy-five to eighty-four and twenty-five to thirty-four.

In the state of Washington, rates of suicide are consistently higher than the national average in the United States. While the national average is around thirteen to fourteen people per 100,000, in Washington, sixteen to seventeen people out of 100,000 have committed suicide. In 2020, 1170 people in the state of Washington alone committed suicide. The most common age group to commit suicide in Washington was forty-five to sixty-four, followed by sixty-five plus. From 2017 to 2018 the most common group was those aged twenty to twenty-four. Males represented about twenty-six while females represented just seven of the total number of suicides in Washington in 2019. Firearms are the most common means, more than suffocation and poisoning combined. In terms of educational status, the most common groups to commit suicide are consistently those with no high school diploma followed by those with a high school diploma. Those with Bachelor's degrees, graduate degrees, and those with no high school education have committed suicide at rates at least fifty percent less. The most common ethnicities to commit suicide are American Indian and Alaskan Native populations. In 2019, this group had about as many deaths by suicide as Black, Asian, and Hispanic populations combined. The White non-Hispanic population has consistently the second highest rate of suicide in Washington.

Etiology and Risk Factors

An important aspect of understanding suicide is glimpsing into the etiology, or cause, of the condition. Each person who commits suicide is different, making it difficult to determine the root cause. There are typically many factors at play and those at risk or who have made a suicide attempt are often reluctant to participate in research regarding it. However, there are some trends among ages and populations with distinct characteristics that point to the cause of suicide and risk factors. These categories fall into one or multiple of the following: mental health, age, sex, financial stability, ethnicity, veteran status, and adverse childhood experiences. Suicide risk can be thought of as a combination of factors, and rarely a singular one.

Mental Health [13]

Adolescents with mental illness have up to a twelve-fold higher risk of committing suicide than their peers without mental illness. Mental health disorders that are proven to contribute to suicidal ideation and attempts include depression, anxiety, substance abuse disorders, personality disorders, trauma-based disorders, and psychosis. Resources estimate that as many as ninety percent of those considering or attempting suicide have at least one mental health disorder.

Depression [14]

Depression is a disorder where brain neurotransmitters of serotonin and norepinephrine are out of balance. It impacts around fifteen percent of people at some point in their lifetime. Symptoms of depression include feeling deep sadness, loss of pleasure in activities that someone normally enjoys, changes in appetite, difficulty sleeping or excess sleep, increased fatigue, feeling guilty or worthless, slowed speech and movement, difficulty concentrating, suicidal ideation, and fidgeting or pacing. To be diagnosed with depression, these symptoms must have lasted at least two weeks and be a change in baseline functioning. Women have a higher risk than men to experience depression and around forty percent of children with parents who have depression will develop depression themselves. Risk factors for depression include brain chemistry, inheritance from family, pessimistic outlook, low self-esteem, and negative experiences (abuse, neglect, poverty, etc.). Depression is becoming more treatable as researchers develop medications, new therapeutic techniques, and innovative psychotherapy methods. Every healthcare provider working with patients should screen for depression in their initial and subsequent visits, as applicable.

Anxiety [15]

Anxiety is the feeling of worry or uneasiness about uncertainty or an event. An anxiety disorder is a continual uneasiness or nervousness that directs behavior or the experience of panic attacks. Anxiety causes physiological symptoms of increased heart rate, blood pressure, and respiratory rate, along with taxing mental health. Anxiety sensitivity is the degree to which a person fears how anxious thoughts will affect their physical and mental state. Anxiety sensitivity produces physical concerns that a person is in poor health (like their heart skipping a beat) and that they could be close to death. Anxiety sensitivity predisposes a person to panic attacks and anxiety disorders along with an increased risk of severe suicidal ideation. This is the case because people with anxiety sensitivity often become isolated in fear of anxious symptoms when they are interacting with others. They perceive themselves as a burden to others and feel a sense that they do not belong. These factors, combined with others place people with anxiety disorders at a higher risk for suicide than the general public.

Substance Abuse Disorders [16]

Substance abuse or substance use disorders are associated with higher suicide rates, even with other factors such as other mental health disorders controlled for. Substance use disorder is defined by the use of a or multiple substances that causes symptoms such as social impairment, risky use, and impaired control, that someone continues to take despite noticing these problems. The DSM – 5 diagnostic criteria[17] are below:

1. Taking the substance in larger amounts or for longer than you are meant to
2. Wanting to cut down or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from the use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home, or school because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational, or recreational activities because of substance use
8. Using substances again and again, even when it puts you in danger
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance

10. Needing more of the substance to get the effect you want (tolerance)
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance

Substances that lead to substance abuse disorders include alcohol, drugs, and tobacco. For people with alcohol use disorder, the risk of suicide death is ten times greater than those without it. Substance use disorders range from mild to severe. In mild disorders, someone would experience two to three symptoms, in moderate, four to five symptoms, and with severe substance use disorder, they would experience six or more symptoms.

In men with substance use disorder, the risk of death by suicide is two times higher than the control for tobacco abuse and eight times higher for alcohol, drug, and tobacco use. For women, the risk of suicide was two and a half times greater for tobacco only and up to nearly seventeen times higher for alcohol, drug, and tobacco use.

Personality Disorders [18]

Personality disorders are defined as behaviors, feelings, and thinking patterns that differ from culturally accepted norms. Personality disorders impact the way someone would think about oneself and others, one's method of controlling their behavior, the way one relates to others, and the way one reacts to situations emotionally. Personality disorders fall into ten categories, which are listed and explained as follows:

Antisocial personality disorder represents a person who may manipulate others or act spontaneously, disregarding the implications on others.

Avoidant personality disorder represents a person who experiences low self-esteem, shyness, inadequacy, and who is very receptive to criticism. They often view themselves as incapable of making social connections due to the constant fear of rejection.

Borderline personality disorder (BPD) is a pattern of volatility in personal relationships, accompanied by strong emotional responses, spontaneity, and damaged self-esteem. Someone with BPD may experience strong feelings of abandonment and experience strong anger and emptiness which is an inappropriate response to the situation at hand. People with BPD are at a high risk of suicide – ten percent of people with BPD will die by suicide. BPD is characterized by periods of chronic suicidal ideation which can last months to years.

Dependent personality disorder occurs when a person exhibits submissive and reliant behavior and needs care from others. They have a very hard time making independent decisions and feel helpless when they have to be alone.

Histrionic personality disorder is characterized by a pattern of extreme emotion and attention-seeking. People with histrionic personality disorder seek to be the center of attention and will make a significant effort to be the center of attention either through physical appearance or emotional outbursts.

Narcissistic personality disorder is characterized by a lack of the ability to feel empathy and the need to be esteemed by others. Other characteristics are an elevated perception of one's importance and entitlement.

Obsessive-compulsive personality disorder is characterized by maintaining control driven by perfection and a need for order. Someone with this disorder may be hyper focused on details, may work extreme hours, and not make time for recreation or relationships.

Paranoid personality disorder is marked by constant suspicion of other people and a belief that people will hurt them in some way.

Schizoid personality disorder is characterized by distance from relationships with others and not showing emotion. A person will prefer being alone and does not value the opinion of other people.

Schizotypal personality disorder is marked by a pattern of discomfort in personal relationships and display of odd behavior. They also may have social anxiety.

These distinct personality disorders are mental health disorders that respond to treatment by a mental health professional. Borderline personality disorder is associated with suicide at the highest rate among these personality disorders, as suicidal ideation is part of the diagnostic criteria. Increased rates are also observed with antisocial personality disorders. Mental health professionals believe that other personality disorders also lead to higher rates of suicide due to feelings of isolation, rejection, and fear, and this is a focus of future research.

Trauma Based Disorders [19]

Trauma-based disorders, like post-traumatic stress disorder (PTSD), can also lead to an increased risk of suicide. The condition PTSD is characterized by reliving a traumatic or multiple traumatic experiences, flashbacks, experiencing distress when exposed to

similar experiences as their traumatic ones, and is a delayed response to a traumatic experience that threatened emotional or physical well-being. PTSD prevalence in women throughout a lifetime is around ten percent and in men around five percent in the United States. Overall, with all variables controlled on average people with PTSD die by suicide at a rate twice as high as those without PTSD. For those with PTSD, PTSD itself and symptoms from it are the reason for suicide in almost fifty-four percent of cases.

Psychosis [20]

Psychosis is defined as severe thought and emotion impairment such that one cannot see external reality. This can be triggered by an injury, illness, poisoning, abuse, trauma, or neurological disorders like Alzheimer's Disease or Parkinson's Disease. Research shows that if one experience's an episode of psychosis, no matter the cause of it, that person has a heightened risk of suicide ideation, attempts, and death by suicide. This risk may be heightened for decades after the experience of psychosis. A person is at a twofold higher risk of suicidal ideation, a threefold higher risk of suicide attempt, and a fourfold higher risk of death by suicide months to years after an episode of psychosis.

Age [21]

People of certain ages are more at risk for suicidal ideation, in combination with other factors. Older adults, that is adults over sixty-five years old, make up eighteen percent of total suicides in the US while this age group is only twelve percent of the population. Several factors contribute to higher suicide rates among older adults. First of all, older adults typically plan out their suicide plan more meticulously than their younger counterparts and they use more fatal means in suicide attempts. Older adults are much less likely to recover from a suicide attempt than younger people. This in addition to more lethal means, is why one in four older adults die by suicide after an attempt while just one in two hundred youths die after an attempt. Older men have the highest overall rate of suicide. This number is higher than in women because men tend to use more lethal means in suicide attempts (such as firearms).

Research and surveys conducted on older adults reveal the top reason for suicide in this age group is loneliness. Many senior citizens have lost many people that they love and find themselves physically incapable of living the life they want to. This leads to loneliness, depression, and a loss of will to live. This is especially true with seniors who live home alone and who have recently lost their spouse. Seniors also face fear of mortality and anxious thoughts around their death. They also experience the highest rates of chronic pain and persistent illness that can be debilitating. This includes

comorbidities like heart disease, arthritis, and diabetes, which come with a loss of quality of life, energy levels, and physical capabilities. Older adults may also face financial stress with living on a fixed income from their retirement packages. Lastly, older adults with cognition impairment (such as mild cognitive impairment and early stages of dementia), may lose the ability to make beneficial decisions or think more spontaneously. All of these factors and more can lead to major depression, which is one of the largest risk factors for suicide.

Sex [22,23]

The rate of suicide is consistently highest in males, no matter what their age. In 2020, almost four times more men than women died by suicide. White males represented around seventy percent of suicides in the US in 2020. Females have a higher rate of depression and a higher number of suicide attempts, however. Male suicide attempts are often more violent, making it difficult to impossible to save a life after the act is committed. Six in ten firearm owners in the United States are men, and guns are used in over half of suicide deaths. Researchers cite many factors for why men are more at risk than women for death by suicide. One of these reasons is the cultural value of males needing to show strength in all circumstances. This is rooted in childhood and by generations. Many boys are ashamed when they display emotions, which shows them at a young age that showing sadness and talking about it is considered weak. Adult males that were sent this message as children will be less likely to ask for help and to talk about their struggles. Research shows that males are less likely than females to identify a mental health problem that puts them at risk for suicide. Males have higher use of substance abuse, which puts them in more danger of suicide. Also, males have around ten percent lower rates than females of receiving mental health treatment and tend to "self-medicate" with drugs and alcohol more often. All of these factors increase the likelihood of males committing suicide more often than females.

Financial Stability [23–25]

Financial stress is a contributing factor in many suicide attempts and deaths. For many, losing a job in the United States means losing affordable healthcare. This means that people in financial crisis are much less likely to seek physical and mental health treatment. For those who are major breadwinners for their families, this stress is intensified. Living paycheck to paycheck and having a high debt-to-income ratio may lead to feelings of hopelessness and depression. An example of the severity that financial stress has on mental health is the link between homelessness, unemployment, financial stress, and suicide. The suicide rate increased in response to the 2008 recession in the

United States. For an increase in one percent of the unemployment rate, there is a population-level increase in suicide by around 0.8%. People who are homeless have a rate of up to ten times higher for suicide. Around half of people who are homeless experience suicidal ideation.

Immigrant Status and Ethnicity [13]

People who are immigrants in the United States have higher rates of suicide than their nonimmigrant counterparts, consistently. Immigrants face several problems such as feeling alone and separated from their families, language barriers, worrying about the safety of their family in their home country, lack of resources for healthcare and finances, no longer having a social network, and cultural differences. All of these factors and more can fuel depression and anxiety, and eventually suicidal ideation.

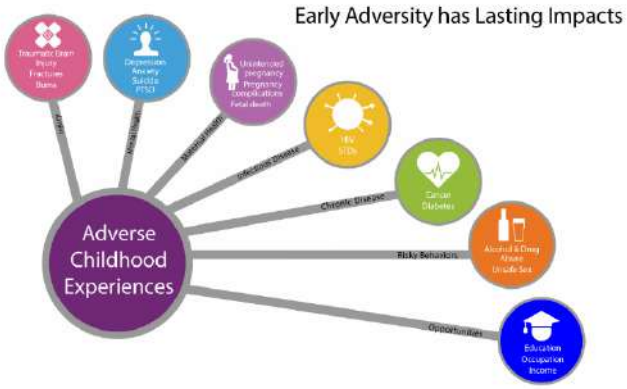
Veteran Status [26]

Veterans are at a higher risk than the general public for suicide due to many factors as well. From 2001 to 2021, over thirty thousand veterans who served in the military died by suicide while in the same twenty-year time period, just over seven thousand died from combat. Factors that put veterans at higher risk of suicide include isolation, a lack of social connection while being deployed, PTSD from experiences in combat or with other duties, undiagnosed mental health disorders like depression, PTSD, and anxiety, and any other factor that puts the general population at risk. Specific efforts and resources exist for veterans to connect to mental health resources. One of these is the specific separate line through the Suicide and Crisis Lifeline (Dial 988 and then dial 1).

Adverse Childhood Experiences [27]

Adverse childhood experiences (ACE) have been consistently studied and linked to poor health status in adulthood. This includes physical and mental health, and in this context mental health disorders and suicide. ACEs include events of trauma that occurred before the age of eighteen. Events that are considered ACEs are abuse, neglect, parental substance abuse, parental incarceration, and domestic violence. Abuse can be emotional, physical, or sexual in nature. Children and adolescents may experience events such as community violence or an abusive dating relationship outside the home as well. The higher number of ACEs a child experiences, the higher their likelihood of poor mental health will be in adulthood. This predisposes children, adolescents, and adults to risky behaviors such as substance abuse and unprotected sex. Children in the United States welfare system likely have experienced at least one ACE, and just over forty percent have experienced four ACEs. Exposure to these harmful events, while the

brain is still developing, will have repercussions for years to a lifetime. Adults who have experienced traumas such as adverse childhood events while growing up tend to experience higher rates of mental health disorders, substance abuse, and cycles of domestic violence where they become the perpetrator themselves.



https://www.in.gov/health/overdose-prevention/resources-for-the-public/adverse-childhood-experiences/

As previously mentioned, attempting suicide is rarely rooted in one cause. Victims typically struggle with many of the factors listed in this section, plus a slew of other personal and environmental factors. PTs and PTAs should approach their patient encounters with empathy and with knowledge of the issue of suicide when learning to screen for and refer patients at risk of suicide. Having an education on this topic will help save the lives of those affected by this serious mental health crisis.

Section 1 Key Words

Suicide - Death caused by purposefully injuring oneself with the intent to die

Suicide Attempt – An act of harming oneself with any intent to end one's life, but do not die as a result of the actions

Suicidal Ideation – A range of persistent contemplations and thoughts of committing suicide

Suicidal Planning - Having a distinct plan including where, when, and how one will commit suicide

Section 1 Summary

Suicide is a widespread health crisis happening across the globe. The idea of suicide has transformed from an illegal and sinful act in medieval times to a mental health crisis in

modern times. Many factors increase one's risk of suicide and it is rare for just one factor to lead to committing suicide. Mental health, financial stability, ethnicity, adverse childhood experiences, age, and many other factors contribute to suicide risk in the United States. The state of Washington has historically had a higher suicide rate than the United States average. This pronounces the need for identification and response training for all healthcare providers working in the state of Washington.

Screening and Identification of Suicide Risk

Physical therapists and assistants need to be trained in methods of screening for suicide and suicidal ideation to provide patient-centered care. Of course, there are different considerations between adults and pediatric patients and in different settings of physical therapy practice. With the training required by all Washington state healthcare professionals, PTs and PTAs should feel competent and able to screen for and detect someone at risk of suicide at any age or in any setting of employment. This section will detail evidence-based strategies to take the first step in suicide prevention – screening and detection.

National Patient Safety Goals [28]

The Joint Commission, the United States organization established in 1951 with the mission to provide the best possible healthcare and safety standards for the public, has developed patient safety goals around healthcare providers and detecting and responding to suicide risk. States can adopt the vision of these goals to ensure the best possible suicide prevention plan. As of 2019, the patient safety goal around suicide prevention is below.[28]

This standard is for any hospital, subacute care center, or behavioral health setting.

1. **NPSG.15.01.01**: *Reduce the risk of suicide*. The health center or hospital needs to complete a risk reduction method such as removing sharp objects, door hinges, and other potential dangers. Sitters and 24/7 supervision may be used to reduce the imminent risk of suicide as well.

The following list is the Joint Commission standard for patients being treated for behavioral health conditions as their primary treatment. PTs and PTAs may be employed in behavioral health settings, psychiatric hospitals, or general hospitals where a patient may be identified as a high risk for suicide.

2. **NPSG 15.01.01, EP 2:** *Screen all individuals served for suicidal ideation using a validated screening tool*. This is required for the prevention of suicide in a standardized approach. Providers should use age-matched screening tools when possible.

3. **NPSG 15.01.01, EP 3:** *Use an evidence-based process to conduct a suicide risk assessment of individuals served who have screened positive for suicidal ideation.* The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. This assessment is performed by a trained mental health professional as a standardized way to determine imminent risk. This is key in directing appropriate treatment.

4. **NPSG 15.01.01, EP 4:** *Document individuals' overall level of risk for suicide and the plan to mitigate the risk for suicide*. It is imperative to keep comprehensive records of patient encounters to inform other clinicians of the patient's suicide risk in future encounters.

5. **NPSG 15.01.01 EP 5:** *Follow written policies and procedures addressing the care of individuals served identified as at risk for suicide.* This includes training and reassessment principles to best keep track of someone's risk of suicide.

6. **NPSG 15.01.01, EP 6:** *Follow written policies and procedures for counseling and follow-up care at discharge for individuals served identified as at risk for suicide.* Practitioners should always provide resources and instructions for the best plan of care after discharge from a hospital or other facility.

7. **NPSG 15.01.01, EP 7:** *Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of individuals served at risk for suicide and take action as needed to improve compliance.* Quality improvement is key in acting to improve the standards of suicide screening and prevention for patients.

The Role of Rehabilitation Professionals in Suicide Risk Identification [29,30]

As a practice of prevention, many organizations are moving to mandatory suicide screening at a state and organizational practice. As of 2017, all states had some sort of suicide prevention plan but just sixteen states had a training requirement for healthcare professionals. In Washington, mental health professionals are required to have six hours of training every six years and physical therapists and assistants are required to take a

three-hour training one time for suicide prevention and response. Physical therapists in best practice ask standardized depression and suicide screening questions at every evaluation. This includes tools such as the Ask Suicide Screening Questions (ASQ) and the Patient Health Questionnaire (PHQ-9).

Physical therapists, physical therapist assistants, occupational therapists, certified occupational therapy assistants, and speech language pathologists are all crucial members of the healthcare team in terms of detecting suicide risk. All rehabilitation professionals tend to spend much more time than other providers such as physicians, physician assistants, nurses, and mental health professionals. This allows patients to often trust their physical therapist or assistant more than other providers, making them more likely to discuss problems not related to their reason for coming to PT. A lot of times, a patient may not say directly "I want to kill myself and I have a plan", but they may say something to the effect of "Everything feels difficult and I do not think I can carry on like this" or "It's just not worth trying anymore". Statements to this effect should necessitate an immediate screening for suicide risk, brought up compassionately, using communication strategies that work well within the patient and therapist relationship.

Considerations for Screening Per Setting

Suicide risk screening will look different with each different setting of physical therapy employment. This is mostly due to the structure of the organization and the patient and physical therapy staff's interactions with other providers. For example, a PT's role in screening and detection may be much more involved in a home health setting with little interaction with other providers than it is in a hospital setting with mental health resources on-site. The most important consideration for PTs and PTAs is to never assume mental health and suicide screening has been completed by another provider. Each provider who is trained for it has a responsibility to screen for health in all of the systems (mental health, cardiopulmonary, integumentary, etc.). This allows the most comprehensive approach to patient-centered care. Providers do need to maintain a balance of staying within their scope of practice, however. That is why providers who are not in the mental health field must screen and refer only, never actually treat someone for a mental health disorder or diagnosis.

Hospital and Subacute

The hospital and subacute settings (skilled nursing, long-term care, long-term acute care hospital) generally have a network of healthcare professionals working with each

patient. However, any provider at any point can detect suicide risk. Just because a patient is in the hospital, a PT or PTA should never assume they have been evaluated for suicide risk. A patient may disclose information to a provider that they trust the most. It is this provider's responsibility to screen the patient using a standardized tool, and then take appropriate action with mental health resources in the hospital or subacute setting. In skilled nursing and long-term care facilities, there are not as many disciplines on-site as in hospitals. This means that PTs and PTAs may be more involved in suicide risk detection than in a hospital setting. Facilities such as hospitals and subacute care organizations likely have a protocol with policies laid out on how to respond to patients at risk of suicide. It is imperative for physical therapists to follow this protocol and be over-communicative rather than under-communicative if their patients are in danger of committing suicide. It is important to keep in mind the demographics of those in subacute settings as well. Elderly populations have high rates of suicide attempts due to feelings of hopelessness, loneliness, and other factors.

School [31]

School physical therapists and assistants may come across students at high risk of suicide. States have different regulations for the training of school support staff like counselors, psychologists, administrators, and school social workers. PTs and PTAs should be aware of the language or behaviors a student may show who is at risk of suicide so they can refer to the appropriate resources. If a student is already receiving mental health services from school staff, PTs and PTAs working in these settings should be aware of this and screen for suicide using a standardized tool such as the Ask Suicide Screening Questions (ASQ), which will be discussed in this section. As providers who spend a good amount of time with their patients each session, students in school may develop a trusting rapport with their PT or PTA. This may lead to the student admitting they are contemplating suicide. If students begin to discuss something related to mental health or suicidal ideation, PTs and PTAs should direct the student to a location where they will not be overheard. This is to protect the confidentiality of the student. Schools typically have a protocol for imminent risk to a student, involving contacting a parent/guardian and prioritizing patient safety. This varies from school to school and all providers working in schools should be trained in this.

Home Health

Suicide screening in home health settings is very important because patients are homebound, may or may not have additional caregivers from family and others, and generally have higher rates of poor mobility and comorbidities. These factors and many

others put this population at risk of things like depression and suicide risk. The protocol for home health suicide screening varies in that PTs and PTAs may take on a more active role than in a hospital or a skilled nursing facility where mental health staff are available. Physical therapists and assistants would need to screen for suicide risk and the patient's readiness, and potentially refer to emergent care from home. This may include dialing 911 if the patient is in immediate danger and not allowing the patient to be alone. Additionally, this could mean calling the suicide hotline number to ensure that the patient has resources. This also means contacting the home health agency's mental health resources if the patient screens as low risk of immediate suicide.

Outpatient

In outpatient, physical therapists and assistants should ensure that patients feel safe and are in a private location away from other staff and patients to be able to disclose health information. This means closing the door to a room for physical therapy evaluations or directing the patient to a private room if they begin to disclose any health information. The protocol may vary for suicide detection based on the organization. Generally, screening should be a standard part of any PT evaluation and done again if necessary (a patient hints at hopelessness, sadness, or suicide).

Youth Screening [32]

Youth suicide is the second most common cause of death in the world. Upwards of six thousand people in the United States under the age of twenty-five died by suicide in 2016. Forty percent of youth who later committed suicide visited a medical facility within one month of suicide. This may be at a preventative care appointment or a hospital for a suicide attempt or other problem. Screening for the prevention of youth suicide starts at a systemic level with leadership, education, and protocol development. The main distinction of youth versus adult screening is involving the parent or guardian in every healthcare decision because the patient is a minor.

Systemic Suicide Risk Screening

As an international effort to improve suicide screening in pediatrics, a group of child and adolescent psychiatry consultation-liaison (CAP-CL) providers created a program called Pathways in Clinical Care. This program began in 2016 and is the largest international effort to identify youth at risk of suicide as early as possible in medical settings. The Suicide Risk Screening Clinical pathway acts as a template for organizations like hospitals and clinics to develop a customized screening tool that works for their specific structure.

There is a three-step process for suicide screening in youth populations. The steps are as follows and performed in sequential order, proceeding to the next step if the prior one is positive: suicide screening for risk with Ask Suicide-Screening Questions (ASQ), a suicide safety assessment (BSSA), and a full suicide safety assessment. The most common settings that screens will be positive are emergency departments, inpatient behavioral health units, and primary care clinics. This can happen in any setting, including settings where physical therapists and physical therapist assistants work with youth patients, such as hospitals, schools, and behavioral health units.

Ask Suicide Screening Questions (ASQ) [33]

The ASQ was originally developed and used for the pediatric population but is valid in youth and adult patients. It takes just seconds to administer as a first-line detection method for suicide screening. This tool is for PTs, PTAs, and any other clinician not specializing in behavioral health. It should be used in every patient interaction as part of a standard evaluation process. The questionnaire is as follows, with "yes" or "no" answers.

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts about killing yourself?
4. Have you ever tried to kill yourself? If yes, how and when?
5. Ask if the patient answers yes to any of 1-4; Are you having thoughts of killing yourself right now?

If the patient answers yes to question 5 it indicates an "acute positive screen" which necessitates emergent action. In a PT setting, this patient should not be left alone and must undergo a mental health and safety full evaluation by a qualified mental health provider (psychiatrist). They should be undergoing emergent care per protocol in the emergency department. If they answer no to question number 5 but yes to other questions, it indicates a "non-acute positive screen" and this indicates the possibility of risk. The protocol here is to have the patient undergo a brief suicide safety assessment to determine if a comprehensive mental health evaluation is necessary. They should not leave until this is completed.

In hospital settings, PTs and PTAs should communicate directly with the healthcare team (primary registered nurse, physician, and behavioral health team) and not leave the patient alone until they arrive. The patient who answers yes to question 5 from the ASQ is at risk of imminent danger and would need constant supervision to prevent the danger of a suicide attempt.

In outpatient settings, PTs and PTAs should immediately alert any affiliated behavioral health specialists. If there is an imminent risk based on answering yes to question 5, there should be an immediate response for emergent care. If the patient is a minor, their parent or guardian should be immediately contacted and the patient should be taken to an emergency department or mental health facility, after coordinating with a qualified mental health professional.

If the patient is in a school setting and at imminent risk of suicide (answering yes to question 5), the physical therapist should direct the patient to the school mental health professional who will initiate a protocol for best practice. This will typically involve a comprehensive evaluation or a transfer to an emergency department or a mental health facility. The protocol will involve a 72-hour stay for the implementation of mental health treatment and crisis intervention.

Columbia-Suicide Severity Rating Scale - Brief Suicide Safety Assessment (BSSA)

The BSSA is a quick ten-minute assessment to determine whether a full safety assessment is needed. This questionnaire should be administered if a patient answers yes to any of questions one through four on the ASQ (a potential risk for suicide). If a patient refuses to be evaluated after screening positive with the BSSA, the attending physician in a hospital should be notified and the appropriate protocol for emergent cases of at-risk suicide will be followed. The BSSA is performed by a mental health provider or trained medical provider.

Conducting the BSSA

First, the provider performing the BSSA must explain why they are doing it. This should be a separate response to the patient and the guardian or parent. The patient should be told something like “I am here to discuss your responses to the suicide risk screening questions. These things are difficult to talk about and I wanted to thank you for telling us. I am required to discuss any safety concerns with your parent/guardian but everything else you tell me will be confidential. The parent/guardian should be told something like “I am here to follow up on your child’s suicide risk screening questions. I acknowledge this is difficult to talk about and I am glad he/she/they had the courage to

discuss this. I need to ask him/her/them more questions. I will let you know if there are any safety concerns after but everything else will be confidential. After, I would appreciate hearing your perspective on any concerns you have for suicide in your child."

Adopted from the Clinical Pathway for Suicide Risk Screening 32

Assess the patient (separated from parent/guardian if possible) by asking questions from the BSSA.

Question 1 assesses for a wish to be dead: *"In the past month have you wished you were dead or wished you could go to sleep and not wake up?" or "In the past month have you thought about being dead or what it would be like to be dead?" or "In the past month, do you ever wish you weren't alive anymore?"*

Question 2 assesses for non-specific active suicidal thoughts: *"In the past month have you had any thoughts of killing yourself?"* Or *"In the past month have you thought about doing something to make yourself not be alive anymore?"*

a. **If the patient responds yes to either question 1 or 2:** Ask questions #3-#5 (see below).
b. **If no to both questions:** Ask question #6

Assess suicidal methods, intent, and plan by asking questions #3-#5.

Question #3 assesses for active suicidal ideation with any methods: *"In the past month have you been thinking about how you might kill yourself?"* or *"In the past month, have you thought about how you would make yourself not be alive anymore?"*

Question #4 assesses for active suicidal ideation with some intent to act: "*In the past month, have you had these thoughts and wanted to act on or carry out the thoughts?"* or *"In the past month, when you thought about making yourself not alive, did you think this was something you might do? This is different from having thoughts but knowing you wouldn't do anything about them."*

Question #5 assesses active suicidal ideation with a specific plan: *"In the past month, have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?"* Or *"In the past month, have you ever decided how or when you would make yourself not alive anymore (or kill yourself)? Have you ever planned out how you would do it? What was your plan? When you made this (or worked out these details), was any part of you thinking about doing it?"*

a. **If the response is YES to any of these questions:** Patient is considered high risk and will require a full suicide safety evaluation (see below). If the patient is having active thoughts of killing themselves now, they are considered at **imminent risk** and need safety precautions in place in addition to an emergent full suicide safety evaluation (see below).
b. **If they respond NO to all questions:** Ask question #6

Assess for past suicidal behavior by asking question #6: *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"* or *"Did you ever do anything to try to make yourself not alive anymore (or kill yourself)? Did you ever hurt yourself on purpose?"* Suicidal behavior includes **actual attempts** (a potentially self-injurious act committed with at least some wish to die), aborted or **self-interrupted attempts** (when a person takes steps towards making a suicide attempt but stops him or herself before actually engaging in any self-destructive behaviors), **interrupted attempts** (when a person is interrupted by an outside circumstance from starting the potentially self-injurious act), and **preparatory acts** or behaviors (acts or preparation toward imminently making a suicide attempt).

a. **If they respond YES to behaviors within the past 3 months:** Patient is considered high risk and needs a suicide safety evaluation. If a patient is having active thoughts of suicide they are an **imminent risk** and need safety precautions in place and an emergent full suicide safety evaluation.
b. **If they respond NO or if behaviors have been longer than 3 months:** Patient is considered low risk and is safe to discharge home from the ED with appropriate safety planning and referrals.

Determine the parent/guardian responses to BSSA questions. *"Your child said (reference positive responses on the BSSA). Is this something he/she has shared with you?" "What do you make of their response?"*

Ask the parent/guardian if there is anything else that they would like to discuss *"Is there anything you would like to tell me here or in private?"* in case they have some information that they want to share separately from their child.

Based on the interview, the patient is at imminent, high, or low risk:

1. **Imminent risk** equates to active and present suicidal thoughts which necessitates an emergent psychiatry evaluation

    a. Ensure safety precautions are in place following organization protocol. The patient should not be left alone and any items that could be dangerous should be removed

    b. Emergency full mental health/safety evaluation

2. **High risk** for suicide needs full mental health safety evaluation

    a. Request full safety evaluation

    b. Ensure safety precautions are in place by following protocol, as necessary. The patient should not be left alone and any items that could be dangerous should be removed

3. **Low risk** for suicide means that no further assessment is needed

    a. Create a safety plan for managing potential future suicidal thoughts. The provider should ask the parent if they have a safety plan. The provider should discuss their safety plan for removing dangerous items from the house. The provider should be sent from the facility with a mental health referral as necessary. They should be notified of the Suicide Prevention Lifeline and the screening of positive answers should be sent to the patient's primary care provider.

Full Safety Evaluation

A full safety evaluation should be conducted when the ASQ or BSSA is positive. The reason to conduct a full safety evaluation is to determine the need for inpatient psychiatric services, the level of safety precautions, and direct supervision. The full safety evaluation should only be conducted by a licensed mental health provider.

The provider will first interview the patient and parents. The safety evaluation will gather information on suicidal ideation and intent, past suicide attempts and self-injury, and gathering information on risk factors such as hopelessness, major depressive disorder, anxiety, acute stressors, childhood abuse, and substance abuse. The provider will evaluate the patient's current mental health status. The mental health provider with their training will recommend that the patient either goes to an inpatient psychiatry setting or home with a safety plan. Signs that the patient could be going into a crisis include feelings of sadness and loneliness and increased irritability or anger.

The PT's Role

The PT may be involved in the ASQ or the BSSA screening if they have training. PTs and PTAs need to be prepared to act after finding a positive screen on their tools (ASQ most commonly). This action involves alerting the providers involved in this patient's care, such as the attending physician, nurse, and behavioral health team if in a hospital setting. If in an outside facility, the PT would need to arrange an urgent referral to an emergency department for if the ASQ and BSSA are positive.

Adult Screening [34]

Adult screening in healthcare settings is similar to youth screening and may involve family but does not have to. If a patient can make independent decisions and is free of intellectual disability or power of healthcare attorney, interactions may be solely with the patient when they are found at risk of suicide. Adult suicide screening is a three-step process: identification of risk factors and actual suicide risk by a thorough review of the patient's risk factors and medical history, determining the patient's imminent safety needs and clinical setting to be treated and distributing information like the crisis hotline for families and patients in a suicide crisis. In addition, some organizations recommend mandatory screening for all patients for suicide ideation with a short screening tool on intake paperwork, which must be reviewed before the patient leaves their appointment. The state of Washington follows the zero suicide initiative, which requires screening for suicide risk at the initial point of evaluation for each patient. The following is a recommended screening process for the identification and screening of adult patients, regardless of the setting of care.

Identification of Risk Factors

Risk factors of suicide can be identified by a thorough family and individual past medical history review. As discussed in a prior section, many factors increase someone's risk for suicide. These include but are not limited to mental health diagnoses, symptoms of an undiagnosed mental health disorder, adverse childhood events, substance abuse, and loneliness. Life events, such as the loss of a loved one are also important to notice and screen for in medical or subjective history. If any indicators are risk factors for suicide, it is appropriate to screen further. In best practice, intake paperwork should include suicide risk screening questions and mental health screening. As PTs review systems, they need to be comprehensive in screening for mental health, just like they do for physical health, like the cardiovascular system.

Screen for Suicidal Ideation [35]

Suicide screening needs a standardized approach so providers from any setting and background can look at a patient's chart and understand prior and current suicide risks and the need for a response. In addition to that, standardized tools help to detect suicide risk more accurately than a conversation. Each screening tool for suicide may ask questions regarding suicide risk in a different way. Having a standardized, evidence-based, and sensitive approach to screening is the best way to detect suicide risk.

PTs and PTAs should verify with their organization to determine the protocol for suicide screening. Some organizations in Washington require mandatory suicide screening on every patient and some require it only if indicated in their past medical history or family medical history. Several tools exist for screening for suicide in adult patients. These are the Patient Health Questionnaire (PHQ-9 and PHQ-2), the Suicide Behaviors Questionnaire, the Columbia Suicide Severity Rating Scale (C-SSRS), and the ED-SAFE Patient Safety Screener. The PHQ is designed to determine the level of depressive symptoms. The C-SSRS is also known as the Brief Suicide Safety Assessment (BSSA) and is used for all patient ages. It determines the severity of suicide risk including ideation and behaviors, the intensity, and the degree of lethal means for suicide attempts. It's mostly used in emergency care and nonclinical settings, like schools. The Patient Safety Screener (PSS-3) is used within ED-SAFE and takes into account the PHQ-2 for depression screening, the C-SSRS for the past two weeks of suicidal ideation, and the C-SSRS section of prior suicide attempts. The Suicide Behaviors Questionnaire-Revised is a screening tool with four items, which determines details around suicidal ideation, the imminent threat of an attempt, and the chance of future suicidal ideation. Details about administering each of these screening tools are in the next section.

Review Screening Questionnaires for Action

After detecting a positive screening, the patient should be directly referred to a mental health professional who can assess the need for a full patient safety evaluation. The PT/PTA who conducted the screening in supportive care settings with mental health resources (hospitals and subacute care) should directly contact mental health staff for this further evaluation. In the meantime, the PT/PTA should stay with the patient or communicate with nursing that the patient is at risk of suicide and follow patient safety protocols. This usually means removing anything with the potential to harm oneself and having a staff member present at all times.

After detecting a negative screen, the PT/PTA should still offer a referral for mental health resources and inform the patient, family, and/or guardian of the national suicide hotline. A referral would be outpatient mental health services.

Appropriate Communication [36]

Communication is the key to detecting suicide risk and suicidal plans among patients. Communication should follow the outlines presented in this section with youth or adult screening, with the general protocol of identifying risk factors, screening, and assessment. Providers should meet patients where they are with communication strategies and appropriately determine the urgency of the situation. For example, for a patient who is at imminent risk of suicide from screenings, providers who are not trained as a mental health providers should do everything to keep the patient safe (environmental safety and supervising the patient) but should never attempt to talk about the specifics of someone's suicidal ideations or plan further. To be most effective, PTs and PTAs in the context of a patient who is at emergent risk of suicide have the role of triage, to alert a trained mental health provider to lead the situation and suicide prevention efforts. However, when discussing suicide in general with colleagues or patients or in a provider's personal life, PTs and PTAs should always use appropriate, patient-centered language to spread neutrality and reduce the stigma associated with the topic of suicide.

A few factors may make communication successful, while a few others will make it less likely that a patient shares information with a provider. When talking about suicide in general with people not at risk of suicide, providers need to use patient-centered language. Examples of this are using phrases like "Patients who are thinking about suicide" or "People who have gone through a suicide attempt". Other appropriate language includes the following: die by suicide, attempted suicide, reasons that may increase someone's risk of suicide, and social and financial costs from suicide. This language reduces stigma, where language like "The mentally ill who have attempted suicide" or "That suicide victim" places blame on the people who have experienced suicide or suicidal ideation. In addition, language like "commit suicide, successful suicide, failed suicide attempt, incomplete suicide, and burden of suicide" are phrases that should not be used. The more the culture changes in healthcare to discuss any problem with patient-centered, people's first language, the more likely that patients will feel respected rather than stigmatized or blamed for their health problems.

To allow someone to reveal they are having strong thoughts of suicide, a provider must foster an environment that is safe and free of any judgment or negative thoughts around the subject. The best approach to this is using facts, neutral language, and patient-sensitive language. When the topic of suicide comes up during evaluations, the PT should convey that suicide is a widespread, complex public health issue that can affect

anyone. They should explain risk factors and general statistics around death by suicide and suicide attempts. This strategy aims to make the patient feel like they are not alone in their thoughts. Communication should always be neutral, factual, and clear. It should be customized to patients considering age, gender, and cultural influence. When possible, communication efforts should neutrally convey positivity and hope. An example of this would be “Many people who have attempted suicide have found helpful resources and mental healthcare which have allowed them to live fulfilled lives.” Communication efforts should avoid comparing the means or locations of other suicide attempts or ideations. Providers communicating with people who are contemplating suicide should never compare negative aspects of their situation to any other patient’s situation. Comparisons are generally not helpful and should instead be replaced with neutral and hopeful messages about the future.

Summary of PT Screening Tools for Suicide Detection

Screening tools are an important way to detect depression, anxiety, and suicide risk for any clinician that works with patients. They may be orally administered as part of an evaluation or administered as a part of intake paperwork. Organizations across Washington state require some sort of mental health screening for all patient-interfacing providers. Physical therapists in best practice should be following their organizational protocol for detection items or inquire to supervisors and department heads to implement such a program after this training. Suicide prevention begins with detection and is most successful when comorbidities such as anxiety and depression are detected even before suicidal ideation. This section summarizes screening tools that physical therapists and assistants should be familiar with and use in daily practice.

SAFE-T Pocket Card [37]

The program Substance Abuse and Mental Health Services Administration as a part of the U.S Department of Health and Human Services developed the Suicide Safe mobile application and SAFE-T pocket card. The purpose of this application is to allow step-by-step suicide prevention methods for all providers with the convenience of not needing to

remember every step. It can make the process of suicide detection more efficient and take errors out of it, which may save lives. Organizations may choose to implement this and require training on using the application as part of their overall approach to suicide prevention.

Patient Health Questionnaire [38]

The PHQ-2, PHQ-4, and PHQ-9 are screening tools used to determine the need for referral to a mental health professional. This tool should be used as common practice in every physical therapy evaluation, acting as a referral method. This is an important and widespread tool in detecting depression and anxiety, which are two very common diagnoses among those with suicidal ideation and who have attempted suicide.

PHQ-2

The PHQ-2 has good sensitivity and specificity (0.9 and 0.87 respectively) in detecting depression in patients of all ages. The questionnaire is as follows:

Over the last two weeks, how often have you been bothered by any of the following problems:

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless

   The patient should respond: Not at all (0), Several Days (1), More than one-half of the days (2), or Nearly every day (3). If the score is greater than 2, it is positive for a depression screening. Providers who detect this screen should immediately refer their patients to a mental health professional.

PHQ-4

The PHQ-4 detects anxiety and depression in patients of all ages, with good sensitivity and specificity. The questionnaire is as follows:

Over the last two weeks, how often have you been bothered by the following problems:

1. Feeling nervous, anxious, or on edge
2. Not being able to stop or control worrying
3. Little interest or pleasure in doing things
4. Feeling down, depressed, or hopeless

The patient should respond: Not at all (0), Several Days (1), More than one-half of the days (2), or Nearly every day (3). Scores that are equal to or greater than three for questions one and two combined indicate anxiety and scores that are equal to or greater than three for questions three and four indicate depression. These cutoff scores equate to the action of referring this patient to a mental health professional at the same time the questionnaire was administered.

PHQ-9 [34]

The PHQ-9 is the full version that the PHQ-2 and PHQ-4 are derived from. It detects the severity of the major depressive disorder. The PHQ-9 has a sensitivity of around 0.7 and a specificity of around 0.85, making it a good screening tool to rule out the possibility of suicide in. This is used as part of a depression diagnosis for mental health professionals. It may be used by physical therapists in evaluation, but more likely used if the PHQ-2 or PHQ-4 are positive for depression. PTs may think of the PHQ-2 as the most common screening tool for every patient evaluation and only use the PHQ-9 when the PHQ-2 is positive, to determine the severity of depressive symptoms and the urgency of a referral to a mental health professional. PTs and PTAs should never communicate diagnostic information on mental health to their patients. They should only use this as a screening tool to indicate the urgency of referral to a qualified mental health provider. The questionnaire is as follows:

Over the last two weeks, how often have you been bothered by the following problems:

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things such as reading the newspaper or watching television

8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual

9. Thoughts that you would be better off dead or hurting yourself

10. If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people (Not difficult, somewhat difficult, very difficult, or extremely difficult)

To questions one through nine, the patient should respond: Not at all (0), Several Days (1), More than one-half of the days (2), or Nearly every day (3). The following scores indicate levels of severity of depression:

- 1-4: Minimal depression
- 5-9: Mild depression
- 10-14: Moderate depression
- 15-19: Moderately severe depression
- 20-27: Severe depression

PTs should refer patients who score from 5-9 to a mental health provider, and from 10 and up urgently to a mental health provider. A positive response to question number nine on suicidal thoughts should be followed up with a different screening and response tool such as the ASQ.

Ask Suicide Screening Questions (ASQ) [33]

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts about killing yourself?
4. Have you ever tried to kill yourself? If yes, how and when?
5. Ask if the patient answers yes to any of 1-4; Are you having thoughts of killing yourself right now?

If the patient answers yes to question 5 it indicates an “acute positive screen” which necessitates emergent action. This means the patient should not be left alone until a full mental health evaluation by a qualified provider is completed. A yes response to other questions means an assessment needs to be conducted by a qualified mental health provider, but not necessarily a full evaluation.

Suicide Behaviors Questionnaire (SBQ) [35]

The SBQ is validated for use with the adult population and adult psychiatric patients in an inpatient psychiatric facility. Psychometric properties for the general adult population are excellent as it has above 0.9 on both sensitivity and specificity. For patients in psychiatric inpatient care, sensitivity is 0.8 and specificity is 0.91. The questionnaire is as follows:

1. Have you ever thought about or attempted to kill yourself? (Lifetime suicidal ideation)

   Answers: Never; It was just a brief passing thought; I have had a plan at least once to kill myself but did not try to do it; I have had a plan at least once to kill myself and really wanted to die; I have attempted to kill myself, but did not want to die; I have attempted to kill myself and really hoped to die

2. How often have you thought about killing yourself in the past year? (Frequency of ideation in the past year)

   Answers: Never; Rarely (one time); Sometimes (two times); Often (three or four times); Very Often (five or more)

3. Have you ever told someone that you were going to commit suicide or that you might do it? (Threat of a suicide attempt)

   Answers: No; Yes, at one time, but did not really want to die; Yes, at one time, and really wanted to die; Yes, more than once, but did not want to do it; Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (Self-reported likelihood of suicidal ideation or attempts in the future)

   Answers: Never; No chance at all; Rather unlikely; Unlikely; Likely; Rather likely; Very likely

The total score ranges from 3 to 18. A cutoff score total score for suicide risk is greater or equal to seven for a test among college students and greater or equal to eight among an adult inpatient population.

ED-SAFE Patient Safety Screener (PSS-3) [39]

The Patient Safety Screener is meant to be a simple method of suicide screening in an emergency department or another setting where the provider asking is not a mental health provider. There are three questions to assess for depression, active suicidal ideation, and a lifetime suicide attempt. The questionnaire is as follows:

Introduction: “Now I’m going to ask you some questions that we ask everyone treated here, no matter what problem they are here for. It is part of the hospital’s policy and it helps us to make sure we are not missing anything important.”

1. Over the past 2 weeks, have you felt down, depressed, or hopeless

   Answers: Yes, No, Patient unable to complete, Patient refused

2. Over the past 2 weeks, have you had thoughts of killing yourself?

   Answers: Yes, No, Patient unable to complete, Patient refused

3. In your lifetime, have you ever attempted to kill yourself?

   Answers: Yes, No, Patient unable to complete, Patient refused

4. When did this happen? (If yes to question 3)

   Answers: Within the past day; Within the past month put not today; Between 1 and 6 months ago; More than 6 months ago; Patient unable to complete, Patient refused

A “yes” response to question number one indicates a depressed mood. A “yes” response to question two indicates Active Suicidal Ideation, which necessitates protocol for further safety assessment by a mental health provider. A “yes” response to question three indicates a Lifetime Suicide Attempt and if it was within six months, it is considered a “recent suicide attempt”. “Yes” to questions two and three indicates a positive screen for suicide risk and the patient should be triaged to have further mental health evaluation. At this point, patient supervision and environmental safety measures may be necessary.

Section 2 Key Words

ASQ – Ask Suicide Screening Questions; used as a first screening tool to determine suicide risk in youth and adolescent patients

PHQ – Patient Health Questionnaire which exists in a two, four, or nine question formats to determine someone's risk of depression

SBQ – Suicide Behaviors Questionnaire; a validated tool among the general adult population and psychiatric inpatient population for suicide risk

ED-SAFE PSS-3 – ED-SAFE Patient Safety Screener and is a four-item questionnaire that determines depressed mood and risk for suicide; meant to be administered by providers who do not specialize in mental health.

Section 2 Summary

The majority of patients who have suicidal ideation have visited a healthcare provider recently. This highlights the importance of identifying those having suicidal ideation and primary care, specialty care, rehabilitation, or any other healthcare appointments. Providers need to communicate in a patient-centered way so patients respond honestly to their thoughts. Physical therapists and assistants in Washington are required to screen for suicide in their evaluations and in treatments when the patient mentions any risk factors of suicide. There are several screening tools, both validated for youth and adult patients, that clinicians should use when screening for suicide. All providers should "speak the same language" concerning suicide screening by using standardized screening methods to help with chart review and future detection efforts.

Physical Therapist Response and Referral

The ultimate goal of suicide prevention is to help to lower the number of cases where suicidal ideation and other risk factors of suicide become active suicide risk. However, despite widespread efforts of changing the culture of communication to avoid stigma around the topic of suicide and directing patients towards mental health resources, some patients unfortunately are still at high risk of suicide. PTs and PTAs need to not only know how to screen for such cases but to respond appropriately. This section will detail how to respond appropriately to different levels of severity among patients after screening with a standardized tool.

Urgency of Response

The purpose of screening tools is to direct providers into which type of response is needed based on the severity of the situation. Using the screening tools from the screening section, PTs and PTAs can follow their organization's protocol and the action that the screening tool suggests. These actions may be divided into two types: high risk and urgent response or low to medium response. One of the primary roles of screening for suicide is to triage the patient into the best possible plan.

High, Imminent Risk Response [36,40]

For patients who score positive on the imminent risk from any of the screening tools, the provider who screened for suicide must take immediate action. The provider needs to take action with a few steps but must ensure that they do not escalate the situation by making the patient feel judged or misunderstood in any way. The best way to keep the situation from escalating is to use neutral word choices and factual information that avoids biases or drawing any conclusions. Patients at this critical point need **one-on-one supervision** at least to prevent injury. The PT/PTA who screens for high suicide risk should immediately **alert other providers and help**, and action will vary on the setting and location of the patient interaction.

If in a hospital or a subacute setting, the PT/PTA should alert the patient's Registered Nurse, Attending Physician, and behavioral health team for a provider trained in suicide risk management. This may vary per hospital protocol. The PT/PTA should stay until another provider verbally commits to one-on-one supervision. In addition, the PT/PTA should visually sweep the area, noting objects that could be harmful to the patient. They should attempt to remove any immediately harmful objects from the patient's reach (things like utensils and cords). The PT/PTA must stay with the patient until other providers take over and after ensuring that one-on-one supervision from a qualified staff member is in place. While alerting other providers by phone or page while still with the patient, the PT/PTA should use neutral language that does not blame the patient. An example script for calling the patient's RN would be "This is (PT/PTA's name), and I am working with your patient (patient's name) in room (room number). (Patient's name) had just let me know that they are actively contemplating suicide. Would you alert a behavioral health team member for a safety evaluation? I will stay with (patient's name) until that team member arrives." *If at any point, the situation begins to escalate and the patient becomes dangerous to themselves or the provider, the provider should activate emergency response by hospital protocol for hospital security response.* The provider

should always protect themselves and escape the situation to find help if they are threatened.

If in an outpatient clinic that is not attached to a hospital or *home health* there is not a network of providers who are qualified to care for a patient who is at imminent risk of suicide. This means emergent action is trifold: keeping the patient calm, removing objects from the vicinity that could be used for injury, and calling 911 for emergency services. It is a difficult balance between whether to momentarily leave the patient alone and calling 911 in private so the situation does not escalate. Many free-standing clinics have a protocol and providers should familiarize themselves with this or discuss it with their supervisor. The provider should ensure that they are not at risk of harm. If the situation escalates and the patient leaves the clinic with a suicide plan rather than going with emergency services, the provider should call 911 and explain the situation. They should give details of exactly what the patient disclosed, where they may carry out their plan, and their address.

If the patient is a child (school, outpatient, or homecare) physical therapists should act to sweep the environment of objects that could cause injury, keep the situation as neutral as possible, and alert emergency services. If in a school, the counselor, administrator, and parents should be contacted. In-home care or outpatient, emergency services (911), and parents should be contacted. The provider needs to stay with the patient, unless in threat of harm, until emergency or behavioral health services arrive.

What Happens After the Full Safety Evaluation? [41]

After a PT/PTA completes the steps of alerting help (911, hospital protocol, etc.), clearing the environment from the potential of injury, and the patient is in the hands of mental health providers, what happens next varies on the situation. Patients will undergo a full safety assessment by a qualified mental health provider employed by a hospital. This is typically done in the emergency department if the patient is coming from outpatient, home health, or a school. If the patient is coming from the hospital, it is done in the emergency department or the hospital floor (wherever the patient is located). If the mental health provider determines that the patient is at high risk, they will recommend one of several options: 24/7 inpatient hospitalization, partial hospitalization, intensive outpatient program, or outpatient treatment.

For an inpatient hospitalization, a patient will be either be voluntarily or involuntarily admitted to a hospital psychiatric unit or general hospital floor on suicide precautions. A **72-hour hold** is an involuntary hold if court-appointed mental health providers and

physicians determine this action is necessary to keep the patient safe. It is also the course of action if the patient is intoxicated or using drugs and is unable to make decisions. This will also be the recommendation if the patient has already made a suicide attempt that resulted in hospitalization. In this case, the patient would need to be stabilized and treated for physical injuries and kept on suicide precautions wherever is appropriate to be treated for their injuries (from intensive care to the general hospital floor). The patient may also be **voluntarily admitted** to an inpatient facility after triage in the emergency department or hospital unit. The average length of stay in an inpatient facility is around one week. The patient will be discharged once they are stable from another mental health safety evaluation. Often, patients who enter an inpatient psychiatric unit or clinic voluntarily and wish to discharge against medical advice are found to still be at high risk of suicide. In this case, patients who were admitted voluntarily can be held on a 72-hour involuntary hold. The 72-hour involuntary hold may also be extended if certain assessment items are in place and with certifications from the court. States vary in the action of the law at this point, and in some states cases of involuntary hold will be passed emergently to court. In Washington state (RCW 71.05.240 - effective until at least July 1st, 2026), the law states that for treatment for a petition may be filed for up to fourteen days of involuntary treatment or for 90 days or eighteen months of less restrictive treatment. This usually goes into effect when a patient refuses voluntary treatment after a full mental health safety evaluation determines a high risk for suicide. At this point, the mental health prosecutor in court may also determine that this patient will lose their right to a firearm (RCW 71.05.230). The court will determine the patient's needs based on mental health safety evaluation and progress visits in the mental health facility. The court may decide at a certain point that less restrictive means of mental health treatment are more appropriate and mandate outpatient treatment for up to a year and a half.

Partial hospitalization involves outpatient psychiatric care including psychiatry and psychotherapy but does not involve staying overnight like an inpatient hospitalization. These programs last around four to eight hours per day, up to five days per week. Lengths of time for this treatment vary depending on progress but may be up to three months or even longer in some cases. Interventions are individual, group, and family therapy, medication management, and may include practices like mindfulness training and yoga. Partial hospitalization may also be a transition from inpatient to outpatient services for many patients discharged from 24/7 inpatient psychiatric hospitalization. Populations in this treatment may include those with substance abuse, suicidal ideation or attempts, or other mental health disorders.

An *intensive outpatient program* is similar to partial hospitalization in that they both involve going to a free-standing (or telehealth in some cases) clinic and returning home each day of treatment. The number of days per week and time per session is typically shorter than a partial hospitalization where the majority of the day is devoted to the program. Like partial hospitalization, populations in this treatment may include those with substance abuse, suicidal ideation or attempts, or other mental health disorders.

Outpatient behavioral health treatment is for patients who either have been in a crisis of suicide in the past or who have risk factors for suicide, like depression, anxiety, post-traumatic stress disorder, or other factors from this course. These services include psychiatric medication management, psychotherapy, and specific therapeutic techniques to treat underlying depression, anxiety, and other contributing conditions. This can be in-person or by telehealth and sessions are typically one hour in length, weekly.

Low Risk Response [13,42]

When a screening tool reveals a patient is at low risk of suicide, PTs and PTAs should be prepared to refer the patient to appropriate resources. This is a crucial point to help those patients who have risk factors for suicide, like undiagnosed depressive or anxiety disorders, get appropriate mental healthcare before they develop suicidal ideation. PTs, PTAs, and other providers should never underestimate the importance of this step. This is a key step to suicide prevention and the best way to avoid patients progressing to a crisis situation. Connecting people at low risk of suicide but with mental health needs is the best strategy for preventing future suicidal ideation and attempts. Physical therapists who screen for suicide and if the screening tool indicates low risk, PTs should have a referral plan in place. They should plan to refer to mental health resources including psychiatry and psychotherapy. Outpatient psychiatry and counseling/psychotherapy are helpful interventions to manage risk factors associated with suicide. For example, more than half of patients who have contemplated, or attempted suicide have major depression. If this alone can be treated, imagine how many suicide attempts across Washington state alone could be prevented. If in an outpatient free-standing clinic, a home health visit, or a school, PTs/PTAs should have a network of behavioral health clinicians they refer to. They should refer patients to resources right away, at the time of the visit. They may even directly call the office of a mental health provider to set up an appointment with the patient present. The important component of this to a patient is having a healthcare provider point out the need and benefit of mental health care, which may be the encouragement the patient needs to seek help. In a hospital, the PT/

PTA may refer to colleagues who are affiliated providers of mental healthcare that work in the hospital system.

PTs and PTAs should keep in mind that their main role in suicide prevention is to refer and encourage patients at low risk of suicide but with mental health needs to follow through with mental health care. Patients who are at the point of suicidal ideation or have a plan for suicide may have never reached that point with proper identification of risk factors and access to mental healthcare when their risk of suicide was low. If a patient is "low risk" for suicide but has suicide risk factors, all providers need to act on coordinating a mental healthcare referral and encouraging the patient with neutral but powerful language to follow through with this. A key point here is that patients may be dishonest about their suicide screening tool because they know that a protocol may lead to involuntary hospitalization. This further highlights referring all patients with mental health diagnoses or with symptoms of undiagnosed mental health disorders to qualified mental health professionals.

Referral Sources [29]

PTs and PTAs should have a network of providers they refer to in the field of mental health, local to where they work. This section will detail different referral sources so physical therapists and physical therapist assistants feel prepared to network with mental health providers. It will prepare PTs and PTAs to have referral sources to give to patients at the time of appointments. The less wait time and delay in care there is, the better outcomes there are in mental (and physical) patient care.

Outpatient Mental Health

Outpatient mental health includes psychiatry and psychotherapy. It may also include treatments that mental health professionals refer to after their evaluation, like eye movement desensitization reprocessing (EMDR) or dialectic behavioral therapy (DBT). Psychiatry services will diagnose and treat patients with medication management and can facilitate a referral to psychotherapy. The credentials for these providers are either a Medical Doctor or a Doctor of Osteopathic Medicine, hold a board certification, and have completed a residency in Psychiatry. A psychotherapist has different levels of credentials. Appropriate providers to refer to should have experience with treating the risk factors associated with suicide specific to the patient's case. Titles of appropriate providers are a Licensed Professional Counselor (LPC), Licensed Mental Health Counselor (LMHC), Licensed Clinical Professional Counselor (LCPC), Licensed Professional Clinical Counselor of Mental Health (LPCC), Licensed Clinical Mental Health Counselor (LCMHC),

and a Licensed Mental Health Practitioner (LMHP). These providers must complete a Master's degree in mental health and have specific supervision hours to complete before seeing patients independently.

Where to Refer? [43]

When working within an organization in Washington state, such as Providence Health or Kaiser Permanente, PTs/PTAs may refer within their organization to qualified outpatient mental health providers. PTs/PTAs may network with their local providers of mental health and refer to one of these providers at their discretion as well. A great resource to find the most available mental health counselors by availability and location is called **Psychology Today**. On this site, anyone can search by discipline (psychiatrist or counselor/psychologist), provider, payment methods including accepted insurances, and specialties of treatment. It will also show the provider's availability to see new patients, including telehealth versus in-person visits.

988 Suicide & Crisis Lifeline [44]

The National Suicide and Crisis Lifeline is available for anyone to call at any time in regard to suicide risk. There are several ways to contact the crisis line. These include text, call, and chat. The line is immediately available in English and Spanish and uses translation services to provide services in over 250 languages. The line is confidential, and callers will be connected to trained counselors across the country. The methods of contact for text, call, and chat are below.

Text: 988

Call: 988

Chat: https://988lifeline.org/chat/

There are many reasons that one should utilize the Suicide and Crisis Lifeline, and PTs/PTAs should educate their patients who may need this line on its services. First of all, it is a resource for people with suicidal ideation. For those with a plan and ready to carry out suicide, providers or friends and family should dial 911 for emergency services, not this crisis line. The crisis line is meant to connect those with suicidal ideation to resources and strategies to manage the situation in their community. In addition to suicide ideation, the crisis line exists to support those with other crises and emotional hardships. Anyone may call the line to discuss things like financial concerns, abuse, depression, physical or mental health difficulties, problems with a relationship,

loneliness, and many other reasons. This confidential line allows communication with a trained professional who is able to offer advice and resources to help the situation at hand. Veterans may dial “1” after being connected to the main 988 line to be connected to Veteran specific resources.

Providers need to educate their patients about this crisis line if their patients disclose any risk factors of suicide at all. An example of a script for a communication strategy to present the lifeline to a patient is below.

“Thank you for disclosing your difficulties with (mental health, financial troubles, or another emotionally distressing topic that the patient brought up). I have a resource that may be helpful for you to utilize. I have seen it help so many people with distressing concerns in their life. The resource is the Suicide and Crisis Lifeline. The line is for people who are thinking about suicide or who are going through an emotionally stressful time. You can access this line anytime by text, chat, or call and the staff that answer will connect you to helpful resources in your geographical area.”

Documentation [34]

It is critical for any provider to screen for and respond to suicide risk and complete the most comprehensive documentation possible. This documentation should be as factual and neutral as possible, leaving out any dialogue that implies bias or discrimination toward mental health and the patient at risk. Following a Subjective, Objective, Assessment, and Plan format, PTs and PTAs should include every detail about patient interactions that involve screening for suicide risk along with their own discipline’s documentation regarding physical therapy. The subjective would include direct quotes that led to the use of the suicide screening tool. The objective would include the screening tool used and the score. The assessment portion should include objective information on the screen and the clinician’s decision of action. This would include something like “Due to scoring in the imminent risk category on the ASQ, the evaluating PT alerted onsite behavioral health services for an imminent patient safety evaluation.” The plan portion of the documentation would state the plan for mental health services and the plan for physical therapy services. For patients at low risk of suicide, this may include a referral to outpatient mental health care. For patients at high risk of suicide, the plan portion may include a statement like “The PT determined that emergent mental healthcare was necessary, and a physical therapy plan was not prioritized this visit to accommodate those needs.”

Documentation is critical because if a clinician does not record a detailed record, there is no long-lasting evidence that the interaction ever happened. This is critical with suicide risk to assess risk in future patient encounters and to direct patients to life-saving resources.

Patient Safety Plan [45]

A patient safety plan is designed to help patients transition to home but has a strategy if they begin to have suicidal ideations. This plan could be put in place after a patient completes inpatient and outpatient psychiatric care or after a patient is discharged from a hospital with low suicide risk. This plan is developed by a licensed mental health professional. Physical therapists and assistants should be aware of these to ensure to see the value in prevention and at times to encourage their patients receiving mental healthcare to reference it.

Here is a sample safety plan to give PTs/PTAs an idea of what it contains.

Be aware of personal warning signs and triggering events

Avoiding triggering events, coping with stressful events and feelings like loneliness, having family fights, and feeling hopeless are all essential elements to address in the safety plan. These strategies will be learned in outpatient psychotherapy.

Remove any lethal means for suicide attempts

One of the best ways to prevent a situation from escalating to suicide is removing any dangerous objects from the environment. This means either restricting access to these things or securing them completely. For example, restricting access to knives may mean they are out during the preparation of meals and in a secure spot the rest of the time.

Individual coping

With help to frame thinking from a mental health provider, patients who are at risk of suicidal ideation and attempts should come up with coping strategies for these situations. This could include making a list of why they want to live, be mindful of ways to distract themselves, relaxation strategies, and exercise.

Interpersonal coping

People at risk of suicide should have a network of trusted people around them. This includes friends and family who know the situation and can be reached at any time to distract the individual and help to cope with suicidal thoughts.

List of Professionals

Sometimes, the prior steps of the safety plan do not work. This is the time to contact professionals. Friends and family from the interpersonal coping step can also direct the person to do this as a reminder. Therapists will give out a phone number to call for emergencies. In addition, the Suicide and Crisis Lifeline can be contacted 24/7, 365 days per year to help people through difficult situations. The suicide plan should always state to call emergency services directly if the person is imminently suicidal (has a plan and is going to execute it). This should be a direct call to 911 and a patient's close family and friends should be prepared to take this step if necessary too.

Helpful Referral Links [43,46–49]

Psychology Today: https://www.psychologytoday.com/us?tr=Hdr_Brand

988 Suicide & Crisis Lifeline Website: https://988lifeline.org/

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

Washington State Department of Health Suicide Prevention Page: https://doh.wa.gov/you-and-your-family/injury-and-violence-prevention/suicide-prevention

Centers for Disease Control and Prevention Suicide Prevention Page: https://www.cdc.gov/suicide/index.html

Section 3 Key Words

Involuntary Psychiatric Hold – a 72-hour hold or longer where mental health providers and the court intervenes to keep a patient safe in cases of high-risk suicide and/or substance abuse

Voluntary Inpatient Psychiatric Hospitalization – when a patient agrees to be admitted for an inpatient hospital stay where providers will work to reduce the patient's risk of suicide

Partial Hospitalization – a program where a patient with substance abuse and/or suicide risk will spend half or full days most days of the week receiving mental health treatment; often used as a bridge from inpatient to outpatient care

Intensive Outpatient Hospitalization – a program where a patient at low risk of suicide (may have been a high risk at one point) spends a few days per week for part of the day on mental health treatment

Section 3 Summary

It is crucial for PTs and PTAs as patient-facing clinicians to be educated on how to respond to patients at risk of suicide in all scenarios. The majority of patients who die by suicide access healthcare within a month of their suicide attempt. These are critical points of interaction where suicide may be prevented. When patients are treated appropriately for their suicide risk and receive excellent mental healthcare, they have the best chance of leading a healthy life. Physical therapists and assistants in Washington should feel prepared to recognize suicide with screening tools and respond in imminently dangerous and other situations. They should also feel prepared to recognize risk factors for suicide and refer patients at low risk of suicide per screening tool to appropriate resources. This is one of the best ways to prevent a patient from reaching a point of severe suicidal ideation and attempting suicide. Several resources for referral to mental healthcare providers exist and it is imperative that physical therapists and assistants are connected to these in their community.

Case Study 1

A physical therapist, Jenny, works in an outpatient clinic where she sees primarily teenage and adult patients. Jenny's current patient is Chris, a fifteen-year-old boy who is seeking PT for an ankle injury. While inquiring about his social life and friends, he reveals that he has been cut from his soccer team, that his parents are fighting a lot at home, he feels isolated from his normal group of friends and is feeling hopeless about the future. He revealed this information just as his mother left the room to take a call. He has not seen any other medical provider in the past year.

Reflection Questions

1. What risk factors may predispose Chris to a mental health crisis or condition?

2. Given this information, what should Jenny inquire about further and how should she approach this with Chris's mother present?
3. If Jenny determines that Chris is at a moderate to high risk of suicide on the screening tool, what is the appropriate action?
4. If Jenny determines that Chris is at low risk of suicide but scores in the mild depression category on the PHQ-4 what is the appropriate action?

Responses

1. Chris has been cut from his soccer team, which is likely one of his forms of identity as an adolescent. He also has been feeling lonely and isolated. His parents have been fighting, which may worry Chris. He also has been feeling hopeless, which is a key feeling in depressive disorders.
2. Jenny should investigate further into Chris's mental health status and any degree of severity of symptoms. She should utilize a screening tool such as the ASQ or the PHQ-4. Jenny should preface the topic by stating something like "I am now going to ask you a few sensitive questions that we ask of all our patients according to policy." This way both Chris and his mother feel like the subject is being addressed with neutrality. If Chris begins to act differently with his mother present than without, it may be appropriate to state something like "It is standard procedure to ask a few questions with and then without a parent present. Is that okay with you?" Jenny should then ask about the screening tool to the parent separately.
3. Jenny should discuss this with Chris and his parent together and then separately. She should use phrases like "the risk is death by suicide" instead of "Chris is at risk of committing suicide". This avoids stigmatizing the issue and may allow a more open conversation. She should contact an onsite mental health provider if applicable. Otherwise, she should discuss with Chris's parent that the most appropriate option is an evaluation in the emergency department to determine a life-saving plan of care. It is best practice for a patient at high risk of suicide to travel by ambulance instead of a personal vehicle to ensure the patient makes it to the emergency department. The parent may offer to bring her son to the emergency department, and although she has this right, Jenny should explain the risk associated with this if the suicide risk screen shows high acuity or imminent

risk. If Chris and his mother leave without agreeing to go into the emergency department, Jenny should call 911 to alert emergency services of the situation.

4. Jenny should discuss the results of the screening with both Chris and his mother. Jenny should be as neutral in her communication as possible, avoiding stigmatizing phrases. She should offer resources to address Chris's screened depressive symptoms. These include providing information about the Suicide and Crisis Lifeline and explaining that its use is for suicide crises and other causes of emotional distress. Jenny should also recommend mental healthcare and offer referrals to licensed mental healthcare providers to evaluate the need for outpatient psychiatry and/or counseling.

Case Study 2

Rebecca is a patient in an acute care hospital being evaluated by John, a physical therapist, after an exacerbation of chronic obstructive pulmonary disease (COPD). In his chart review, John notes that Rebecca did attempt suicide twenty years ago but has had no recent information on this. She has diagnoses of recurrent major depression, COPD, malnutrition, is a widow, and is an active smoker. During his evaluation, John finds Rebecca to have a cheery disposition until asked about her family and home life. John explains to Rebecca that he needs to know what level of support she has at home in order to determine a discharge recommendation. Rebecca refuses to answer and John then avoids the subject for the remainder of the evaluation.

Reflection Questions

1. What are possible reasons that Rebecca reacted so strongly to John inquiring about family and home life?

2. What are some strategies, including communication techniques John could use to investigate further into Rebecca's mental health status?

3. When John brings up a suicide screening questionnaire in an appropriate and neutral manner, Rebecca stands up and begins to shout at John to stop being nosey. She states it is none of his business and that he is not a psychotherapist. John sees her glancing around the room and is not sure what she is looking for. What should John do in this situation?

4. If Rebecca agrees to a suicide screening by John and scores a 3 on the SBQ, what should John do?

Responses

1. It is possible that Rebecca is struggling with her personal life, especially considering she is a widow and has had major depressive disorder in her past medical history. She appears to be using an avoidant strategy with the subject, making it difficult for John to complete his subjective history on home setup and home support.

2. From her medical history and social history, it appears that Rebecca has multiple risk factors for suicide. She is a widow, is avoidant to respond to questions regarding her home life, has a history of a suicide attempt, and has major depression. If not already done by a social worker, RN, or any other staff, John needs to screen for suicide risk. An example script is "I need to now ask a few questions that are standard hospital policy for every patient that I see on the first visit. These questions may be sensitive but I need to make sure I am not missing anything important." He may then proceed with a suicide screening tool such as the ASQ or SBQ. If Rebecca is resistant to this, John should consult with a mental health provider who is trained further in gathering this information despite patient resistance.

3. The situation here has escalated into an unpredictable state. Rebecca could be scanning the room for an object to harm either herself or John. She could be looking to escape the hospital room as well. John should in this situation calmly tell Rebecca he will leave the room and he should mobilize hospital security. He should leave the room, contact Rebecca's Registered Nurse and contact a trained mental health professional for a safety evaluation. Even if Rebecca was not looking to harm anyone, she had displayed enough aggression that she or the staff could be at risk.

4. John should explain what Rebecca's score indicates (low suicide risk) and provide resources to Rebecca. This includes an offer to refer to mental health outpatient therapy. He could bring this up by validating the difficulties that Rebecca has faced in her life and normalizing mental health care. In addition to this, he should provide information about the Suicide and Crisis Lifeline, explaining all of its uses for it in addition to suicide risk mitigation. John should document his interaction that propagated the suicide screening assessment, the screening tool used, the

score of the screening tool, and his plan of action. John should document this for other providers in the future to reference and to refer per protocol to a mental health professional while in the hospital. This provider would be able to offer additional resources to Rebecca in terms of specific referrals to arrange care in Rebecca's discharge location.

Conclusion

Suicide is a widespread issue, affecting more than 46,000 individuals each year in the US. Healthcare professionals in Washington must be trained in prevention, recognition, and response in order to help patients at risk of suicide. Both physical therapists and physical therapist assistants with patient interacting roles have a role in recognizing suicide warning signs in their patients. PTs should always screen for suicide risk in their evaluation by asking the ASQ or PHQ as a routine process. PTs and PTAs should be knowledgeable about their organization's protocol for an appropriate response after recognizing someone at risk of suicide. Rehabilitation professionals may have a large role in this health crisis because they generally spend more time with their patients, allowing patients to trust their relationship. PTs and PTAs should now feel prepared to screen for suicide risk and refer to mental health providers on an emergent or nonemergent basis.

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