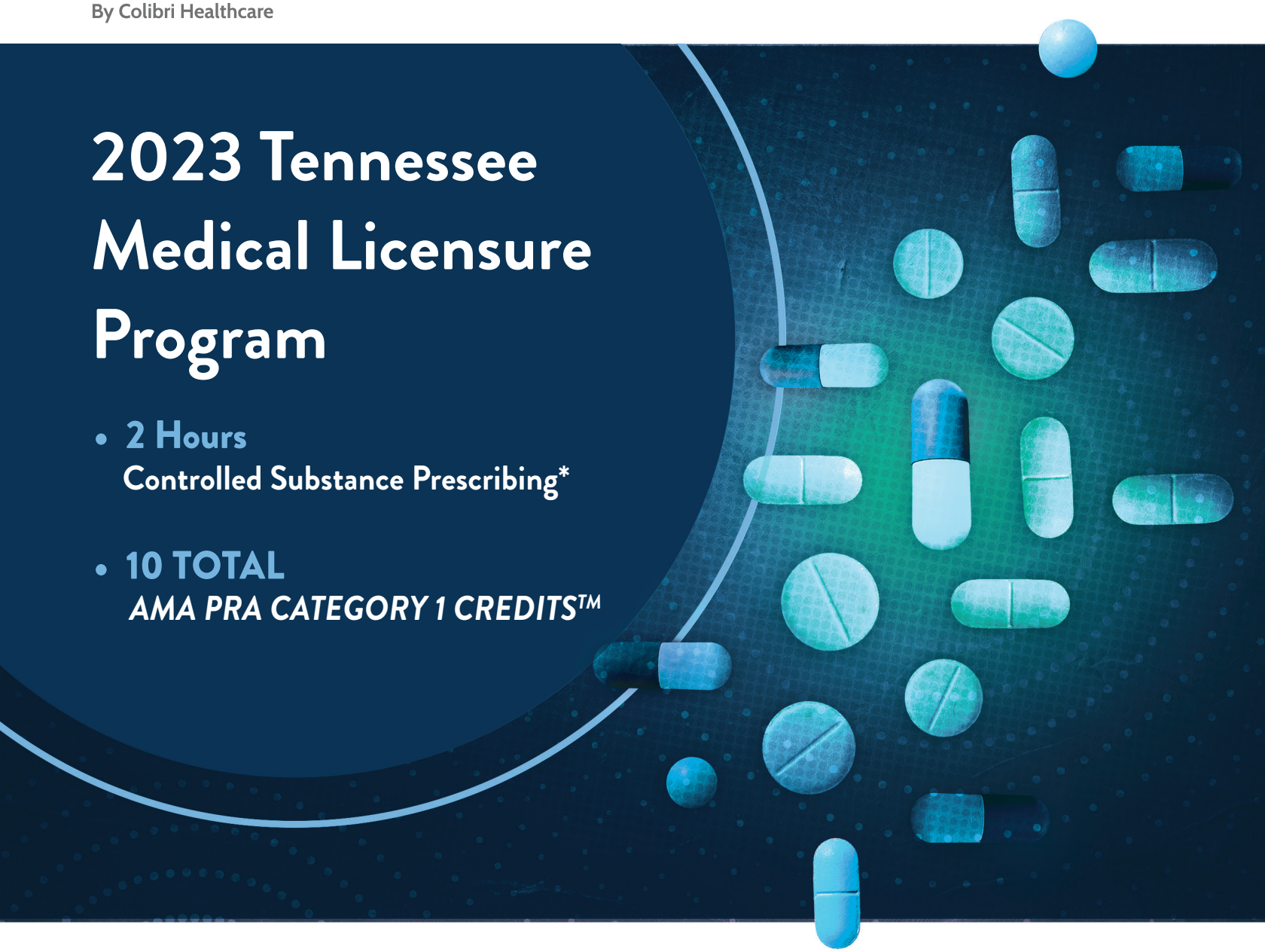
InforMed
Continuing Medical Education
By Colibri Healthcare

State Specific Continuing Medical Education

2023 Tennessee Medical Licensure Program



- **2 Hours**
  Controlled Substance Prescribing*
- **10 TOTAL**
  AMA PRA CATEGORY 1 CREDITS™

ACCME ACCREDITED

*Mandatory CME Requirement

Tennessee physicians must complete two (2) hours of CME in controlled substance prescribing in accordance with board rules.

CME FOR: *AMA PRA CATEGORY 1 CREDITS™* MIPS MOC STATE LICENSURE

TN.CME.EDU

ONLINE

2023 TENNESSEE

01 TENNESSEE GUIDELINES FOR MANAGING CHRONIC PAIN

COURSE ONE | 2 CREDITS*

***Completion of this course satisfies the mandatory CME requirement in controlled substance prescribing which must include instruction in the Department's Chronic Pain Guidelines.**

20 IMPROVING ACCESS TO CARE FOR LGBTQ PATIENTS

COURSE TWO | 2 CREDITS

35 ASSESSMENT AND PREVENTION OF SUICIDE

COURSE THREE | 6 CREDITS

64 LEARNER RECORDS: ANSWER SHEET & EVALUATION

REQUIRED TO RECEIVE CREDIT

CME that counts for MOC

Participants can earn MOC points equivalent to the amount of CME credits claimed for designated activities (see page iii for further details). InforMed currently reports to the following specialty boards: the American Board of Internal Medicine (ABIM), the American Board of Anesthesiology (ABA), the American Board of Pediatrics (ABP), the American Board of Ophthalmology (ABO), the American Board of Otolaryngology–Head and Neck Surgery (ABOHNS), and the American Board of Pathology (ABPath). To be awarded MOC points, you must obtain a passing score, complete the corresponding activity evaluation, and provide required information necessary for reporting.

$75.00	$55.00
ENTIRE PROGRAM	COURSES 1 & 2

DATA REPORTING: Federal, State, and Regulatory Agencies require disclosure of data reporting to all course participants. InforMed abides by each entity's requirements for data reporting to attest compliance on your behalf. Reported data is governed by each entity's confidentiality policy. To report compliance on your behalf, it's mandatory that you must achieve a passing score and accurately fill out the learner information, activity and program evaluation, and the 90-day follow up survey. Failure to accurately provide this information may result in your data being non-reportable and subject to actions by these entities.

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How to complete

Please read these instructions before proceeding.

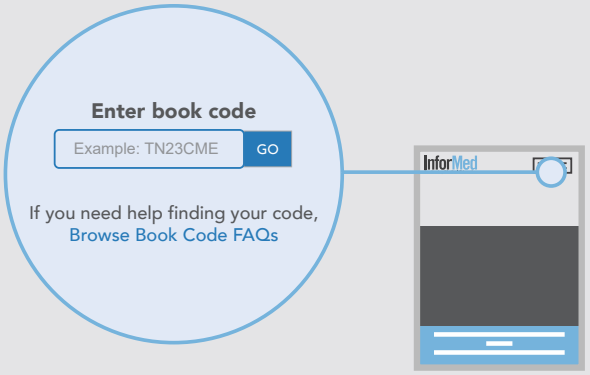
Read and study the enclosed courses and answer the self-assessment questions. To receive credit for your courses, you must provide your customer information and complete the mandatory evaluation. We offer three ways for you to complete. Choose an option below to receive credit and your certificate of completion.

Fastest way to receive your certificate of completion

Online

- Go to **BOOK.CME.EDU**. Locate the book code **TN23CME** found on the back of your book and enter it in the box then click **GO**. If you would like to choose a different program option, use the table below and enter the corresponding code in the box.
- If you already have an account created, sign in to your account with your username and password. If you do not have an account already created, you will need to create one now.
- Follow the online instructions to complete your self-assessment. Complete the purchase process to receive course credit and your certificate of completion. Please remember to complete the online evaluation.

Program Options	Code	Credits	Price
Entire Program	TN23CME	10	$75.00
Courses 1 & 2	TN23CME-55	4	$55.00
Course 1	TN23CME-50	2	$50.00



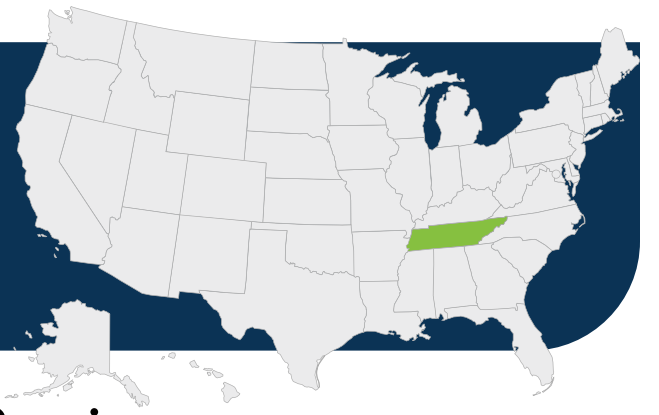
By mail

- Fill out the answer sheet and evaluation found in the back of this booklet. Please include a check or credit card information and e-mail address. Mail to **InforMed, PO Box 2595, Ormond Beach, FL 32175-2595**.
- Completions will be processed within 2 business days from the date it is received and certificates will be e-mailed to the address provided.
- Submissions without a valid e-mail will be mailed to the address provided.

By fax

- Fill out the answer sheet and evaluation found in the back of this booklet. Please include credit card information and e-mail address. Fax to **1-800-647-1356**.
- All completions will be processed within 2 business days of receipt and certificates will be e-mailed to the address provided.
- Submissions without a valid e-mail will be mailed to the address provided.

INFORMED TRACKS
WHAT YOU NEED, WHEN YOU NEED IT



Tennessee Professional License Requirements

NEW CHANGE TO CME CYCLE FOR TENNESSEE PHYSICIANS

Due to recently enacted regulations, physicians licensed by the Tennessee Board of Medical Examiners may now complete their CME requirements in the twenty-four (24) months preceding their license renewal.

MANDATORY CONTINUING MEDICAL EDUCATION REQUIREMENT FOR LICENSE RENEWAL

PHYSICIANS

By Board Rule, all licensees are required to complete forty (40) hours of continuing medical education courses within twenty-four (24) months preceding their license renewal. **All licensees (unless exempt under TENN. CODE ANN. § 63-1-402(c)) shall complete at least two (2) of the forty (40) required hours of continuing education on controlled substance prescribing, which must include instruction in the Department's Chronic Pain Guidelines on opioids, benzodiazepines, barbiturates and carisoprodol and may include topics such as medicine addiction, risk management tools and other topics approved by the Board.**

OSTEOPATHIC PHYSICIANS

During the two (2) calendar years that precede licensure renewal, all osteopathic licensees must complete forty (40) hours of courses approved by the Board in Category I-A, II-A and/or I-B continuing medical education. **At least two (2) of the forty (40) required hours shall be a course designated specifically to address prescribing practices. The course should include, but not be limited to, instruction on controlled substance prescribing practices.**

PHYSICIAN ASSISTANTS

All physician assistants must, within a two (2) year period prior to the application for license renewal, complete one hundred (100) hours of continuing medical education satisfactory to the Committee. At least fifty (50) hours shall be obtained in certified medical education Category I. **If you're a licensee with a DEA Registration at least two (2) Category I hours of the required continuing education hours shall address controlled substance prescribing, which must include instruction in the Department's treatment guidelines. Licensees without a DEA registration must complete one (1) hour in prescribing practices.**

We are a nationally accredited CME provider.
For all board-related inquiries please contact:

Tennessee Board of Medical Examiners
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243
615-532-3202 local or
1-800-778-4123 nationwide

CME DEADLINE:
Prior to your upcoming license renewal

LICENSE TYPES:
Physicians and Physician Assistants

Disclaimer: The above information is provided by InforMed and is intended to summarize state CE/CME license requirements for informational purposes only. This is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. All information should be verified independently.

MOC/MIPS CREDIT INFORMATION

In addition to awarding *AMA PRA Category 1 Credits™*, the successful completion of enclosed activities may award the following MOC points and credit types. To be awarded MOC points, you must obtain a passing score and complete the corresponding activity evaluation.

Table 1. MOC Recognition Statements		
Successful completion of certain enclosed CME activities, which includes participation in the evaluation component, enables the participant to earn up to the amounts and credit types shown in Table 2 below. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting MOC credit.		
Board Programs		
MOCA®	**ABA**	American Board of Anesthesiology's redesigned Maintenance of Certification in Anesthesiology™ (MOCA®) program, known as MOCA 2.0®
ABIM CME MOC ACCREDITED	**ABIM**	American Board of Internal Medicine's Maintenance of Certification (MOC) program
	ABO	American Board of Ophthalmology's Maintenance of Certification (MOC) program
ABOHNS	**ABOHNS**	American Board of Otolaryngology – Head and Neck Surgery's Continuing Certification program (formerly known as MOC)
CME for ABPath CC	**ABPath**	American Board of Pathology's Continuing Certification Program
PART 2 MOC THE AMERICAN BOARD of PEDIATRICS	**ABP**	American Board of Pediatrics' Maintenance of Certification (MOC) program.

Table 2. Credits and Type Awarded							
Activity Title	***AMA PRA Category 1 Credits™***	**ABA**	**ABIM**	**ABO**	**ABOHNS**	**ABPath**	**ABP**
Tennessee Guidelines for Managing Chronic Pain	2 *AMA PRA Category 1 Credits™*	2 Credits LL	2 Credits MK	2 Credits LL & SA	2 Credits SA	2 Credits LL	2 Credits LL + SA
Improving Access to Care for LGBTQ Patients	2 *AMA PRA Category 1 Credits™*	2 Credits LL	2 Credits MK	2 Credits LL & SA	2 Credits SA	2 Credits LL	2 Credits LL+SA
Assessment and Prevention of Suicide	6 *AMA PRA Category 1 Credits™*	6 Credits LL & PS	6 Credits MK & PS	6 Credits LL, SA, & PS	6 Credits SA & PS	6 Credits LL	6 Credits LL+SA
Legend: LL = Lifelong Learning, MK = Medical Knowledge, SA = Self-Assessment, , LL+SA = Lifelong Learning & Self-Assessment, PS = Patient Safety							

Table 3. CME for MIPS Statement
Completion of each accredited CME activity meets the expectations of an Accredited Safety or Quality Improvement Program (IA PSPA_28) for the Merit-based Incentive Payment Program (MIPS). Participation in this Clinical Practice Improvement Activity (CPIA) is optional for eligible providers.

TENNESSEE GUIDELINES FOR MANAGING CHRONIC PAIN

COURSE DATES:	MAXIMUM CREDITS:	FORMAT:
Release Date: 4/2022 Exp. Date: 3/2025	*2 AMA PRA Category 1 Credits*™	Enduring Material (Self Study)

TARGET AUDIENCE

All health care professionals who participate in the management of patients with pain.

HOW TO RECEIVE CREDIT:

- Read the course materials.
- Complete the self-assessment questions at the end. A score of 70% is required.
- Return your customer information/ answer sheet, evaluation, and payment to InforMed by mail, phone, fax or complete online at program website.

COURSE OBJECTIVE

This course is designed to increase physician knowledge and skills regarding Tennessee guideline-recommended principles of pain management. An overview of controlled substances and addiction complications, with an emphasis on the Tennessee Chronic Pain Guidelines will be presented.

LEARNING OBJECTIVES

Completion of this course will better enable the course participant to:

1. Describe the different Schedules of Controlled Substances.
2. Understand terminology regarding medications in the different groups, their uses and risks.
3. Discuss recommended guidelines for use of opioids in the treatment of chronic, non-malignant pain.
4. Describe factors that contribute to risk of substance use disorder.

ACCREDITATION STATEMENT

InforMed is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

DESIGNATION STATEMENT

InforMed designates this enduring material for a maximum of 2 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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DISCLOSURE OF INTEREST

In accordance with the ACCME Standards for Integrity and Independence in Accredited Continuing Education, InforMed implemented mechanisms, prior to the planning and implementation of this CME activity, to identify and resolve conflicts of interest for all individuals in a position to control content of this CME activity.

COURSE SATISFIES

2

Prescribing Controlled Substances

SPECIAL DESIGNATION

Completion of this course satisfies the Tennessee Board of Medical Examiner's requirement in controlled substance prescribing which must include instruction in the Department's Chronic Pain Guidelines on opioids, benzodiazepines, barbiturates and carisoprodol.

Tennessee Licensees must complete at least two hours of controlled substance prescribing CME as a condition of renewal (unless they are exempt under TENN.CODE ANN. § 63-1-402(c)).

FACULTY/PLANNING COMMITTEE DISCLOSURE

The following faculty and/or planning committee members have indicated they have no relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients:

- Russel Yoon, MD
- Beth Dove
- Dawn Demangone-Yoon, MD
- Michael Brooks

STAFF AND CONTENT REVIEWERS

InforMed staff, input committee and all content validation reviewers involved with this activity have reported no relevant financial relationships with commercial interests.

DISCLAIMER

Introduction

Controlled substances (CS) are used to treat many medical conditions but are associated with risks to patients and society.[1-4] Research suggests that the potential for misuse of non-opioid medications is under appreciated by heath care providers (HCPs).[5-8] Although most overdose deaths still involve opioids,[9] polysubstance involvement is on the rise and includes prescription stimulants, benzodiazepines, and sedative-hypnotics.[6-8] Misuse of any prescription drug is a serious problem, and that includes opioid and non-opioid CS.[1-4,10]

Actions aimed at containing the societal opioid crisis have paralleled increased prescription rates for non-opioid CS,[11,12] some of which are recommended as first-line agents for pain treatment.[13] Despite these efforts, reductions in opioid prescriptions[14] have not seen a corresponding drop in overdose drug deaths in the United States.[9] At the same time, interest in non-opioid CS has grown: prescriptions for stimulants have risen sharply, and benzodiazepines are among the most commonly prescribed CS (Figure 1).[4] An analysis based on a single commercial insurance provider found a "concerning" 5-fold rise in stimulant use over 15 years (2004-2019).[4]

Opioid-use disorder (OUD) can develop with opioid medication use, significantly affecting quality of life. Yet, significant barriers prevent broad access to treatment for OUD, despite strong evidence that treatment with medications approved by the US Food and Drug Administration (FDA) for OUD reduces morbidity and mortality.[15] Fewer than a third of people with OUD receive treatment, and those who do often wait years to begin.[15,16] Additional barriers include stigma, lack of professional education and training related to the evidence base for using medication to treat OUD, and a fragmentary health care system that does not incentivize best care.[15]

To appropriately manage patients while minimizing diversion and misuse, HCPs must stay abreast of the existing and evolving laws, regulations, and policies that govern CS prescribing and to comply with all requirements.[17] To improve patient outcomes and minimize misuse, HCPs should aim to recognize the signs and symptoms of appropriate medical indications for prescribed CS.[5,17]

This activity is designed to educate HCPs about select controlled substances as required by the State of Tennessee.

Introduction to Controlled Substances

Drugs or medications with the potential for misuse and a high risk of resulting in substance-use disorder (SUD) are strictly controlled by the federal government. The aim is to protect access to drugs with a legitimate medical purpose while preventing the detrimental effects of illegal importation, manufacture, distribution, possession, and improper use.

The Drug Enforcement Administration (DEA) enforces federal CS laws in all states and territories. In recent decades, the agency's approach to curtailing drug misuse and diversion of pharmaceutical opioids has been to focus on traffickers and doctors who prescribe inappropriately rather than on individuals who illegally obtain opioids.[18]

Drug Schedules

The Controlled Substance Act (CSA), which took effect in 1971 regulates manufacture, distribution, and dispensing of CS with specifics laid out in the Code of Federal Regulations (CFR) Title 21, §§1300-1316. Under the CSA, illegal and prescription drugs are classified into 5 schedules according to:[18,19]

- Actual or relative potential for misuse
- Known scientific evidence of pharmacological effects
- Current scientific knowledge of the substance
- History and current pattern of misuse
- Scope, duration, and significance of misuse
- Risk to public health
- Psychic or physiological dependence liability
- Whether the substance is an immediate precursor of an already-scheduled substance

Two federal agencies, the DEA and the Food and Drug Administration (FDA), determine which substances are added to or removed from Schedules I-V.[12]

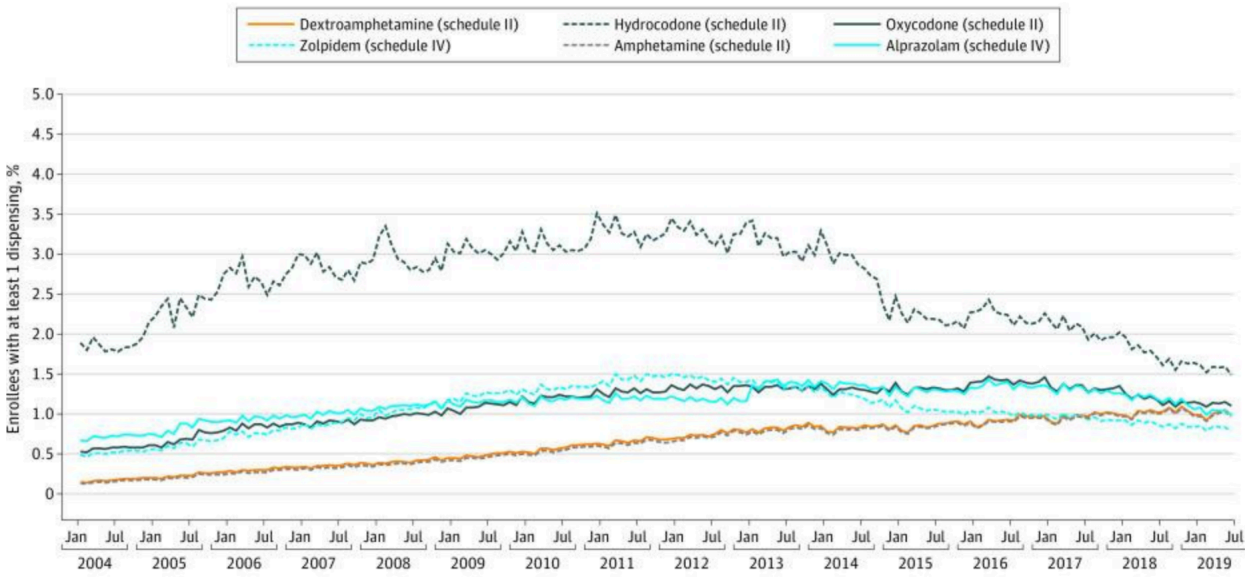
Each schedule is defined as shown in Table 1. Schedule I drugs have the highest risk for substance use disorder (SUD) and misuse and no accepted medical uses. Cannabis, although legal in some states, is still a Schedule I drug at the federal level. It is the only Schedule I drug that is legal at the state level for medicinal and recreational uses. The DEA does allow research to be conducted with Schedule I drugs when an investigator is deemed to be qualified and the protocol is found to have merit.

Schedule II medications do have accepted medical uses (some with restrictions), including opioids for acute or chronic pain severe enough to warrant an opioid prescription and stimulants used to treat attention deficit hyperactivity disorder (ADHD). Use of Schedule II drugs may lead to severe psychological or physical dependence.

The medications in Schedule III may lead to a moderate or low degree of physical dependence or "high." Schedule III opioids include products containing not more than 90 mgs of codeine per dosage unit. This is also the schedule that contains stimulants and anabolic steroids.

Although Schedule IV drugs are considered to have low potential for SUD and misuse relative to Schedule III, cautions do apply. This schedule contains medications that are frequently prescribed for insomnia and anxiety disorders.

Figure 1. Trends for Most Commonly Dispensed Controlled Substances in US Commercially-Insured Adults (January 2004 to June 2019)



*Based on de-identified longitudinal claims data on beneficiaries of a large US employer-sponsored commercial health insurance provider and covers approximately 9 million individuals ages 19 to 64 years in any given month across all 50 states.

Table 1. Drug Schedules I-V Established by the Controlled Substances Act					
Schedule	**Risk Level**	**Medical Use Status**	**Prescriptions**	**Refills allowed**	**Examples**
I	Highest risk for SUD and misuse	No currently accepted medical use Lack of accepted safety for medical use	No	N/A	Heroin LSD Mescaline MDMA Methaqualone Marijuana
II	High potential for SUD and misuse (less than Schedule I)	Currently accepted medical use	Paper Electronically transmitted with strict requirements Phone only in emergencies with written prescription to follow within 7 days	No*	Amphetamine Opioids: Codeine Fentanyl Hydrocodone Hydromorphone Meperidine Morphine Methadone Opium Oxycodone Methylphenidate Pentobarbital
III	Less potential for SUD and misuse than Schedules I or II	Currently accepted medical use	Paper Electronically transmitted Phone, fax	Up to 5 refills within 6 months	ACET with codeine Anabolic steroids Buprenorphine Ketamine
IV	Low potential for SUD and misuse relative to Schedule III**	Currently accepted medical use	Paper Electronically transmitted Phone, fax	Up to 5 refills within 6 months	Benzodiazepines: Alprazolam Clonazepam Diazepam Lorazepam Midazolam Temazepam Triazolam Carisoprodol
V	Low potential for SUD and misuse relative to Schedule IV	Currently accepted medical use	Paper Electronically transmitted Phone, fax	No limits, except partial refills must occur within 6 months of issue date	Cough preparations with codeine Ezogabine

SUD = Substance-use disorder
LSD = Lysergic acid diethylamide
MDMA = Methylenedioxymethamphetamine
ACET = Acetaminophen
*See exceptions under "Federal Restrictions Regarding Refills"
**Benzodiazepines carry risks of substance dependence and respiratory depression, particularly in combination with other substances that also depress respiration.[21,22]

These drugs, which include alprazolam, diazepam, and lorazepam, are frequently mentioned in overdose statistics involving opioids, and expert guidance urges caution in their use and taper and particularly discourages the combination with opioids unless deemed necessary.[13,20,21]

Schedule V contains drugs with limited quantities of opioids that include cough preparations, containing no more than 200 milligrams of codeine per 100 milliliters or per 100 grams. Although this lower schedule has less misuse danger relative to other schedules, patients prescribed any CS still must be managed with care.

Part of the role of the DEA is to ensure medications are not diverted for misuse. Table 2 contains common terms associated with the use and misuse of opioids and other prescription drugs that are categorized under CS schedules.[5] The DEA provides manuals for HCPs and other practitioners to keep abreast of federal requirements in implementing the CSA.[22] As of this writing, the DEA Diversion Control Division is currently updating all manuals but did issue an updated pharmacist's manual as of 2020.

The Purpose of a Prescription in Legitimate Medical Practice

The DEA tracks the flow of CS from manufacture to ultimate use and enforces the CSA, including the tenets of lawful prescribing.[12] In order to be legal, a CS prescription must be issued for a legitimate medical purpose in the course of professional practice.[23] In general, this means HCPs must practice in accordance with medical standards recognized and accepted in the United States.[22] The totality of circumstances particular to each HCP and patient must be evaluated on its own merits.

Table 2. Definitions Related to Prescription Drug Use and Misuse	
Term	**Definition**
Physical dependence	• Not the same as addiction • Occurs because of physiological adaptations to chronic exposure to a drug • Withdrawal symptoms occur when medicine is suddenly reduced or stopped or when antagonist is administered • Symptoms can be mild or severe and can usually be managed medically or avoided through slow drug taper
Tolerance	• Same dose of drug given repeatedly produces reduced biological response • Higher dose of drug is necessary to achieve initial level of response
Misuse	• Taking medication in a manner or dose other than prescribed • Taking someone else's prescription, even if for a medical complaint like pain • Taking medication to feel euphoria (i.e., to get high) • *Nonmedical* use of prescription drugs refers to misuse
Addiction	• Primary, chronic disease of brain reward, motivation, memory, and related circuitry • Dysfunction in circuits leads to characteristic biological, psychological, social, and spiritual manifestations as individual pathologically pursues reward and/or relief by substance use and other behaviors • Characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and dysfunctional emotional response • Involves cycles of relapse and remission • Without treatment or recovery activities, is progressive and results in disability or premature death
Opioid-use disorder	• A problematic pattern of opioid use leading to clinically significant impairment or distress • Defined in DSM-5* • Previously classified as "opioid abuse" or "opioid dependence" in DSM-4 • Also referred to as "opioid addiction"
*DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; diagnostic criteria given later in this activity	

Registration Requirements to Prescribe Controlled Substances

The cornerstone of CS regulation is that all handlers of CS must register with the DEA. The registration requirement extends to HCPs, drug manufacturers, wholesale distributors, hospitals, pharmacies, and scientific researchers.[24] One person or the institution itself (for example, a hospital) may serve as the registrant, and nonregistered agents may write prescriptions under that registration.[22] If an HCP has more than one practice, each location must have its own DEA registration to prescribe CS.[22] This applies to a business location and not to HCPs who practice at multiple locations within the same state.

The DEA may act to suspend or revoke a prescriber's registration, for example, if the prescriber has:[22]

- Falsified any application
- Been convicted of a felony related to a CS
- Had a state license or registration suspended, revoked, or denied
- Committed an act that would render DEA registration inconsistent with public interest
- Been excluded from participation in a Medicaid or Medicare program

Considerations in determining the public interest include recommendations of state licensing boards, compliance with CS law at the state, federal, or local level, conviction record pertaining to CS, experience with respect to CS, and "such other conduct" that may threaten public health and safety.[22] The registrant takes responsibility for compliance with the CSA and for ensuring CS are distributed only to those authorized to receive them.[22]

A registrant must notify the local DEA Diversion Field Office in writing within a business day of discovery of a theft or significant loss of a CS.[19]

The DEA may also move to investigate a prescriber for alleged criminal acts. The agency assures HCPs that investigation and prosecution are reserved for instances where "conduct is not merely of questionable legality, but instead is a glaring example of illegal activity," and that cases "typically involve facts that demonstrate blatant criminal conduct;" however, the agency does not set a clear standard or signify a basis for prosecution.[24]

The DEA does provide some examples of prescribing in violation of the CSA (i.e., for other than a legitimate medical purpose or outside the usual course of professional practice).[24] While there are no set criteria, some recurring patterns cited by the DEA that might indicate inappropriate prescribing include:[22]

- An inordinately large quantity of CS or numbers of prescriptions in comparison to other area HCPs (while also recognizing that some practitioners, for example, those who treat cancer, may prescribe more than others)
- Lack of physical exam
- Warnings to the patient to fill prescriptions at different pharmacies
- Prescriptions issued that are known to be delivered to others
- Prescriptions issued in exchange for sex or money
- Prescribing intervals inconsistent with legitimate medical treatment
- Use of street slang for medical drugs
- No logical relationship between prescribed drugs and alleged medical condition

The DEA further clarifies that the existence of any of the foregoing factors does not automatically mean a prescriber has acted improperly. For example, some patients require doses that would be considered large for other patients, and the DEA asserts that each case is individually considered.[24]

Information on Prescriptions

CS prescriptions must be dated and signed on the day when issued and include the patient's full name and address as well as the registrant's full name, address, and registration number.[22] In addition, the prescription must include:[22]

- Drug name
- Drug strength
- Dosage form
- Quantity prescribed
- Directions for use
- Number of refills (may be 0)

CS prescriptions must be written in indelible ink or pencil or else be typewritten.[22]

Federal Restrictions Regarding Refills

Schedule II prescription orders must be written and signed by the HCP and may not be phoned into the pharmacy except in an emergency. If phoned in under emergency circumstances, the HCP must present the written and signed prescription to the pharmacy within 7 days.[19,22] One further exception is that a fax may serve as the written prescription for residents of long-term care facilities, hospice patients, or compounded IV opioids.[22]

Prescriptions for Schedule III-IV drugs may be written or phoned in and may be refilled up to 5 times within 6 months of issue.[19] Schedule V drugs have no refill limits but are restricted in that the patient must be at least 18 years old and must offer some form of identification to fill a prescription.[19]

Commonly Prescribed Controlled Substances

The 5 drug classes regulated by the CSA are opioids (called "narcotics" by the DEA), sedative-hypnotics, stimulants, hallucinogens, and anabolic steroids. Each class produces its own effects in the body, but all share the commonality that they have the potential for being misused by patients and non-patients. They are also among the most highly sought-after drugs for diversion.[25]

Many CS drugs are commonly prescribed for indicated medical conditions. Others, such as cocaine, have very limited medical indications. Non-opioid medications can minimize opioid exposure, and different medications can complement one another; however, each has unique risks and benefits as well as mechanisms of action,[5] and their effects can be synergistic when used in combination.[5] A risk-benefit analysis is always recommended based on the individual patient's medical, clinical, and biopsychosocial circumstances.[5]

Specific categories and medications will be described as required by the State of Tennessee.

Opioids

As Schedule II medications, opioid prescriptions are not limited by quantity or treatment by the CSA; however, many states and insurance carriers do set limits on quantity, frequency, and duration of prescriptions as well as other facets of treatment and monitoring. Remember that the more restrictive law trumps the less restrictive in regard to prescribing CS. Prescribing for pain has dropped off in recent years after peaking in 2011.[17] However, the danger from the opioid crisis is ongoing, and HCPs are called on to prescribe judiciously, reserving opioids for pain that does not respond to other treatments.

Despite some recent progress on several fronts, the situation in Tennessee remains dire as illustrated by the following statistics:

- In 2019, 1,543 Tennesseans died from an opioid-related overdose, an average of more than 4 deaths every day, a 49% increase compared to 1,034 deaths in 2015.[26]
- Tennessee had the nation's third-highest rate of opioid prescriptions (68.5 for every 100 persons) in 2020, which was almost one-and-a-half times higher than the national average of 45.9 prescriptions per 100 persons.[27]
- The number of cases of Neonatal Abstinence Syndrome increased slightly from 810 in 2019 to 824 in 2020.[28]

Opioids are classified according to their action at mu receptors as full agonists, mixed agonist-antagonists, or antagonists (Table 3).[29-32] Most clinically prescribed opioids are full mu agonists. Buprenorphine has a reduced potential for respiratory depression and acts as an antagonist at the kappa receptor, which is shown to reduce anxiety, depression, and the unpleasantness of opioid withdrawal.[5] Tapentadol and tramadol have dual modes of action as agonists at the mu receptor and SNRIs.[5] Considerations with dual-mechanism opioids include lowering of the seizure threshold in susceptible patients and the risk of serotonin syndrome.[33]

Formulations may be extended-release (ER) or immediate-release (IR), and delivery systems for outpatients include oral, transmucosal, and transdermal routes of administration. Combination products contain products such as acetaminophen (ACET) together with an opioid, necessitating careful tracking of daily dose limits so as not to incur risk for liver and GI toxic effects.[34] All transdermal and transmucosal fentanyl and hydromorphone ER products are for use only in opioid-tolerant patients and never for acute or short-term pain.[35] ER/LA opioids are primarily intended to be taken once or twice a day, are not indicated for acute pain, and are for use only in patients who are already tolerant to opioids.[13,35]

The primary risk with opioids is respiratory depression leading to death. Some opioids (e.g., methadone) can prolong the QTc interval. ER/LA opioid tablets should be swallowed whole, never crushed, chewed, broken, cut, or dissolved, which may result in rapid release and absorption of a potentially fatal dose.[35,36] Transdermal systems and buccal films should not be cut, torn, or damaged before use nor chewed, swallowed, or patches exposed to heat, which may lead to fatal overdose.

Possible opioid side effects include but are not limited to:[5,13]

- Lightheadedness
- Dizziness
- Sedation
- Nausea and vomiting
- Drowsiness
- Mental clouding
- Constipation

Table 3. Opioid Analgesic Classifications

Type	Generic Name	Notes/Cautions
Pure agonists	Codeine Dihydrocodeine Fentanyl Hydrocodone Hydromorphone Levorphanol Meperidine* Methadone Morphine Oxycodone Oxymorphone Propoxyphene	*Meperidine not recommended for long-term treatment or in patients with renal compromise due to toxicity risks
Agonist-antagonists	Partial agonist: Buprenorphine Mixed agonist-antagonists: Butorphanol Dezocine Nalbuphine Pentazocine	May produce withdrawal with physical dependence
Pure antagonists	Naloxone Naltrexone	Administered to reverse opioid effects
Other	Tramadol Tapentadol	Dual action mu-agonist and serotonin–norepinephrine reuptake inhibitor Dual action mu-agonist and norepinephrine reuptake inhibitor

- Hormonal deficiencies
- Pruritis
- Myoclonus
- Irritability
- Respiratory depression

Signs of an opioid overdose include:[37,38]

- Small, constricted "pinpoint pupils"
- Falling asleep or loss of consciousness
- Slow, shallow breathing
- Choking or gurgling sounds
- Limp body
- Pale, blue, or cold skin
- Snoring heavily and cannot be awakened
- Periods of ataxic (irregular) or other sleep-disordered breathing
- Trouble breathing
- Dizziness, confusion, or heart palpitations

Acute Pain

Opioids in acute pain settings should only be prescribed for the duration of the pain at the lowest effective therapeutic dose.[13,39] Prescriptions beyond 3 days are rarely necessary,[13] while more severe episodes rarely need more than 7-14 days, although there are exceptions, and each patient should be treated as an individual.[13,40] Be aware also that localities and states may have strict regulations governing maximum duration of prescriptions for acute pain. Acute pain should not be treated with ER/LA formulations of opioids, and opioids typically are not recommended for nonspecific back pain, headaches, or fibromyalgia, if the HCP should see a patient experiencing acute pain flares with these conditions.[33] HCPs should check the PDMP ahead of prescribing opioids for acute pain whenever possible[5] and reevaluate the pain diagnosis and treatment plan if pain persists beyond the expected healing period.

Chronic Pain

Patients need access to appropriate and effective pain relief with a commitment to avoiding or managing adverse effects arising from treatment with CS. Some 50 million U.S. adults live with chronic daily pain, and 19.6 million experience high-impact pain that interferes with daily life and work.[5] Patients who suffer pain long term have reduced quality of life and are at risk for morbidity when pain goes untreated or is managed inappropriately. Effective pain management skills are part of quality medical practice.

Effective treatment for pain does not usually involve ongoing opioid therapy, which should be reserved for patients with pain severe enough to warrant an opioid and for whom more conservative therapies would not be effective or have previously failed to be effective.[13] Numerous non-opioid pharmacologic therapies are available for pain, and these should be tried or considered, alone or in combination, before initiating long-term opioid therapy.[5] A trial of opioids, when indicated, should be part of a comprehensive treatment approach, typically in combination with one or more treatment modalities.[33]

In 2020 the Tennessee Department of Health issued the latest edition of its clinical practice guidelines for the outpatient management of chronic non-malignant pain.[41] The guidelines can serve as a resource for any prescriber who may be utilizing opioid medications in the treatment of patients with chronic pain, with an emphasis on the avoidance of adverse outcomes or addiction. The guidelines provide detailed recommendations when considering, initiating and continuing the use of opioid medications in the treatment of chronic, non-malignant pain. Many useful resources are available to the prescriber within the guidelines including assessment tools, special population concerns, examples of informed consent/ patient agreements, as well as information of Emergency Department opioid prescribing guidelines and acute pain management.

The guidelines may be found at: https://www.tn.gov/content/dam/tn/health/healthprofboards/pain-management-clinic/ChronicPainGuidelines.pdf

The following represents a summary of some of the key principles included in the Tennessee Chronic Pain Guidelines.

Considerations for the Prescriber: Prior to the Initiation of Opioid Therapy

1. Prior treatment of pain with opioids, provided by a previous provider, does not obligate, or necessitate continued opioid treatment.
2. Non-opioid treatment modalities should be attempted prior to initiating treatment with opioid medications.
3. Telemedicine is not an appropriate modality for treatment of chronic pain with opioids (or other controlled substances).
4. Birth control methods should be discussed to avoid unintended pregnancy in women of childbearing age.
5. A thorough history, physical examination and review of a patient's prior medical records should be completed and documented.
6. A thorough history of the patient's painful condition should be pursued, including prior diagnostic testing and treatment attempts.
7. Risks for abuse, misuse, addiction, and diversion must be assessed.
8. A current diagnosis must be established to justify opioid medications.
9. The prescriber and patient must identify a plan that includes treatment modalities beyond opioids.
10. Goals of treatment should be established and emphasize reduction of pain for improved daily function, not necessarily complete elimination of pain. Functional goals could include improved activities of daily living, increase social participation or returning to work. To be effective, functional treatment goals should be realistic and tailored to each patient. A helpful strategy is to help the patient define SMART goals (specific, measurable, action-oriented, realistic, and time-sensitive).[42]
11. Informed consent regarding the potential risks of opioid medications such as physical dependence, physical impairment, over-sedation, addiction, and death must be obtained. The guidelines include an example of an Informed Consent document.

The patient should be counseled that the goal of chronic opioid therapy is to increase function and reduce pain, not to eliminate pain. Most randomized controlled trials have shown modest reductions in pain with opioids averaging 30%. A recent systematic review found that only 44.3% of patients had 50% pain relief with opioids in the short term.[43] Documentation of this discussion should be included in the medical record.

The possible presence of co-occurring mental health disorders should be considered, and screening tests should be used if depression, anxiety, PTSD, current or past substance use disorder, or any other mental health conditions are suspected. Prescribers should obtain a Urine Drug Test (UDT) (or a comparable test on oral fluids) prior to initiating opioid therapy and they should access the Tennessee Controlled Substances Monitoring Database (CSMD) to obtain data about a patient's risk of misuse, abuse or diversion of medications. [41]

Considerations for the Prescriber: Initiation of Opioid Therapy

1. Written agreements/ treatment plans between patient and prescriber should define reasons for discontinuance of opioids, refill policies, lost prescription/ medication policies, safe storage of medications, intermittent drug testing and use of one pharmacy for obtaining medications. The guidelines offer an example of a patient agreement.
2. The patient must acknowledge that initiation of treatment with opioids is a therapeutic trial.
3. Treatment should begin with the lowest dose of opioids and titrate to effect.
4. Patients should be monitored closely for any evidence of abuse, misuse, or diversion.
5. Patients must acknowledge that unannounced urine drug testing is required at least twice yearly.[41]

Patients initiated on a trial of opioids for chronic pain should be initiated at the lowest effective dose and titrated slowly to analgesic effect.[44] Short-acting (SA) opioids are preferred and considered safer when initiating a therapeutic trial of opioids and are often prescribed for use as needed, every 4 to 6 hours.[44,45] If patients require long-term treatment and pain is severe enough to require around-the-clock, long-acting (LA) analgesia that is not adequately relieved by IR/SA opioids or other therapies, consider a transition to ER/LA opioids with scheduled dosing.[46] Methadone for pain presents special clinical challenges due to properties that include a long and variable half-life and pain relief that wanes even though the concentration in the body remains and depresses breathing.[24]

Only HCPs with experience and knowledge of methadone should prescribe it (only for severe pain unrelieved by other opioids) or else seek expert consultation.[38] Dual-mechanism opioids may control pain with less opioid, and opioid-sparing techniques, such as combining therapeutics should be considered.

Certain cautions are necessary for special populations. Women should be informed of the risks of long-term opioid therapy during pregnancy to the developing fetus, including *neonatal opioid withdrawal syndrome* (NOWS),[13,46] birth defects, preterm delivery, poor fetal growth, and stillbirth.[13] Adults older than 65 years need cautious opioid dosing and consideration of risks that include falls, cognitive effects, interaction with other medications, and increased sensitivity to analgesic effects.[44] Initial doses should be 25–50% lower than in those who are younger.[40] Caution is necessary when initiating and titrating opioid doses in people with renal and hepatic impairment.[47]

Naloxone co-prescription is recommended with patients at higher risk of opioid overdose. This includes those with a history of overdose, history of SUD, clinical depression, opioid dosages ≥50 MME/day, concurrent benzodiazepine use,[13] or with evidence of increased risk by other measures.

Clear rationale for prescribing or increasing dosages of opioids should be documented in the medical record, particularly if dosages exceed current recommended guidelines.[48] (Table 4)

The CDC guideline identified a dose limit of 90 morphine milligram equivalents (MMEs) daily after which caution is advised.[13] However, no dose is completely safe,[49] and much of the risk at higher doses appears to be associated with co-prescribed benzodiazepines.[50] Evidence is strong that prescribing opioids together with benzodiazepines increases risk for overdose,[33,51] and evidence also suggests that co-prescription of opioids and gabapentinoids may increase overdose risk.[33]

Considerations for the Prescriber: Ongoing Opioid Therapy

1. Opioid medication prescriptions should be obtained from a single provider/ practice and filled by a single pharmacy.

Table 4. Items to Perform and Document in the Patient Record When Prescribing Opioid Therapy for Chronic Pain[18,32,38,52,53]

1. Signed informed consent
2. Signed opioid treatment agreement(s)
3. Pain and medical history
Chief complaint
Treatments tried and patient response
Past laboratory, diagnostic, and imaging results
Comorbid conditions (e.g., medical, substance-use, psychiatric, mood, sleep)
Social history (e.g., employment, marital, family status, substance use)
Pregnancy status or intent, contraceptive use
4. Results of physical exam and new diagnostic and imaging tests
Review of systems
Pain intensity and level of functioning
One or more indications for opioid treatment
Objective disease/diagnostic markers
5. Results of opioid risk assessment prior to prescribing opioids
Clinical interview or any screening instruments
Personal history of SUD, mental health disorder
Family history of SUD, mental health disorder
Co-management or treatment referral for patients at risk for SUD
Treatment or referral for patients with active OUD
Treatment or referral for patients with undiagnosed depression, anxiety, other mental health disorders
6. Treatment goals for pain relief, function, quality of life
7. Treatments provided
With risk-benefit analysis after considering available nonpharmacologic and non-opioid pharmacologic options
All medications prescribed (including the date, type, dose, and quantity)
All prescription orders for opioids and other controlled substances whether written or telephoned
8. Prescription of naloxone, if provided, and rationale
9. Results of ongoing monitoring toward pain management and functional goals
10. Presence and treatment of adverse events
11. Results of initial and ongoing PDMP checks
Consider risk for dangerous drug-drug interactions
Consider risk for misuse with opioids
Collaborate on transition with primary prescriber if opioids previously prescribed
12. Results of initial and ongoing UDT
13. Counseling and instructions to the patient and significant others
Directions for medication use
Ongoing discussions of risks and benefits
Adherence to prescribed therapies, including results of UDT and PDMP checks
Actions taken regarding aberrant medication use (e.g., document results, collaborate with multidisciplinary team, institute taper)
14. Referrals given and notes on consultations for specialists in pain, SUD, mental-health, and medical comorbidities
15. Notes on continuing, revising, or discontinuing opioid therapy (e.g., titrate, rotate, taper, OUD management)
16. Authorization for release of information to other treatment practitioners

SUD = substance-use disorder OUD = opioid-use disorder; PDMP = prescription drug-monitoring programs; UDT = urine drug testing

2. Follow up visits should document analgesia effectiveness, reports of activities of daily living, medication side effects, compliance with the specified medication schedule, review of a Controlled Substance Monitoring Database and the patient's affect.
3. Any patients on large doses of opioid medications should be referred to a Pain Management specialist.
4. Patients should be observed for any findings suggesting aberrant medication-taking behaviors.
5. Opioid medications should be discontinued when risks of continued treatment outweigh the benefits. These risks could include aberrant medication taking behavior, lack of efficacy, or side effect severity. Medications may require a taper to prevent withdrawal symptoms.
6. Any patient exhibiting signs of substance use disorder should be referred to an Addiction Specialist. [41]

After treatment begins, adjust the dose and other components of therapy to the patient's individual needs, utilizing non-opioid treatment modalities whenever possible. Items to evaluate and document include analgesia, daily activities, adverse effects, aberrant drug-related behaviors, cognition, function, and quality of life.[41]

Throughout treatment, patients must be continually assessed for risks of overdose as respiratory depression leading to fatal or nonfatal overdose is a chief risk. Risk factors for overdose in people taking opioids medically or nonmedically include:[50,54-57]

- Middle age
- History of SUD
- Comorbid mental and medical disorders
- High opioid dose (>90 mg morphine equivalents, although risk is present at any dose)
- Recent upward titration of opioids (within the first 2 weeks)
- Recent opioid rotation
- Methadone use
- Benzodiazepine use
- Antidepressant use
- Unemployment
- Use of non-prescribed illicit substances
- Recent release from jail or prison
- Recent release from substance treatment program
- Sleep apnea
- Heart or pulmonary complications (e.g., respiratory infections, asthma)
- Pain intensity

A query of the Tennessee Controlled Substances Monitoring Database (CSMD) should also take place before opioids are initiated or continued.[13,33,44] These importance checks of the patient's past and present opioid prescriptions are done at initial assessment and during the monitoring phase. CSMD data can help to identify patients who have had multiple practitioner episodes or potentially overlapping prescriptions that place them at risk of a misuse or drug interaction problem. The use of the CSMD is also aimed at stopping the spread of opioid misuse and diversion as a public health problem.

If baseline UDT and CSMD checks indicate unauthorized prescriptions or there are other signs suggestive of opioid misuse, the results should be discussed with the patient and, if OUD or another substance-use issue is suspected, treatment should be offered and/or a specialist referral can be given.

Using the Tennessee Controlled Substances Monitoring Database

The CSMD contains prescription information from all dispensers of controlled substances in Tennessee and those dispensers who ship to a patient residing in Tennessee. This includes mail-order pharmacies and some Veteran's Affairs pharmacies as well. The CSMD collects and maintains dispensing data regarding all Schedule II, III and IV, and Schedule V controlled substances.

All data in the CSMD are reported as submitted to the data collection website by the dispenser. Therefore, if there are any questions about the data a practitioner should contact the dispenser identified within the report. The dispenser can, in turn, correct any errant information by coordinating with the state's data collection vendor. Neither the data collection vendor nor the Department of Health can edit prescription information found in the CSMD.

Registration

The state of Tennessee requires all prescribers and dispensers of CS to register for access with the CSMD. Registration may be completed through the website: www.TNCSMD.com. By choosing the "register" link, the healthcare provider may enter information to validate their status to access the CSMD data. Registrants will be assigned a username and password once approved by the CSMD administration.[41]

Additionally, two unlicensed physician extenders associated with the practice location may register with CSMD to retrieve information specifically on behalf of the registrants. Extenders may use the same website mentioned above to register for their account. The extenders are required to provide information about the registrant for whom they will access information, as well as their own self-identifying information. The supervisor will then be required to approve the extender once CSMD administrative staff have processed the request. And the supervisor does possess the ability to revoke the extender's access. All use of the CSMD information is tracked and can be monitored by CSMD administration if indicated.[41]

Patient Report

The information contained in the CSMD patient report includes prescriber, dispenser as well as controlled substance information. Prescriptions filled by the individual will be listed in reverse chronologic order. Additionally, information regarding estimated morphine equivalent doses will be generated. The individual accessing the CSMD must be cautioned to verify that they are choosing the correct patient, as many patients have similar names or date of birth. Choosing an incorrect patient could lead to incorporation of erroneous information into the patient report.[41.]

Prescriber Self-Lookup

Prescribers may also perform self-lookup reports. These reports may indicate potential cases of prescription fraud such as stolen prescription pads or phoned-in prescriptions not authorized by the prescriber. It also provides a "snapshot" regarding the prescribers typical CS prescribing habits, and their patient population.[41]

BEFORE MOVING ONTO THE NEXT SECTION, PLEASE COMPLETE CASE STUDY 1 ON THE NEXT PAGE.

Depressants and Sedative-Hypnotics: Benzodiazepines and Barbiturates

The class of depressants includes many widely misused medications. Furthermore, from 2004 to 2019, benzodiazepines and sleep medications zolpidem, zaleplon, and zopiclone were (together with opioids) the most dispensed categories of CS in the United States (Figure 2).[4]

Benzodiazepines (Schedule IV) are prescribed for short-term use as anxiolytics and for insomnia. Benzodiazepines include:[58]

- alprazolam
- chlordiazepoxide
- clonazepam
- clorazepate
- diazepam
- estazolam
- flurazepam
- lorazepam
- midazolam
- oxazepam
- temazepam
- triazolam
- quazepam

Benzodiazepines appear to affect neurotransmitters in the brain, in particular, enhancing gamma-aminobutyric acid GABA with the effect of reducing anxiety.[58] Onset and duration of action vary among benzodiazpines.[58]

Prescriptions for benzodiazepines have increased along with involvement in overdose deaths.[50] An FDA boxed warning details the risks of prescribing opioids and benzodiazepines together, a combination of medications that has increased in recent years but which is associated with extreme sleepiness, respiratory depression, coma, and death.[20,33] The CDC recommends against combining these 2 medications whenever possible but allows for rare instances when the combination may be indicated (e.g., severe acute pain in the presence of long-term, stable, low-dose benzodiazepine therapy).[13]

Case Study 1

Instructions: Spend 5-10 minutes reviewing the case below and considering the questions that follow.

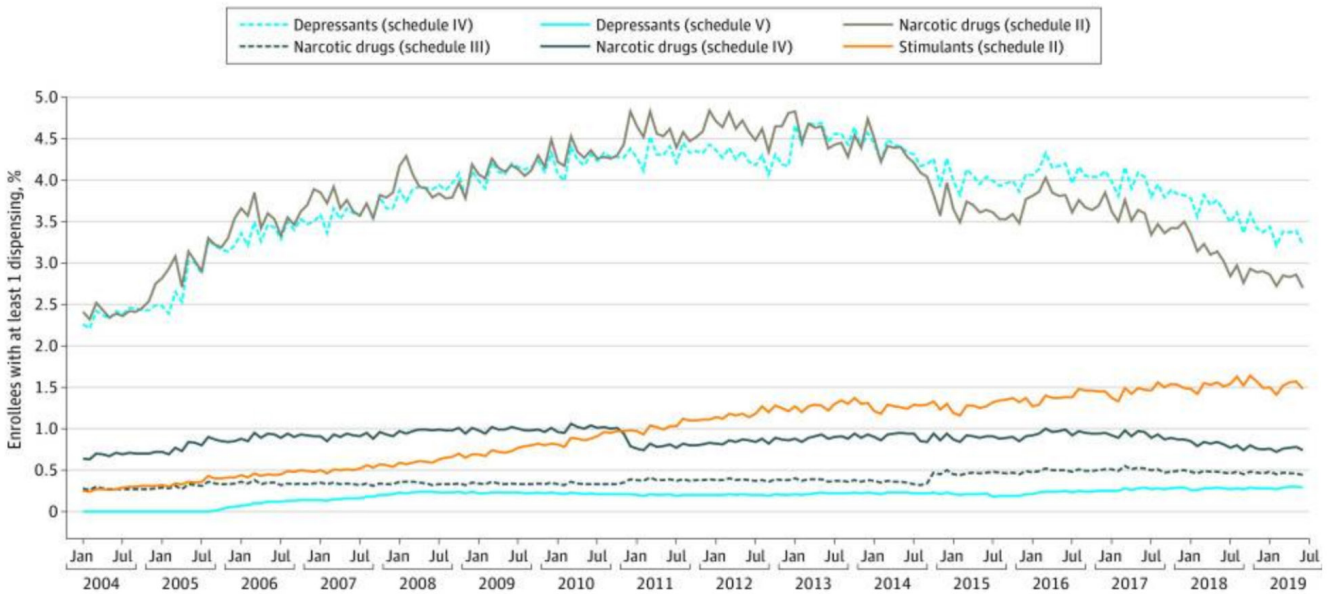
Mr. Connors, 54, has chronic neck pain for which he is prescribed short-acting 10 mg hydrocodone/ACET to take as-needed up to 4 per day. He does not take this medication daily but only on days when the pain spikes to 7/10 at rest, usually after exertion such as weeding his flower bed or taking a bike ride. He has always had consistent UDTs and PDMP checks, and the hydrocodone prescription helps him meet his goals of an active life. He drinks 2 beers several evenings a week and has no other history of or current substance use. He is treated for depression and has been stable on his escitalopram dose for years. His HCP and he have discussed the wisdom of limiting alcohol use with his current medications, and he has promised to try. While mowing his lawn one weekend, he strains his neck more than usual and is in significant pain that is constant, throbbing, and intense (9/10). He ices the area and takes 800 mg ibuprofen but finds the pain is still so intense he cannot sleep that night. His grown daughter offers him one of her alprazolam 1 mg, and he accepts so that he can sleep.

1. **Consider what would be the responsibility of the prescriber of CS in such a scenario. Consider the components of the treatment agreement previously assigned. How would one appropriately counsel and follow-up with the patient?**_____

_____

_____

Figure 2. Trends for Most Commonly Dispensed Categories of Controlled Substances in US Commercially-Insured Adults (January 2004 to June 2019)*



Six most commonly dispensed categories as of January 2019-June 2019 are presented:
Depressants (schedule IV) contained benzodiazepines and sleep medications zaleplon, zolpidem, and zopiclone
Depressants (Schedule V) contained brivaracetam, ezogabine, lacosamide, and pregabalin
Opioids (Schedule III) contained codeine ≤90 mg per dosage, morphine ≤50 mg/100 mL or 100 g, both in a combination with another non-opioid ingredient, and buprenorphine
Stimulants (Schedule II) contained amphetamine, methamphetamine, methylphenidate, lisdexamfetamine, and dextroamphetamine
*Based on de-identified longitudinal claims data on beneficiaries of a large US employer-sponsored commercial health insurance provider and covers approximately 9 million individuals ages 19 to 64 years in any given month across all 50 states.

The Department of Veterans Affairs/Department of Defense (VA/DoD) practice guideline lists concomitant use of benzodiazepines as a contraindication to initiating a trial of long-term opioid therapy.[33]

Benzodiazepines should be stopped gradually and perhaps with the help of a specialist. Abrupt cessation with not only benzodiazepines but also baclofen, carisoprodol, or barbiturates, can cause significant morbidity and even death.[59] Acute withdrawal symptoms with sedative-hypnotics can include anxiety, tremors, tachycardia, fever, hypertension, insomnia, seizure, and delirium.[59-61]

Scheduled sleep medications include zaleplon, zolpidem, and zopiclone (Schedule IV), known as "Z-drugs," and brivaracetam, ezogabine, and lacosamide (Schedule V). Like benzodiazepines, Z-drugs enhance the effect of GABA, the major inhibitory neurotransmitter. Evidence shows they have reinforcing effects and carry risks for abuse potential, tolerance, physical dependence, and subjective effects.[62] While Z-drug addiction is uncommon, the risk increases at higher doses and in patients with an SUD history.[62] Z-drugs can cause withdrawal symptoms if abruptly discontinued after prolonged use.

Side effects include nightmares, agitation, hallucinations, dizziness, daytime drowsiness, headache and gastrointestinal (GI) problems.

Barbiturates include amobarbital, pentobarbital, phenobarbital, secobarbital, and tuinal. Some are very short-acting drugs with effects lasting only a few minutes while others may have effects that last up to 2 days.[63] Barbiturates have a history of medical uses as sedative-hypnotics for insomnia and anxiety but also have a history of recreational misuse and a narrow therapeutic index.[64] Current medical indications largely center on preoperative sedation and antiseizure, and misuse has dropped in recent decades as barbiturates have been largely replaced in practice by benzodiazepines.[64]

With misuse at low doses, people feel drowsy, disinhibited, and intoxicated; at higher doses, they begin to stagger and develop slurred speech and confusion, possibly resulting in coma and respiratory depression leading to death.[63] Withdrawal symptoms include difficulty sleeping, agitation, tremor, hallucinations, high temperature, and seizures.

Hallucinogens: Limited Medical Uses

Hallucinogens are synthetically made or plant-based and are marked by sensory and psychic effects that include perceptual distortions.[65] Physiological effects of the class can include elevated heart rate, increased blood pressure, dilated pupils, nausea, and vomiting. Medical research into the use of Schedule I hallucinogens has been increasing. Most are drugs that are used recreationally (e.g., hallucinogenic mushrooms, LSD, and MDMA or "ecstasy").

Few have medical indications with a notable exception being ketamine, a Schedule III drug with accepted medical uses for short-term sedation and anesthesia.[66] Ketamine is a dissociative anesthetic, distorting sight and sound and giving the patient a sense of detachment from pain and the environment. For this reason, it has been researched as a treatment for some types of intractable pain. In addition, the FDA has approved a nasal spray version of the S(+) enantiomer of ketamine (esketamine) for treatment-resistant depression that is only available at a certified doctor's office or clinic.[66] Ketamine misuse may lead to moderate or low physical dependence or high psychological dependence. Overdose can occur with ketamine and when serious can lead to respiratory depression, coma, convulsions, seizures, and death due to respiratory arrest.[66]

Stimulants

Schedule II stimulants include amphetamine, methamphetamine, methylphenidate, lisdexamfetamine, and dextroamphetamine.[4] Prescriptions have increased significantly,[4] and involvement in overdose deaths is increasing. During 2015–2016, age-adjusted psychostimulant-involved overdose death rates increased by 33.3% as part of what has been called a "growing polysubstance landscape."[67] From 2016 to 2017, death rates involving cocaine and psychostimulants increased across age groups, racial/ethnic groups, county urbanization levels, and multiple states.[67] Among all 2017 drug overdose deaths, 10,333 (14.7%) involved psychostimulants that include prescription drugs, such as dextroamphetamine and methylphenidate.[67]

Opioids frequently contribute to stimulant-involved overdose deaths.[67] However, stimulant deaths are also increasing without opioid involvement. Death rates involving cocaine and psychostimulants, with and without opioids, have increased, and synthetic opioids frequently are involved.[67] Responses should evolve to improve access to care, focus on protective and risk factors for substance use, and improve risk reduction messaging.[67] Harm reduction might also include expanded surveillance measures and naloxone availability.

Effects of stimulants as a class include increased alertness, wakefulness, and concentration.[68] Common medical indications include ADHD, obesity, and narcolepsy. Stimulants are associated with adverse effects such as tolerance, risks with withdrawal, and potential for misuse and SUD.[68] With abrupt cessation, withdrawal can be marked by depression, anxiety, and extreme fatigue.[68]

Signs of a stimulant overdose include high fever and convulsions, and cardiovascular collapse may precede death.[68] Physical exertion can increase these hazards.

Carisoprodol

Carisoprodol is the only muscle relaxant that is a scheduled drug (Schedule IV).[69] It metabolizes meprobamate with hypnotic, anti-anxiety, sedative, anticonvulsant, and some indirect muscle relaxant properties that can cause drowsiness and dizziness. This medication is not recommended for long-term use or by those with a history of addiction. Because of its limited clinical effectiveness and elevated risks, general use of this medication is best avoided.

Recognizing Substance-Use Disorder

The American Society of Addiction Medicine (ASAM) refined its definition of addiction in 2019. Its brief description may help HCPs view the condition as the "treatable, chronic medical disease" that it is, one which involves "complex interactions among brain circuits, genetics, the environment, and life experiences."[176] The ASAM further described how behaviors become compulsive and often continue despite harmful consequences and suggested that prevention and treatment generally succeed on a par seen with other chronic diseases.[70]

Clinically, an SUD is diagnosed using DSM-5 criteria; OUD is specified if opioids are the drugs used (Table 5).[71,72] A minimum of 2-3 criteria are required for a mild OUD diagnosis, while 4-5 is moderate, and >6 is severe. Addiction, while not a DSM-5 diagnosis, is a frequently used term and typically describes severe SUD. The presence of tolerance and physical dependence does not contribute to the diagnosis of OUD if opioids are prescribed, and the patient takes the medication as prescribed.

Table 5. Criteria for Opioid-Use Disorder from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
• Opioids are often taken in larger amounts or over a longer period of time than was intended
• There is a persistent desire or unsuccessful efforts to cut down or control opioid use
• A great deal of time is spent in activities to obtain the opioid, use the opioid, or recover from its effects
• Craving, or a strong desire or urge to use opioids
• Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home
• Continued opioid use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of opioids
• Important social, occupational, or recreational activities are given up or reduced because of opioid use
• Recurrent opioid use in situations in which it is physically hazardous
• Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that's likely to have been caused or exacerbated by the substance
• Tolerance,* as defined by either of the following: a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect b. A markedly diminished effect with continued use of the same amount of an opioid
• Withdrawal,* as manifested by either of the following: a. The characteristic opioid withdrawal syndrome b. The same—or a closely related—substance is taken to relieve or avoid withdrawal symptoms
*This criterion is not met for individuals taking opioids solely under appropriate medical supervision. Severity: mild = 2–3 symptoms; moderate = 4–5 symptoms; severe = 6 or more symptoms.

Risks for development of SUD should be assessed prior to initiating treatment, particularly when treating pain with opioids. Factors that contribute to risk are many and include the following:[5,73-75]

- Younger age (<30 years)
- Personal history of substance misuse
- Adverse social and life circumstances
- Comorbid mental conditions
- Social exposure to others with SUD
- Exposure to parental SUD
- History of trauma or childhood adversity
- Obtaining CS from more than one HCP without authorization
- Obtaining multiple CS from multiple sources
- Use of illicit street drugs during therapeutic treatment with CS
- Sleep disturbances
- Mood disorders
- Stress

When evaluating a patient and during periodic clinical follow-up, it is important to watch for signs and symptoms of dangerous non-adherence with treatment directives. One such important characteristic is obtaining CS prescriptions from more than one prescriber, sometimes at multiple facilities (aka "doctor shopping") although the patient has agreed to use only one prescriber and one pharmacy to fill all CS prescriptions.[76,77] Other indicators of continuing non-adherence to medical direction include taking too much medication, taking medication by the wrong route of administration, use of illicit substances, and use of unauthorized prescription drugs obtained from nonmedical sources. In addition, pay attention if the patient exhibits ongoing problems with interacting and fulfilling roles related to family, work, and personal life. Trips to the emergency department (ED) are concerning, particularly if CS are requested there and this type of medical care utilization becomes a pattern that repeats. Data show a correlation of patients frequently obtaining opioids in EDs with "pill shopping" in that 5% to 10% are already taking opioids from other providers.[17]

Benzodiazepine SUD may present with particular physical signs that include:[78]

- Speech problems
- Incoordination
- Dizziness
- Disorientation
- Poor memory
- Inability to concentrate
- Sedation
- Decreased blood pressure
- Decreased respirations
- Coma

As with other SUD, behavioral difficulties may include relationship conflicts, poor school or work performance, financial and/or legal issues, multiple prescribers, early medication refills, and use of the medication (in this case, benzodiazepine) together with other CNS-depressant drugs.[78]

Any misuse can threaten the integrity of CS therapy if not addressed. Not all misuse is intentional; for example, taking an incorrect dose. Similarly, not every instance of failure to comply with medical direction indicates an SUD has developed in the patient who has lent medications to a family member or taken an extra pill. However, repeated failure to adhere to the treatment agreement along with increasingly dangerous patterns of usage call for action on the part of the HCP. These actions might include a switch to less risky treatments or medications to manage symptoms of the medical condition for which the CS was prescribed. Referral to specialists in pain, SUD treatment, or mental health may be indicated. In some cases, the patient may need to be referred entirely for specialist management and, in other cases, co-management of the patient with a specialist or specialists may be possible and advisable. If, after a risk-benefit analysis, it appears CS should be tapered, it is important to do so carefully and safely.

Tapering Controlled Substances

Tapering to reduce a long-term opioid dosage or to discontinue opioid therapy can be done for the following reasons:[79]

- Patient has requested to discontinue or taper doses
- Pain improves
- A new treatment is expected to improve pain
- Pain and function are not meaningfully improved with opioids
- Patient is receiving higher opioid doses without evidence of benefit
- Patient has current evidence of opioid misuse
- Patient experiences side effects that diminish quality of life or impair function
- Patient experiences overdose or other serious event (e.g., hospitalization, injury) or has warning signs (e.g., confusion, sedation, slurred speech) for an impending event
- Risk for adverse outcomes is increased through co-administration of medications (e.g., benzodiazepines) or medical conditions (e.g., lung disease, sleep apnea, liver disease, kidney disease, fall risk, advanced age)
- Long-term opioid administration has been prolonged (e.g., years) and current benefit-harm balance is unclear

HCPs should ensure patient understanding of tapering plan while maintaining that the plan remains patient centered. In considering whether opioids or other CS continue to meet treatment goals, evaluate risks versus benefits and avoid insisting on tapering or discontinuation when opioid use may be warranted (e.g., treatment of cancer pain, pain at the end of life, or other circumstances in which benefits outweigh risks of opioid therapy).

HCPs should avoid dismissing patients from care. Instead, refer patients for medication treatment for OUD (MOUD) as described below and ensure that patients continue to receive coordinated care.[79]

Patients who are discontinued or tapered non-collaboratively are at risk for acute withdrawal, pain exacerbation, anxiety, depression, suicidal ideation, self-harm, ruptured trust, opioid overdose, and seeking opioids from high-risk sources.[5,79,80] Taper without the patient's consent is a challenging situation and the risks versus benefits of treatment should be clearly defined. If the prescriber decides that the risks of the treatment outweigh the benefits, the prescriber may need to recommend taper. One should continue to treat pain and withdrawal with pharmacologic and nonpharmacologic options. If the patient has serious mental illness, a high suicide risk, or suicidal ideation, offer or arrange for consultation with a behavioral health provider before initiating a taper.[79] Treating common comorbid mental disorders (e.g., depression, anxiety, and PTSD) can improve the likelihood of opioid tapering success and reduce dropouts.[79]

Access appropriate expertise if considering opioid tapering or managing OUD during pregnancy.[79] Opioid withdrawal risks include spontaneous abortion and premature labor. For pregnant women with OUD, MOUD is preferred over detoxification.

HCPs should advise patients that there is an increased risk for overdose on abrupt return to a previously prescribed higher dose.[79] One should strongly caution them that it takes as little as a week to lose tolerance. Patients should be provided with opioid overdose education and possibly offered naloxone.

Taper should be slow enough to minimize opioid withdrawal, and longer duration of therapy entails slower taper (common tapers involve dose reductions of 5% to 20% every 4 weeks). Signs of withdrawal with opioids occur when stopping or decreasing doses or administering an opioid antagonist. Acute opioid withdrawal symptoms include drug craving, anxiety, restlessness, insomnia, abdominal pain or cramps, nausea, vomiting, diarrhea, anorexia, sweating, dilated pupils, tremor, tachycardia, piloerection, hypertension, dizziness, hot flashes, shivering, muscle or joint aches, runny nose, sneezing, tearing, yawning, and dysphoria.[79] Pain often worsens with withdrawal and, although the pain may be prolonged, it does tend to diminish over time for many patients.[79]

If patients on high opioid dosages are unable to taper despite worsening pain and/or function, whether OUD criteria are met, HCPs may consider transitioning to buprenorphine. Buprenorphine is a partial opioid agonist that can treat pain as well as OUD, result in less opioid- induced hyperalgesia (i.e., heightened pain response), and easier withdrawal than full mu-agonist opioids, and less respiratory depression than other LA opioids.[79]

Treatments for withdrawal symptoms include alpha-2 agonists clonidine and lofexidine.[79] Other medications may be NSAIDs, ACET, or topical menthol/methyl salicylate for muscle aches; trazodone for sleep disturbance; prochlorperazine, promethazine, or ondansetron for nausea; dicyclomine for abdominal cramping; and loperamide or bismuth subsalicylate for diarrhea.[79]

Some patients are taking opioids and benzodiazepines concurrently, and one or both medications are to be tapered. Although tapering may be accomplished more rapidly in a controlled setting like a detox unit, benzodiazepines must be tapered gradually in the outpatient setting due to risks of withdrawal that include anxiety, hallucinations, seizures, delirium tremens, and, in rare cases, death.[79] Long-acting benzodiazepines should be slowly discontinued over several months.[61] If needed, gabapentinoids, carbamazepine, or valproic acid may help facilitate self-managed reduction or normalize sleep, reflexes, and anxiety.[60,81-84]

Treating Opioid-Use Disorder

At least 2.35 million people in the United States have OUD involving prescription opioids, illicit opioids such as fentanyl and heroin, or a combination of these.[16] Yet over 70 percent of people who needed treatment for OUD in 2017 did not receive it.[16] The recommended evidence-based treatment for OUD is MOUD, which is treatment with medication combined with behavioral counseling and such services as case management and peer support. FDA-approved medications for OUD are methadone, buprenorphine, and extended-release naltrexone. MOUD relieve the withdrawal symptoms and psychological cravings and are safe to use for months, years, or even a lifetime.

Patients who are suffering with OUD (or another SUD involving a CS) need encouragement to seek treatment and reassurance that they are not trading "one addiction for another," which is a common misperception. Research shows that people treated with opioid agonist medications are less likely to die from overdose or otherwise prematurely, are more likely to remain in treatment, have improved social functioning, and are less likely to inject drugs and transmit infectious diseases.[16] In pregnant women with OUD, the risk of opioid exposure from opioids used to treat OUD should be discussed and balanced against the risk of untreated OUD, which might lead to illicit opioid use associated with outcomes such as low birth weight, preterm birth, or fetal death.[85]

Provision of MOUD in a clinic setting is regulated by the federal government. Oversight of MOUD remains a multilateral system involving states, the Substance Abuse and Mental Health Services Administration (SAMHSA), HHS, the Department of Justice, and the DEA. SAMHSA's Division of Pharmacologic Therapies, part of SAMHSA's Center for Substance Abuse Treatment, manages the day-to-day oversight activities.

HCPs need a separate DEA registration to treat OUD with methadone (a Schedule II drug).[22] Use of buprenorphine/naloxone (a Schedule III drug) to treat OUD no longer requires specific training, but a waiver from the DEA is required to prescribe, administer, or dispense it.[22]

Practitioners are encouraged to receive training prior to use of buprenorphine, and new short trainings are freely available (see the following link): https://elearning.asam.org/products/buprenorphine-mini-course-building-on-federal-prescribing-guidance#tab-product_tab_overview. Recent practice guidelines released by the Substance Abuse and Mental Health Services Administration within HHS are available here: https://www.samhsa.gov/newsroom/press-announcements/202104270930.

Become a Buprenorphine Waivered Practitioner:
https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner

Federal Register Practice Guidelines for Buprenorphine for OUD:
https://www.federalregister.gov/documents/2021/04/28/2021-08961/practice-guidelines-for-the-administration-of-buprenorphine-for-treating-opioid-use-disorder

If an HCP is unable to treat the patient in need of addiction treatment, existing facilities can be found through the following websites:

- Opioid Treatment Program Directory: https://dpt2.samhsa.gov/treatment/directory.aspx
- SAMHSA's Behavioral Health Treatment Services Locator: https://findtreatment.samhsa.gov/
- SAMHSA's Buprenorphine Treatment Physician Locator: https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator
- SAMHSA's National Helpline – 1-800-662-HELP (4357): https://www.samhsa.gov/find-help/national-helpline
- Substance Use Treatment Locator (FindTreatment.gov): https://findtreatment.gov/

A number of measures have been aimed at increasing access to buprenorphine. Federal regulations and legislation related to OUD treatment include the following:[86]

- The Code of Federal Regulations provides for certification in using CS to treat OUD in opioid treatment program (OTPs) overseen by SAMHSA; MOUD patients receiving care in OTPs are also required to receive counseling.
- The Drug Addiction Treatment Act of 2000 (DATA 2000) permits physicians who meet certain qualifications to treat OUD with FDA-approved medications, including buprenorphine, in treatment settings other than OTPs.
- The Comprehensive Addiction and Recovery Act of 2016 (CARA), signed into law in 2016, endorses the use of MOUD for OUD and amends the CSA to, under certain conditions and restrictions, raise the total number of patients to which the prescriber can dispense buprenorphine from 30 to 100 per year.
- The SUPPORT for Patients and Communities Act of 2018 extends the privilege of prescribing buprenorphine in office-based settings to qualifying nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse-midwifes until October 1, 2023. HCPs may treat up to 100 patients in the first year of the waiver if the physician is board certified in addiction medicine or addiction psychiatry or the clinic is a "qualified practice setting."

A qualified practice setting under the SUPPORT ACT meets the following conditions:[86]

- Provides professional coverage for patient medical emergencies during hours the practice is closed
- Provides access to case-management services (e.g., medical, behavioral, social, housing, employment, educational, other)
- Uses health information technology systems such as electronic health records
- Is registered for the state PDMP
- Accepts third-party payment for health services

After one year at the 100-patient limit, qualifying practitioners who meet the above criteria can apply to increase their patient limit to 275. Certain qualifying practitioners may treat OUD with MOUD without a buprenorphine waiver under special circumstances that include medical emergencies and are detailed as follows: https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines/special-circumstances.

Guidance for state medical boards and HCPs in office-based OUD treatment is available. The FSMB Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office may be downloaded from the following link: http://legalsideofpain.com/uploads/FSMB-2013_model_policy_treatment_opioid_addiction.pdf.

Diversion

Diversion of CS a significant public health problem that contributes to harm in the form of increased fatal and nonfatal overdoses, criminal activity, ED visits, and SUD development. The economic burden of opioid misuse reaches $78.5 billion a year in healthcare, lost productivity, addiction treatment, and criminal justice costs.[87] Diversion occurs any time a prescribed, controlled medication is deflected from its intended medical source to an unintended purpose and can occur at any point along the supply chain. Common types of diversion are shown in Table 6.[25] Diversion and misuse create a loop that leads to more overdoses deaths and widespread development of SUDs.[17]

Table 6. Common Types of Drug Diversion	
Method	**Definition**
Selling Prescription Drugs	Patients and non-patients sell prescription drugs that were obtained illegally
"Doctor Shopping"	Soliciting multiple prescribers under false pretenses to obtain CS prescriptions
Illegal Internet Pharmacies	Rogue websites under the guise of legitimate pharmacies provide CS to people without prescriptions, evading state licensing requirements, operating across state and international borders
Theft	May occur at any step of the supply chain (examples: manufacturers, patients, patient's relatives or friends, HCPs, pharmacists)
Prescription Pad Theft and Forgery	Printing or stealing prescription pads to write fraudulent prescriptions, altering existing prescriptions to obtain unauthorized quantity
Illicit Prescribing	Providing unnecessary prescriptions or larger quantities than medically necessary (i.e., "pill mills")
CS = Controlled substances HCPs = Health care providers	

Most misused opioids are obtained through diversion. Year after year, the National Survey on Drug Use and Health, conducted annually by SAMHSA, reports that most people who misuse prescription opioids either bought them, were given them, or took them without asking from family members or friends.[88] About a third of people who misuse opioids get them by prescription from one doctor.[88]

Leftover pills from acute pain prescriptions are a chief source of diverted and misused opioids. One systematic review found that 42% to 71% of opioids obtained by surgical patients went unused.[89] Leftover CS in medicine cabinets can then become a significant source for diversion. Patients should be counseled never to share opioids or other CS with any other person and to store opioids in a locked area away from other family members and visitors.[44]

Certain medications are highly sought for diversion as identified by the DEA and NIDA and shown in Table 7.[25] Some prescription drugs sell on the street for as much as $50 a pill and, unfortunately, some patients sell the drugs prescribed to them as a way of earning money to pay expenses or to finance their desire to buy street drugs.[17] To be clear, most patients who take opioids for pain do not misuse or divert their pills.[88] However, HCPs should understand that some people who visit a medical facility for pain are actually seeking opioids to divert or misuse and take relevant precautions to prevent diversion as required by the DEA. Some patients may have the disease of OUD and should be managed accordingly.

Distinguishing would-be diverters from patients is difficult at best. Although no behavior reliably indicates drug diversion, the chances of detecting such deception increase when HCPs watch for patterns of behavior. The DEA has listed some common behaviors that should not be considered an exhaustive list but that might indicate a person seen in-clinic is seeking drugs to divert or misuse:[24]

- Demanding to be seen immediately
- Stating that they are visiting the area and need a prescription to tide them over until seeing a local HCP
- Appearing to feign symptoms, such as abdominal or back pain or pain from kidney stones or a migraine to obtain opioids
- Claiming non-opioid analgesics do not work
- Requesting a particular opioid
- Complaining that a prescription has been lost or stolen and needs replacing
- Requesting more refills than originally prescribed
- Using pressure tactics or threatening behavior to obtain a prescription
- Showing visible signs of drug abuse, such as track marks

Clinical practices to minimize the potential diversion when seeing patients include:[25]

- Caution when prescribing to patients who request combinations of drugs that may enhance effects, such as opioids with benzodiazepines
- Thorough documentation when prescribing or choosing not to prescribe opioids
- Keeping a DEA registrant or license number confidential unless disclosure is required
- Protecting access to prescription pads
- Ensuring that prescriptions are written clearly to minimize the potential for forgery

Table 7. Drugs with Highest Potential for Diversion and Misuse	
Drug Class	**Examples**
Anabolic Steroids	Methyltestosterone Testosterone
Depressants	Barbiturates: pentobarbital Benzodiazepines: alprazolam, diazepam
Hallucinogens	Ketamine
Opioids	Diphenoxylate Fentanyl Hydrocodone Hydromorphone Meperidine Methadone Morphine Oxycodone Oxymorphone
Stimulants	Amphetamine Dextroamphetamine Methamphetamine Methylphenidate
Centers for Medicare and Medicaid Services. Partners in Integrity: What is a Prescriber's Role in Preventing the Diversion of Prescription Drugs? https://www.pharmacy.umn.edu/sites/pharmacy.umn.edu/files/prescriber_role_in_preventing_diversion.pdf Accessed Sep 17, 2021.	

- Moving to electronic prescribing so that paper prescriptions are not required
- Adhering to strict refill policies and educating office staff
- Using PDMPs in accordance with state regulation and expert guidance
- Referring patients with extensive pain management or prescription needs to specialists in relevant fields
- Collaborating with pharmacists and other providers to verify prescription authenticity and medical necessity
- Collaborating with pharmacy benefit managers and managed care plans that seek to determine medical necessity of prescriptions

Prescription drugs are also diverted by HCPs in various health care settings.[90] Medical professionals engage in diversion for myriad reasons that include recreation, an active SUD, financial gain, self-medication for pain or sleep, or to manage withdrawal symptoms.[25] Mismanagement of patients by HCPs can also happen because the HCPs were duped into believing claims of pain were legitimate, because their practice ideas are dated, or because they are themselves dishonest and are aware their patients are diverting. Financial gain can motivate fraud on the part of a prescriber. For example, in August 2010, a New York physician was charged with leading a drug ring that allegedly provided oxycodone prescriptions to patients with no medical need, arranged to resell the drug to third parties, and distributed more than 11,000 pills resulting in a $1 million expense to the Medicaid program.[25]

Certain signs should alert supervisors to the possibility that diversion may be occurring, for example:[91]

- Removing CS without a doctor's order
- Removing CS for patients "not assigned" to them
- Removing CS for patients that have been discharged
- Removing CS and not documenting them
- Pulling excessive quantities of as-needed medication compared to other health care workers assigned to the patient
- Exhibiting discrepancies in inventory on a regular basis
- Pulling out CS in lower dosages to obtain more pills when the exact dosage is available
- Removing as-needed medications too frequently, for example pulling every 2 hours when the order is for every 4 hours
- Pulling out larger dosages of injectable medications to obtain more waste
- Experiencing continuing patient complaints of pain, despite documented administration of pain medications
- Falsifying records and failing to document waste

Staff members who are engaging in diversion within a facility such as a hospital may often volunteer to witness or administer CS, have major life changes or injuries, frequently disappear from the floor, or have periods of high and low productivity not consistent with colleagues.

Staff members other than HCPs may also divert medications. Support staff employees who may be diverting CS may be spotted in areas where they are not unauthorized, may unnecessarily touch syringes, may stay late when their services are unnecessary, and may always volunteer to help dispose of waste.[91] If either HCPs or support staff are impaired, they may appear sleepy, exhibit personality changes, commit multiple errors or be unable to perform routine tasks, take excessive sick leave or extended breaks, and be the target of multiple patient complaints.[91]

To effectively combat diversion, cooperation is necessary across multiple teams and facility divisions. The Mayo Clinic has laid out the following set of recommended steps when diversion in the workplace is suspected or identified:[90]

- Secure whatever evidence is available
- Initiate drug testing
- Initiate a discussion with the employee's supervisor
- Review of any records documenting handling of CS
- Institute additional surveillance if necessary
- Initiate recurring meetings of a drug diversion response team to review findings
- Quickly remove from patient care any employee found to have diverted CS
- Quickly close the case of any employee determined not to have diverted CS
- Report findings to the DEA, the state pharmacy board, and local law enforcement

More possibilities include urine drug screening and agreement to comply with diversion prevention policies prior to hiring in addition to ongoing random or "for cause" testing. Newly hired facility workers should receive education to prevent diversion, and that education should be ongoing. Mandatory reporting procedures and methods of surveillance, including checks of prescribing records and video surveillance, should be in place. It is important to check relevant laws in the state of practice as some states require that diversion of CS be reported to federal authorities and result in loss of license to practice medicine.

After taking some time to absorb the signs of diversion within a healthcare facility, read over the case example that follows and consider what steps should be taken.

BEFORE MOVING ONTO THE NEXT SECTION, PLEASE COMPLETE CASE STUDY 2 ON THE NEXT PAGE.

Conclusions

This activity summarizes the regulatory framework and clinical recommendations necessary to prescribe CS safely. Knowledge of best practices must be accompanied by clinical implementation to ensure appropriate treatment of patients commonly treated with CS for a variety of medical indications. Key precautions in prescribing CS include selecting appropriate candidates based on their medical condition and degree of risk, following evidence-based protocols for treatment, and recognizing problematic or dangerous use patterns that call for intervention. This includes recognizing the value of evidence-based medications for OUD.

It is imperative that HCPs keep current with changing federal, state, and local requirements, to prescribe the lowest effective doses of CS used with a variety of medical conditions, to monitor patients for any ill effects, and to help safeguard society from the dangers brought by the misuse and diversion of these powerful drugs.

Case Study 2

Instructions: Spend 5-10 minutes reviewing the case below and considering the questions that follow.

Georgia is an intensive care unit nurse with twenty years' experience in caring for critically injured patients. She is training Moshe, a new nurse fresh from graduate school. One day, as he is returning from lunch, he sees Georgia leaving the room of one of his patients. This pattern repeats over the course of the next month. On one of these occasions, he questions Georgia as to the patient's condition. Georgia replies that the patient was in pain and needed a bolus dose of fentanyl.

The next day, when Moshe sees Georgia leaving his patient's room, he inspects the fentanyl drip and sees that it has more volume than when he left on break earlier. He further learns that patients on fentanyl drips on this floor have been showing signs of inadequate analgesia. Subsequent investigation shows that the fentanyl drips have been diluted.

1. **What is Moshe's responsibility in this scenario?**_____

2. **How might the management of the facility respond?**_____

3. **What steps might be taken to safeguard the integrity of patient treatment?**_____

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TENNESSEE GUIDELINES FOR MANAGING CHRONIC PAIN

Self-Assessment

Choose the best possible answer for each question and mark your answers on the self-assessment answer sheet at the end of this book. There is a required score of 70% or better to receive a certificate of completion.

1. **Schedule I Drugs:**
   A. Include benzodiazepines.
   B. Include opiates such as fentanyl.
   C. Are considered to have the highest risk for misuse.
   D. May be prescribed for 5 refills within a 6-month time period.

2. **Tolerance refers to:**
   A. The same dose of drug given repeatedly produces reduced biological response.
   B. Onset of withdrawal symptoms when medication is abruptly discontinued.
   C. Individuals prescribed controlled substances who allow other family members to take the controlled substance medications for medical purposes.
   D. Taking medication to feel euphoria.

3. **A prescriber's DEA license may be suspended or revoked for all the following EXCEPT:**
   A. Revocation or suspension of a state medical license.
   B. Felony conviction related to Controlled Substances.
   C. False statements entered in the Controlled Substance application.
   D. Theft of controlled substances from the prescriber's secured storage.

4. **Inappropriate prescribing behavior of controlled substances may include:**
   A. No logical relationship between the prescribed drug and medical condition.
   B. Lack of physical examination documentation in patient chart.
   C. Instructing patients to fill their medications at different pharmacies.
   D. All of the above.

5. **Prior to instituting opioid use for chronic, non-malignant pain, prescribers must consider:**
   A. Telemedicine appointments as an appropriate visit.
   B. Birth control for any woman of childbearing age.
   C. Elimination of pain as the primary goal of treatment.
   D. Which patients require urine drug testing.

6. **Examples of functional goals for treatment of chronic, non-malignant pain with opioids may include:**
   A. Improved activities of daily living.
   B. Increased social participation.
   C. Return to work.
   D. All the above.

7. **Risk factors for opioid overdose include all the following EXCEPT:**
   A. Recent release from jail or prison.
   B. Benzodiazepine use.
   C. Recent release from substance treatment program.
   D. Age >65 years old.

8. **Regarding the Tennessee Controlled Substances Monitoring Database (CSMD):**
   A. Two approved physician extenders may utilize the database to obtain relevant information to the practice site.
   B. Only prescribers of controlled substances are required to register with the CSMD.
   C. Data is collected only for Schedule I, II and III medications.
   D. Patient report data is limited only to medication name, dose and date prescription filled.

9. **Benzodiazepines:**
   A. Are included in Schedule II controlled substances.
   B. Should be avoided in combination with opioid medications.
   C. May be abruptly discontinued with no harm to patients.
   D. Include all the medications known as "Z-drugs".

10. **An example of a controlled substance that is FDA approved for treatment of Opioid Use Disorder (OUD) is:**
    A. Diphenhydramine.
    B. Codeine.
    C. Methadone.
    D. Clonidine.

IMPROVING ACCESS TO CARE FOR LGBTQ PATIENTS

COURSE DATES:	MAXIMUM CREDITS:	FORMAT:
Release Date: 3/2022 Exp. Date: 2/2025	*2 AMA PRA Category 1 Credits*™	Enduring Material (Self Study)

TARGET AUDIENCE

This course is designed for all physicians (MD/DO), physician assistants, and nurse practitioners.

HOW TO RECEIVE CREDIT:

- Read the course materials.
- Complete the self-assessment questions at the end. A score of 70% is required.
- Return your customer information/ answer sheet, evaluation, and payment to InforMed by mail, phone, fax or complete online at program website.

COURSE OBJECTIVE

The purpose of this course is to help improve care and health outcomes of the LGBTQ population by recognizing the existing disparities and increased health risks present in this population. This course will examine system and provider/client barriers to equality in healthcare.

LEARNING OBJECTIVES

Completion of this course will better enable the course participant to:

1. Discuss concepts regarding healthcare disparities of the LGBTQ population.
2. Identify strategies to improve healthcare access of the LGBTQ population.
3. Describe health risks within the LGBTQ community resulting from healthcare disparities.
4. Identify strategies to improve health outcomes in the LGBTQ community.

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COURSE SATISFIES

2

AMA PRA Category 1 Credits™

SPECIAL DESIGNATION

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DISCLAIMER

Introduction

People who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ) come from all walks of life, including people of all races and ethnicities, all ages, all socioeconomic statuses, and from all geographic regions. The Centers for Disease Control and Prevention (CDC) and many professional organizations assert that the perspectives and needs of LGBTQ people should be routinely considered in all medically related interactions to improve overall health and eliminate health disparities.[1]

To have productive and health-promoting interactions with LGBTQ patients, clinicians need to recognize the differences among sexual orientation, gender identity, and gender role, understand the health disparities faced by people who identify as LGBTQ, be able to identify specific health risks, and ensure they create a welcoming environment for all people. The purpose of this course is to discuss the disparities in healthcare and increased health risks that exist in the LGBTQ population; identify system, provider, and client barriers; and examine ways to provide better care. In addition, this CME learning activity is designed to improve the care and health of LGBTQ patients by educating providers on the perspectives and needs of LGBTQ patients as well as ways to improve practices, office settings, policies, and staff training to make them welcoming and supportive for everyone. The author would like to emphasize there is no single definition of the LGBTQ community. Instead, just as any other group or community, the LGBTQ community is made up of a group of individuals from a variety of racial/ethnic backgrounds, cultures, incomes, religions, and many other characteristics, resulting in unique diverse groups of individuals.[2] Stigma is a commonly shared experience among the groups.

A Note About Acronyms

This learning activity uses LGBTQ as the acronym for discussing the entire range of sexual orientation, gender, and sexual behavior, with the acknowledgement that there are some variations not captured explicitly by the terms "Lesbian," "Gay," "Bisexual," "Transexual," and "Queer." ("Queer" and "genderqueer" are non-pejorative terms describing people whose sexual orientation is not exclusively heterosexual or homosexual.) LGBTQ is the acronym currently used by the Human Rights Campaign, the Gay and Lesbian Medical Association, and many (but not all) other organizations focused on sexual minority/gender non-conforming individuals. Still, language and usage are constantly changing. In the future, variations that attempt to be more inclusive such as LGBTQ+ or LGBTQ* may become more standard.

To date, the available research has mainly focused on lesbian, gay, and bisexual individuals with limited information on transgendered individuals. Findings vary among different sources, primarily because of differing methodologies for data collection.[1] Sexual orientation is a multidimensional construct that consists of sexual identity, sexual and romantic attraction, and sexual behavior. Sexual orientation describes a person's identity in relation to the gender(s) that they are attracted to and how they act on that attraction. This orientation includes heterosexuality (attraction to the opposite sex), homosexuality (attraction to the same sex), bisexuality (attraction to both male and female sexes), pansexuality (attraction to all sexes), and asexuality (no attraction to any sex).[3]

Similar to sexual orientation, significant changes have occurred over time in the scientific understanding of gender. Gender is a ubiquitous and multi-faceted social category. When discussing the concept of gender, scientists distinguish between biological sex, gender identity, and gender expression. Though one's biological sex, gender identity, and gender expression are distinct constructs, society expects that they will align. For most individuals this is true – that is, most individuals who are assigned female at birth identify as girls or women and adopt a feminine gender expression, while most individuals who are assigned male at birth identify as boys or men and adopt a masculine gender expression.[4] However, for some individuals, these constructs do not align. The term transgender refers to individuals whose gender identity is not consistent with their sex assigned at birth. The terms gender nonconforming or gender incongruence refer to individuals whose gender expression does not conform to the stereotypical norms in their culture for any assigned sex at birth.[3,5] Infants' biological sex is labeled at birth, almost always based solely on external genital appearance; this label given at birth is referred to as one's assigned sex at birth.

Sex assigned at birth helps to determine health risk factors and the need for screening, particularly if there are remaining natal organs (i.e., breasts, ovaries, testes).[6] Gender identity refers to a person's deeply felt, inherent sense of being. A person can identify as a girl, a woman, or female; a boy, a man, or male; a blend of male or female; or an alternative gender. Gender expression refers to the ways a person communicates their gender within a given culture, such as clothing choices and communication patterns. A person's gender expression, the ways in which a person demonstrates their gender, including naming conventions, social presentation, and pronouns, and often aligns with gender identity.[5]

In the past, diverse sexual orientation has been considered pathologic or a medical condition in need of treatment. The first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) listed homosexuality as a sociopathic disorder. Homosexuality was not removed as a diagnostic category until 1973 when the American Psychiatric Association (APA) decided that homosexuality did not fit the criteria of mental disorder. However, until 1987, the APA continued to include a diagnostic category for individuals who were unhappy with their sexual orientation, which supported the development of conversion therapies.[7]

Since that time, many organizations, including the American Medical Association, the American Academy of Pediatrics, and the American Counseling Association, have issued statements condemning conversion therapy and supporting gender-affirming care.

Furthermore, scientists and clinicians now understand that identifying with a gender that does not align with sex assigned at birth, as well as a gender expression that varies from that which is stereotypical for one's gender or sex assigned at birth, is not inherently pathological.[4] However, people may experience distress associated with discordance between their gender identity and their body or sex assigned at birth (i.e., gender dysphoria) as well as distress associated with negative social attitudes and discrimination. This shift in the understanding of gender identities and expressions was reflected in the replacement of the category "Gender Identity Disorder" with "Gender Dysphoria" in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders*.[8] The diagnosis of Gender Dysphoria, which is marked in children and adolescents by clinically significant distress associated with the discordance between biological sex and gender identity that disrupts school or social functioning, depathologizes diverse gender identities and expressions. This newer definition focuses instead on the potential psychosocial challenges associated with gender diversity.

Sexual orientation questions are included in 11 federal surveys and, of these, seven also have an inquiry regarding gender identity.[9] Gender identity questions were added to the National Health Interview Survey (NHIS), a principal source of US population health, beginning in 2013,[3] and in the National Survey on Drug Use Abuse and Health (NSDUH) in 2015. It is important for healthcare providers to understand the differences between gender identity, sexual orientation, and sex assigned at birth and how these factors are important.

The 2020 census was the first census that included a question specifically about same-sex relationships. Optional answers included opposite OR same-sex husband/wife/spouse and opposite OR same-sex unmarried partner.[10] Use of census data assists in determining federal funding to states. In 2015, $175 million in funding for Housing Opportunities for Persons with AIDs, $312 billion for Medicaid, and $71 billion in money for food stamps was received through census data.[11] LGBTQ people are among those most likely to rely on these programs, and under-representation may affect financial assistance.[11] Unfortunately, a single question is unable to reflect this diverse population.

Epidemiology

The most accurate and current information about LGBTQ demographics is based on independent polling and survey organizations. The most recent large-scale survey was a 2021 Gallup report based on interviews with a random sample of approximately 15,000 U.S. adults, which showed that the proportion of American adults identifying as LGBTQ increased to 5.6% from 4.5% in 2017. Millennials (born 1981-1996) and Generation Z (born 1997-2002) are more likely to identify as bisexual compared to lesbian, gay, transgender, or other.[12]

As the general population ages, the number of older LGBTQ adults will increase as well. By 2030, there will be an estimated 2 million to 6 million LGBTQ adults ≥65 of age in the United States (vs. an estimated 1 million to 2.8 million in 2000), approximately 120,000 of whom are projected to be living in nursing homes.[13] These individuals will have distinct healthcare needs and face well-documented health-related disparities including disability, poor mental health, smoking, and increased alcohol consumption. In addition, older lesbians have a higher risk of developing metabolic syndromes and cardiovascular disease (CVD). Older transgender adults are at significantly higher risk of poor physical health, disability, depression, and perceived stress compared with cis-gender patients.[13,14]

Risk Identification

To identify risk, healthcare providers need to see, talk to, and examine patients. This point sounds obvious, but there are many barriers that may prevent this examination and communication from occurring. One of the most common barriers in caring for LGBTQ people is the lack of provider training and experience in caring for sexual minority persons.[15,16] This lack of training may cause a fear of missing or doing something wrong or result in inadvertently doing or saying something offensive.

Provider implicit bias can also prevent risk identification in the LGBTQ population. Bias can stem from religious or cultural backgrounds, fear of the unknown or unfamiliar,[16,17] and preconceived ideas from media representation. If the healthcare community in general or individual caregivers have a preconceived concept of gender as male or female, sexual orientation as based on gender at birth, or sexual activity as between heterosexual individuals, and do not venture from this idea, information will be missed that may affect the health of an individual. Provider discomfort with inquiry into sexual orientation, gender identity, and sexual activity may inhibit an open discussion on sexual risk factors. There also may be a lack of awareness of the risks of LGBTQ patients or a desire to remain impartial and avoid cultural discussions.[18] In both cases, providers may potentially miss important information.

In examining disparities in healthcare, it is crucial to consider patient factors such as access to care. Is the population (or person) able to receive care? There are a variety of factors that can affect the ability to access care, including the following: insurance coverage or the financial means to pay for care; ability to access the care, which can relate to location, transportation, finances, and/or desire; and locating a qualified provider one feels comfortable with, which may vary according to culture, gender, race, and sexual identity to name a few. Additional difficulties can arise in small tight-knit communities and rural areas where decreased access to care, lower incomes, and lack of public transportation may already exist.[19] Transgender people in particular report difficulty finding gender-affirming healthcare.[20,21]

While these examples are mainly interpersonal/relational, there are also system/institutional barriers. Smith and Turell[22] identified several themes in their study, including substandard care, lack of determinants for quality care, heteronormativity in forms, extra documentation for partner participation in care, geographic barriers to LGBTQ-friendly care, and inadequate insurance. Under the Winsor & Obergefell ruling, federal and state employees with same-sex married spouses are guaranteed the same benefits as heterosexual married couples.[2] However, 45% of the LGBTQ population lives in states that do not have LGBTQ-inclusive insurance protection.[23]

Healthy People Goals

A goal of Healthy People 2020 was to increase the health, safety, and well-being of LGBTQ people.[24] Progress has focused on population-based data systems to increase their collection on Healthy People objectives, or recommendations for LGBTQ or states and territories to increase their data collection in the Behavioral Risk Factor Surveillance System.[25] Additional important goals are to increase the quantity and uniformity of data collected on transgender individuals. The inclusion of sexual orientation and gender identity questions on health history forms is an excellent beginning to open discussions in the healthcare setting.

LGBTQ objectives for Healthy People 2030 fall under the major goal of improving the health, well-being, and safety of LGBTQ people.[26] The objectives are then classified under the following categories: adolescents, drug and alcohol use, mental health, infrastructure, and sexually transmitted infections. Within these categories, there are a variety of objectives including reducing bullying, illicit drug use, and increasing the number of entities collecting data on LGBTQ health.[25] The focus of the adolescent objectives is to reduce bullying, both in-person and cyberbullying. The 2019 Youth Risk Surveillance Survey found that 32% of adolescents who identify as a member of a sexual minority group report they were bullied at school and 26.6% report being cyberbullied. Almost twice as many students who are lesbian, gay, or bisexual compared to their heterosexual peers reported missing school because of concerns for their personal safety.[27]

Accessing or Avoiding Healthcare

Quality of care is important for all patients and providers and is paramount to achieving positive outcomes. Part of the healthcare experience results from the patient-provider relationship along with the general experience of the patient in the healthcare setting, whether clinic, hospital, or community. A qualitative study by Smith and Turell[22] examined the differences in expressed needs of different groups (lesbian, trans woman, gay, and HIV+ gay men) seeking healthcare in the LGBTQ community. Participants had a wide range of feelings on topics and several areas of agreement.

Terms to Avoid

These terms may have been used in the past but are now considered outdated and may be offensive. In addition, while patients may use these terms, when in doubt, the provider should ask the patient which terms they prefer.

Unacceptable	Acceptable
Berdache (to describe gender non-conforming indigenous people)	Two-spirit
Gender reassignment surgery	Gender assignment surgery
Homosexual	Gay or lesbian
Intersex/hermaphrodite	Disorders of sex development
Sex change	Gender affirmation surgery
Sexual preference	Sexual orientation
Transgendered/a transgender	Transgender

First, there were differences regarding identity disclosure to providers, with the HIV+ group noting the importance of informing the clinician on their positive status. Levels of comfort on disclosure varied from no concern "for the straight people's discomfort"[22(p643)] to great concern about how one's healthcare would be affected by disclosure and how the information would be stored and shared.[22] Participants also shared that they experienced lapses in confidentiality such as using incorrect pronouns, physician sharing HIV+ status with family at bedside rounds after surgery, and other situations that eroded patient trust.

Although this study has several limitations, including small sample size (n=26) and exclusion of persons of color/trans men, similar findings were identified in other studies.[2,28,29] Participants also perceived discomfort and heteronormative expectations of healthcare professionals. These examples ranged from unfamiliarity with terms of address, lack of knowledge of LGBTQ health needs, too much focus on sexual health, and implicit bias such as assuming that a woman needed birth control because she is sexually active, that a lesbian's partner is her "husband," or that gays or lesbians do not have children. Participants also identified overt discrimination, homophobia, and transphobias and discussed being made to feel like a "freak" by staff and providers through refusal of care, excessive use of personal protective equipment inappropriate for the situation, and putting the LGBTQ person on display.[22,28] Overall, findings revealed general heteronormativity in healthcare, lack of knowledge of LGBTQ healthcare needs, and microaggressions or phobias of clinicians and staff. These experiences led to patients feeling stressed and stigmatized.[22]

Nondiscrimination in Access to Healthcare

The Affordable Care Act (ACA) implemented in 2010 and the expansion of Medicaid in 2014 increased the rate of LGBTQ adults who have insurance. In states that have adopted the expansion, 8% are uninsured and 25% have Medicaid compared to states that did not adopt the expansion where rates are 20% uninsured and 13% have Medicaid.[21,30] The ACA set nondiscrimination protections for LGBTQ people, which included prohibition of discrimination or refusal of care based on sexual orientation and gender identification in any ACA health plan as well as any health program receiving federal funds (including Medicare and Medicaid).[21] These protections and the removal of limits on chronic or pre-existing conditions mean an increase in access to care. However, there are still problems for transgender individuals, especially people of color, desiring transition-related care. A Center for American Progress study[21] found that 43% of transgender individuals and 48% of transgender people of color were denied transition surgery, with 38% of transgender individuals and 52% of transgender people of color being denied hormone therapy for transition.[21]

A note about conversion therapy

Conversion therapy—the effort to change an individual's sexual orientation, gender identity, or gender expression—is not supported by credible evidence and has been disavowed by behavioral health experts and associations. Conversion therapy perpetuates outdated views of gender roles and identities as well as the negative stereotype that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm.[31]

Importance of History

Health disparities and unidentified risks exist for many reasons, including poverty, inadequate access to healthcare, environmental threats, and individual factors. One important potentially unrecognized weakness is obtaining the appropriate health history in a nonjudgmental manner. Each provider should act as a concerned practitioner, looking out for the well-being of each patient. Providers should ask open-ended questions, encourage patients to share important information about potentially risky behaviors, and listen in a nonjudgmental manner.

While a provider may be aware that certain patients are lesbian or gay, or that certain heterosexual patients have high-risk sexual practices, social discomfort regarding the topics may lead to avoidance. It is important for a provider to talk openly and objectively with these patients about potential risk factors. In addition, health history forms may contain presumptive language about sexual partners. Staff members may exhibit a bias based on a patient's appearance or way of speaking. A patient's perception of bias may lead to a reluctance to discuss symptoms or may even cause them to avoid seeking additional care. This could lead to missed opportunities for screening, consideration, diagnosis and treatment of potential disease processes.

Evidence-Based Practice

A 2017 national survey showed that LGBTQ patients experienced discrimination in healthcare settings because of their sexual orientation, and this discrimination keeps them from seeking care or may lead to trouble finding care if turned away.[32] This study demonstrates the discrimination that still exists against the LGBTQ population and the need to educate healthcare providers to mitigate such disparity.

No Judgment

The National LGBTQIA+ Health Education Center has published suggestions for improving healthcare environments for LGBTQ patients.[33] One suggestion includes posting a nondiscrimination policy, signed by the staff, in plain view of patients. A nondiscrimination policy helps ensure commitment to an environment in which all people are valued and respected and provides an opportunity for staff members to examine their own beliefs and assumptions about race, age, sex, gender, and marital relationships. Another suggestion is to provide an area to display local LGBTQ resource information.

Using an intake form that allows a patient to provide personal information in a nonjudgmental manner will set the tone for quality patient-provider interactions. The inclusion of domestic partnership under the "relationship status" of a history form as well as options for transgender individuals, such as male-female or female-male, may help patients feel more comfortable sharing this information. Additional suggestions include providing more inclusive options for screening questions, using open-ended questions, and using the term "partner" rather than "spouse."

It is dangerous to assume how others may behave. When a provider believes a particular person, group, or community has a characteristic or action, they risk overlooking potential conditions. Asking the patient about their definition of behavior, sexual activities, language, or terminology helps prevent misperceptions that endanger health. An example may be a person who does not consider themselves in terms of sexual orientation, that is, they do not identify as heterosexual, homosexual, bisexual or asexual, and may have sexual partners of both genders; Providers should avoid assuming that a lesbian, or her female partner, has never had intercourse with a male or has never been pregnant. Focus on questions about anatomy and behavior to gain information about potential health risks and opportunities for health promotion.

Obtaining a sexual history—questions to consider and use[6]:

- Are you sexually active?
- With whom do you have sex?
- What parts of your body do you use when having sex?
- What do you do to practice safe sex?

To obtain pertinent health-related information, it is important to ensure confidentiality and gather a complete sexual history during a nonjudgmental discussion. This sexual history form should be used with all patients in the healthcare practice. If staff members are obtaining this information, practitioners should display a privacy statement in the office and/or provide such a policy to patients. Ensuring privacy is important and should be guaranteed for everyone.

Many forms used today assume heterosexual and monogamous behavior. Changing the form to include gender rather than sex, and providing the options "male," "female," "transgender," or "both" to questions about recent sexual partners, recognizes that alternative relational patterns exist. This use of an inclusive form provides patients with the opportunity to provide accurate information.

Creating a welcoming environment

LGBTQ patients often assess a clinical practice for clues to help determine what information they feel comfortable sharing with a healthcare provider.

The following are among the measures that can promote a more welcoming environment and encourage patients who are LGBTQ to access care:

- Post a rainbow flag, pink triangle, unisex bathroom signs, or other LGBTQ-friendly symbols or stickers.
- Exhibit posters showing racially and ethnically diverse same-sex couples, transgender people, or posters from nonprofit LGBTQ or HIV organizations.
- Display brochures (multilingual when appropriate) about LGBTQ health concerns.
- Distribute or visibly post a nondiscrimination statement stating that equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, or gender identity/ expression.
- Display magazines or newsletters about and for LGBTQ and HIV-positive individuals.
- When possible, diversify staff. Hire openly lesbian, gay, bisexual, and/or transgender staff, who can provide valuable knowledge and perspectives about serving LGBTQ patients, as well as help patients feel comfortable. Ensure non-discrimination statements are included in job postings.
- Review and consider rooming and visitation policies to ensure they are inclusive.
- Physicians communicate an impression of their practice and can set a positive tone with patient
- intake forms. These inclusive forms can help patients feel more comfortable and open about their sexual orientation or gender identity/expression.
- Ensure that clinic staff is aware of the process for responding and reporting discrimination.
- The following ideas may improve the inclusivity of forms and help clinicians with in-person discussions:
- Intake forms and electronic medical records/ patient portals should include questions about sexual orientation, gender identity, and sex assigned at birth.
    - Use neutral terms on forms such as "relationship status" instead of "marital status."
    - Avoid referring to questions as "female only" or "male only" and instead leave a box for "not applicable."
- Ensuring that gender options include "transgender" and "nonbinary" allows for people to choose the option that most applies to them and offers an initial sign of acceptance. It may also be helpful to include a body map for patients to identify anatomic elements of their bodies. There should also be a space about how they would like to be referred to including asking about preferred pronouns.
- Train front desk staff to avoid assumptions about identity and teach techniques to clarify ambiguity in a patient-centered way. Front desk staff should not make assumptions about patients' gender or sexual identity or the gender of their spouses/ partners, and they should use gender-neutral terms whenever possible. When it is unclear or a staff member is unsure, she or he should ask the patient how they would like to be addressed. By anticipating the event where there may be a discordance between names/ genders on official identifications or insurance forms and what a patient is currently using, staff members can more effectively address the situation. Another strategy might be adding a name/identity reconciliation box or form. This strategy is particularly relevant for transgender patients in the process of transitioning from one gender identity to another.
- Clinicians can encourage openness by explaining that patient-provider discussions are confidential and that they, the clinicians, need complete and accurate information to provide optimum and appropriate medical care.
- Developing and distributing a written confidentiality statement will encourage people who identify as LGBTQ and other patients to disclose information pertinent to their health. The statement should be prominently displayed and distributed to each patient.

Consider careful communication: Clinicians should always ask patients how they identify and wish to be addressed. Patients may use words that are considered derogatory like "dyke" to describe themselves. Although individuals might have reclaimed the terms for themselves, they are not appropriate for use by healthcare providers. The key is to follow the patient's lead about self-description while exploring how this self-description relates to their current and potential medical needs. For example, avoid using the term "gay" with a patient even if they have indicated a same-sex or same gender sexual partner because if the patient has not indicated a particular identity or has indicated a sexual orientation other than gay, using this term may cause alienation and mistrust that can interfere with the patient-provider relationship. Therefore, clinicians need to elicit and understand all three aspects of sexual orientation: attraction, self-described identity and behavior, as well as gender identity.

Respect transgender patients by making sure all office staff are trained to use their preferred pronouns and names. Clearly indicate this information in their medical record for easy reference for future visits. Traditional personal pronouns are based on a binary she/he framework. An inclusive approach to addressing both gender nonconforming and transgender patients is to use non-binary personal pronouns. An optimal approach is to first provide your own personal pronouns and then ask patients how they would like to be called. For transgender patients, their answers may include pronouns such as "they," "ze" (pronounced "zee"), or "xe (also pronounced "zee"). Some clinicians may be challenged using a pronoun that they learned in English classes as a plural now as a singular noun. However, this accommodation may improve rapport with patients.

Tips for clinical encounters:

- Don't make assumptions about a patient's body or behavior based on their initial visual presentation.
- Get in the habit of assessing preferred pronouns at every visit. The most common format used is to introduce yourself and state your preference, as in "I'm Dr. Jones, and I use the pronouns she/her; how about you?"
- Understand that discussing genitals or sex may be very sensitive, stressful, or possibly traumatic for certain patients. Therefore, always ask permission before any physical contact and clearly explain all processes, tests, or examinations before they are done. For more information, visit the National LGBTQIA+ Health Education Center at www.lgbtqiahealtheducation.org .

> Clinical consideration: Used the wrong pronoun or name? Overheard your staff? A simple apology and dedication to do better may make the difference in your patient staying with your practice or not. "I'm sorry I used the incorrect pronoun. I did not intend to be disrespectful."

BEFORE MOVING ONTO THE NEXT SECTION, PLEASE COMPLETE CASE STUDY 1 ON THE NEXT PAGE.

Health Risks for LGBTQ Patients

LGBTQ patients have the same risk factors as any patient, but they also have risk factors and healthcare disparities that require special consideration. Healthy People 2020 targeted health disparities for elimination among LGBTQ people.[34] Research showed that negative health outcomes of LGBTQ individuals are often related to stigma, discrimination, and denial of human rights.[34] Eliminating disparities and improving LGBTQ health are important in contributing to increased longevity, decreased expenditure for healthcare, reduced disease transmission, and increased physical and mental wellness.[34]

Case Study 1 - Part 1

Instructions: Please read through the case study below and consider the questions that follow, then do the same for Part 2.

Sam had been searching for a primary care provider for months. He wanted to find someone who would treat him like a person, not a freak. In the previous primary care clinic where he received care, he overheard a front desk person commenting it was a shame that such a pretty girl was going to be a male. Fortunately, that was a different place, and he was now away at graduate school in a liberal arts college with a Campus Pride Index of 4.5. Someone in the resource center recommended this office, and he had a few things he hoped to find once he arrived. Sam called to inquire and received a package of information electronically that already gave him some comfort. Instead of the questions Sam had normally seen, these forms had options for gender that included transgender and relationship questions that did not assume married or single but allowed for partnered.

1. **From the information in the case study, how does Sam identify?**

2. **What type of barrier to care did Sam experience in his previous primary care practice?**

Discussion for Question 1: Gender identity is a personal feeling or idea that one has of themselves. One may choose to express their gender identity through the way they dress, behave, and mannerisms they use. They may also select pronouns they feel express who they are. The most identified genders are male, female, intersex, non-binary, trans, and non-conforming. Gender identity may or may not conform to assigned sex at birth. At birth Sam was identified as female according to anatomy and now identifies as male and is referring to himself as "he." Gender transition occurs when a person begins to live their gender identity. This transition is different for each individual and may include changing clothing, appearance, name, pronoun, identification, and for some, may include hormone therapy and/or surgery.

Discussion for Question 2: Multiple barriers can affect a person's access to healthcare. Relational or interpersonal interactions and system or institutional functions can present barriers impeding or serving as a discouragement for individuals needing or desiring healthcare. Sam purposefully left a previous healthcare provider because of insensitivity and bias from an employee who commented on his male identification. This is an example of a personal or relational barrier that created a stressful situation for Sam and resulted from the bias of another person. The experience of stigma is common among LGBTQ people and is a cause for stress and avoidance of healthcare. Insensitivity and/or discomfort of providers and office staff and occasionally refusal of care are also in this personal/relational category. System or institutional barriers are issues like transportation, distance, access to appropriate care, insurance restrictions, and assumed heteronormativity.

Case Study 1 - Part 2

Sam entered the office and scanned the waiting room/reception area. There were several areas for literature around the room, with one section dedicated to sexual minorities. The receptionist greeted Sam, and he handed her his previously filled out forms. The receptionist asked for a preferred first name and pronoun. Sam felt relieved that he could tell the office his preferred pronouns were he/him/his because the legal-name-change paperwork was not finalized. He grabbed a brochure and had a seat to wait for his appointment. In about 10 minutes, he heard someone call his name and he stood to walk in the back. After having his height and weight measured, he was led to an exam room. The nurse introduced herself, and Sam noticed a framed print on the wall titled "We Promise." The nurse saw him looking at it and explained the people who worked here felt very strongly that each person deserved respect and privacy for who they were and what they believed, and that everyone signed it. She asked a few questions and then handed him a form, saying they have all adult patients complete it and that the nurse practitioner would go over it with him. He turned it over and saw it was a sexual history form.

3. **What are some methods the office used to provide a welcoming environment for LGBTQ people?**

Discussion for Question 3: This office provided a section in the waiting room for literature relating to local resources and information for LGBTQ individuals. The intake form included preferred gender and pronoun, which was reinforced by the receptionist. Instead of asking only for marital status, it included additional options. In the exam room there was a nondiscrimination policy statement signed by employees, which showed their support for all individuals. Finally, the use of a sexual history form to be reviewed with a provider serves as a starting point for a discussion related to sexual practices and assists with risk identification. There are additional methods including displaying sexual minority couples, displaying a rainbow flag or sticker, providing a gender-neutral toilet facility, and listing your office on the Gay and Lesbian Medical Association (GLMA) directory.

Equality in healthcare has not yet been achieved, but what has been accomplished is an increase in sexual orientation and gender identification data collection.[35] This information will assist in identifying disparity, increasing recognition of the need to obtain unbiased social and sexual histories, and increasing provider education related to sexual minorities and social determinants of health to increase the potential for culturally competent care.[34]

Social Stressors and Mental Health

Social stressors contribute to increased rates of mental health issues, suicide, substance abuse, obesity, and victimization in this population. Chronic stress resulting from stigma, discrimination, and prejudice in the social environment has been referred to as minority stress and is a topic of interest in sexual minority individuals.[35] One frequently used framework for understanding the factors involved in the health disparities experienced by members of the LGBTQ community is the minority stress model.[37] Meyer[37] identifies the processes of minority stress, as related to LGBTQ populations, as having distal to proximal factors. These factors include experiencing external objective stressors, expecting such events to take place and the vigilance this expectation entails, and internalizing negative attitudes. Individual response to stressors varies as do stress-relieving factors. Many minority groups respond with group solidarity, which serves to support the morale and protect individuals from adverse stressors.[37] When a person does not have access to group-level resources, it can lead to increased stress and alienation.

Mental health issues are prevalent among LGBTQ people of all ages. Much of the risk for mental health conditions is thought to result from discrimination, bullying, violence, and loss of support. LGB identified youth were more than eight times more likely to have attempted suicide if their family rejected them than LGB peers with low or no level of family rejection.[38] LGB individuals have a two-to-six-time higher lifetime risk of suicide and/or depression.[39] A 2015 US study on transgender individuals found that 81.7% contemplated suicide and 40.4% had attempted suicide at some point.[39] In addition to risk factors common to the non-transgender public, elevated risks of suicidal thoughts and attempts were more likely among transgender people who report heavy substance use, have poor general health, have a disability, or have experienced recent homelessness or an arrest.[39]

In addition to stress and mental health issues, people who identify as LGBTQ are at risk for misuse of tobacco, alcohol, and other substances. In 2016, the Centers for Disease Control and Prevention (CDC) reported that 20.5% of LGB adults smoked compared to 15.3% of heterosexual adults.[40] This report means that about one LGB adult in five is a person who smokes. While limited information exists on transgender tobacco use, it is reported to be higher than among the general population.[40] Although actual substance abuse rates are unknown, the Substance Abuse and Mental Health Services Administration (SAMHSA) reports rates of 20% to 30% vs. 9% for the general population.[41] In 2019, 7.6 million LGB adults > 18 had a mental health or substance use disorder. That figure is a 20.5% increase from 2018.[42]

Although, historically, intimate partner violence has not been widely recognized or reported among the LGBTQ population, studies show that it is experienced as frequently or more frequently by LBGTQ individuals compared to those who identify as cis-gender.[43] Clinicians should include gender-neutral screening tools, such as the Partner Violence Screen, and be prepared with appropriate resources for positive screening results.[6] Violence against transgender people, especially transgender women of color, continues to occur in the United States. People who identify as transgender are 2.2 times more likely to experience physical IPV and 2.5 times more likely to experience sexual IPV compared to those who identify as cisgender.[44] Social stigmatization and other factors may lead to an under-reporting of acts of violence committed against transgender people.[44]

Findings from several studies illustrate the seriousness of criminal and interpersonal violence in transgender communities.

- The Human Rights Campaign began tracking fatal violence against transgender people in 2013. In 2020, 44 transgender or gender non-conforming people were killed. In November of 2021, 47 fatalities had already been recorded.[45]
- In 2016, the National Coalition of Anti-Violence Programs received information on 1,036
- incidents of hate violence from 12 antiviolence organizations across the United States. The information showed 21% self-identified as transgender women and 5% as transgender men.[46] Despite the known risk, 13 states do not have hate crime laws that cover sexual orientation or gender identity, and four states and three US territories do not have hate crime laws at all. In addition, only 12 states require hate crime training for law enforcement that includes crimes based on sexual orientation or gender identity.[47] Moreover, 20 states and five territories do not require hate crime data collection,[47]suggesting that the true crime numbers are higher.

Medical Risk Factors

Although cardiovascular deaths have declined since 2010 in the US, there remain significant differences in cardiovascular death rates based on race, sex, and income.[48,49] Caceres and colleagues[50] found that sexual minority persons experienced a higher prevalence of elevated cardiovascular (CVD) risk because of largely modifiable conditions than their heterosexual peers. For women, these risks included tobacco, alcohol, and illicit drug use, mental health issues, and elevated body mass index. For men, the risks were tobacco use, illicit drug use, and poor mental health.[50]

Repeat exposure to interpersonal stress (discrimination, family rejection, expectation of stigma), general stress (financial, life adversity, childhood trauma), and the potential for additional physical stress from hormone or antiretroviral treatments, combined with risks of tobacco, illicit drugs, excess alcohol, and elevated BMI, are believed to increase CVD risk. These findings were based on subjective data rather than physical markers and show the need for further research. According to Caceres and colleagues,[49] cardiovascular health research in sexual minorities has not been prioritized because of other health concerns such as HIV/AIDS and substance use.

In 2018, there were 37,968 new diagnoses of HIV in the US and its territories, with 69% being among gay and bisexual men.[51] A 2019 systematic review found 14% of transgender women have HIV, with 44% of these individuals identifying as African American, 26% as Hispanic/Latino, and 7% as White transgender women.[52] Sixty-four percent of new cases of HIV are among men who have sex with men (MSM), ages 13 to 34, with higher representation in African American and Hispanic/Latino groups. Use of pre-exposure prophylaxis is lower among these two racial/ethnic groups than among White MSM.[51] Sexually transmitted infections (STIs) are also more prevalent among MSM, with more than 8 in 10 new cases of gonorrhea and primary and secondary syphilis, 10% of new hepatitis A, and 20% of new hepatitis B cases are found in this group.[2]

Lesbian and bisexual women are less likely to obtain routine care, are more likely to be overweight or obese, and less likely to receive screening mammography.[6,53,54] Lack of insurance or lack of knowledge about cervical cancer risk may contribute to the fact that only 74.6% of lesbian women obtain cervical screening compared to 83.3% of heterosexual and 77.9% of bisexual women.[54] As a group, lesbian and bisexual women have breast cancer risks from a higher BMI, higher frequency of nulliparity, socioeconomic disparity, delay in care, and potential lack of provider relationship, which should spur a conversation about screening mammogram before age 50.[56] When considering screening for cancer, clinicians should remember the maxim "screen what you have" in addition to considering surgical history and use of hormones to ensure thorough screening.[6]

Caring for LBGTQ Youth

In the 1960s, Kohlberg hypothesized that gender-related development begins in infancy and continues progressively throughout childhood following three key concepts: gender constancy, gender consistency, and gender identity. On average, children develop gender constancy – stability across time in the identification of their gender – between ages 3 to 4 and gender consistency – recognition that gender remains the same across situations – between ages 4 to 7.[57,58]

The development of gender identity appears to be the result of a complex interplay between biological, environmental, and psychological factors.[5,59]

The period during which gender identity is clarified and solidified is unclear. There is no single trajectory of gender identity development for gender minority children. Some gender non-conforming children experience significant distress, currently termed gender dysphoria. Signs of gender dysphoria may emerge as early as the preschool years. One study found that nearly all transgender men and women experienced gender dysphoria by age 7. Furthermore, most participants continued to experience gender dysphoria without treatment until their adult years.[60] However, gender incongruence in early childhood is variable whereas adolescents experience a more constant identity.[61]

Health concerns of LGBTQ youth

Given the caveat that this group is understudied, especially through prospective longitudinal studies, it appears that gender diverse children who come to clinical attention, on average, have poorer relationships with parents and peers, experience high rates of mistreatment from peers, and are at increased risk of physical and sexual abuse in childhood, as compared to their gender conforming peers.[31,62,63] Compared with the general population, LGBTQ youth are at a higher risk for a wide variety of health concerns: substance use, STIs, cancers, CVD, obesity, bullying, isolation, rejection, anxiety, depression, and suicide.[1] It is difficult to tease out cause and effect in these associations. They also often receive lower quality of care because of stigma, lack of awareness among healthcare providers, and insensitivity to their unique needs. Twenty-nine percent of LGBTQ youth reported they had attempted suicide at least once in the previous year vs. 6% of heterosexual youth. In 2014, young gay and bisexual men accounted for 8 out of 10 HIV diagnoses among youth.[1]

Changing Mindsets

Healthcare providers must be caring and open in a non-biased way to provide an equal level of care for all patients. Sensing negativity may cause patients to withhold important information about sexual identity or avoid returning for follow-up care. It is important that personal belief systems are mutually exclusive of the healthcare relationships with all patients, including LGBTQ patients, to avoid influencing the interaction and quality of the healthcare provided. Although research and public advocacy groups cluster LGBTQ patients into categories, variances exist among each group, as do potential ethnic and familial risk factors. These factors compound the serious nature of LGBTQ health risks.

Healthcare professionals traditionally receive minimal education about the LGBTQ population's needs. The National LGBTQIA+ Health Education Center[33] has published resources and maintains a website with webinars and learning modules. Knowledge of basic terms and definitions will assist in establishing a mutual understanding and increasing communication with LGBTQ people.[64-66] Previous studies have demonstrated that healthcare providers felt their medical education was inadequate in regards to issues specific to patients who identify as LGBTQ.[67,68] Calls have gone out to reform undergraduate and graduate medical education to better prepare clinicians to address the health of this population and decrease the documented health disparities.[69,70] In addition, new curricula are available for medical residency and training programs to provide formal education about appropriate care for LGBTQ patients.[71]

Clinician Consideration

Clinicians should ensure that they keep up to date with the concerns and needs of the LGBTQ population through continuing education opportunities. Continuing education with a focus on human sexuality, sexual minorities, and specific aspects of LGBTQ healthcare can increase knowledge and provider/staff comfort, as well as decrease bias.

In addition to self-education and national guidelines, healthcare providers and their patients benefit from identifying specialty providers familiar with LGBTQ concerns and risks and knowledge of local LGBTQ-friendly resources. Displaying sensitivity to the healthcare needs of all patients is an important step in decreasing healthcare disparity in the United States.

Healthcare Preferences

Martos and colleagues[72] examined qualitative data from Lifestyle Interviews of LGB persons in three age cohorts from the Generations Study, looking for influences on healthcare preferences in the population. Findings centered on themes of stigma, expertise, identity, service type, and access. Stigma was the factor that most influenced participants' preferences and communication with providers. Martos and colleagues[72] defined stigma as "real or perceived negative social attitudes directed toward participants about one or more of their identities". Findings showed that stigma influenced participants' communication with their providers and varied from concern over one's own comfort to comfort of both provider and participant. Although avoiding stigma was a high priority, there were many different ideas on how to achieve this goal in the healthcare experience. They included a desire for an LGB-provider/venue, or a provider of a particular gender, to no concern at all if the provider was comfortable with the patient's sexuality. Expertise was also a priority, and providers were frequently selected based on their specific skills. Barriers in access to healthcare were varied by age groups and insurance coverage. A frustration for many was the additional cost for utilization of a provider outside the network or the compromise between preferences such as skill set or "queer friendly."[72]

Cultural Differences

The concept of understanding and demonstrating respect in interactions with individuals from different cultures has long been labeled "cultural competency". But, more recently, the term "cultural humility" is being favored over cultural competency. Can one every really be competent in a culture other than their own? And, if you are not culturally competent, are you then, in fact, culturally incompetent? Still, many bureaucratic agencies continue to promote "cultural competency" in their educational considerations for members of healthcare fields. In contrast, cultural humility emphasizes a continuum of education, self-evaluation, self-critique and improvement in our interactions with communities that are different from our own, rather than the "either or" implication of cultural competency.[73] The following section will explore both cultural competency and humility.

Cultural competence in healthcare is understood as the ability to provide care to people from diverse backgrounds and adapting or designing that care to meet their social, cultural, and linguistic needs.[74] To achieve cultural competence in healthcare systems, there must be policies in place along with training and education to change behaviors at the systems and personal levels. For systems, there may be the provision of language assistance or a cultural specialist that is part of the care team and interacts in the community. Benefits to these changes are social, such as promoting inclusion, increasing community participation in their health, and increased trust. Health benefits include improved preventive care, fewer missed appointments, and reduced disparity.

There are several stages in cultural competency: blindness (ignorance), awareness (you know you do not know), knowledge (you see differences and accept the person and their beliefs), and skills (gain ability to interact with different cultures).[75] Cultural competence develops in stages with individuals moving through stages at various rates with the assistance of education, training, commitment, and practice.[75] While cultural competency training can be beneficial, there is a concern of forming assumptions and stereotypes,[75] and no one person manifests all expectations of their culture.

Cultural humility involves a personal commitment to self-evaluation and critique to focus on improving relationships.[76] The benefit to cultural humility is a focus on individuals, getting to know a person's health goals, fears, and expectations, allowing for person-centered care. Cultural humility also calls for self-reflection of one's thoughts and biases, allowing for an equal provider-patient relationship and not requiring specific courses.

Regardless of the method, identification of one's feeling as they encounter someone with a different lifestyle or experiences is important in both cultural competence and humility.

Culturally affirming care seeks to support, validate, and honor the culture of the individual while recognizing current and historical oppression experienced by members of that culture.[77]

People who are transgender or gender diverse have expressed difficulty in finding culturally affirming medical care, especially in rural areas. Both healthcare providers and community members have identified the need for improved data collection and gender-inclusive intake forms, signage, and education of providers.[20] One study introduced an intervention over the course of one year to train staff at federally qualified health centers on culturally affirming practices, increase the collection of sexual orientation and gender identify information, and improve targeted screening. Post-intervention, the percentage of sites collecting sexual orientation and gender identity information had increased from 13.5% to 50.8%. Screening practices also indicated improvement. The authors note, however, that some of the centers felt the staff needed more training in culturally affirming care to better collect data and perform screening.[78]

Treatment Recommendations

This course has discussed some of the general recommendations for creating a welcoming, nonjudgmental environment and incorporating intake and sexual history forms that provide more inclusive and open-ended questions. The Gay and Lesbian Medical Association recommends discussing patient confidentiality and developing a written statement to explain how their information is protected, how it remains confidential, who can access it, and what circumstances may require sharing of information. The preventive care topics are no different than for any client and, as always, we must take the time to determine which is a specific risk for each patient. Each new patient visit should assess sexual risk, safety related to lifestyle (e.g., seatbelts, firearms, sunblock), domestic violence, and substance use.[79]

As many as 45% of lesbian and bisexual women are not out to their providers, which reinforces the need to obtain a nonjudgmental sexual history and reinforces the need for confidentiality. Social and behavioral risk factors include stress and failure to seek care, being overweight, as well as smoking and substance use.[79] Completing screening for substance use, interpersonal violence, depression, and anxiety are important to identify these possible risks. Consideration should be given for breast cancer screening at age 40 in women who are nulliparous or experienced early menarche, and in those with a positive family history. Do not assume a lesbian or bisexual woman does not plan to have children. Pap smears should be completed on all individuals with a uterus, including HPV testing at the recommended intervals, since transmission of HPV can occur among WSW. Additional screening and health concerns should be age-appropriate and focused on the actual behaviors of each client.

Gay and bisexual men should receive the same screenings as any male (i.e., colon, prostate, and testicular cancers; coronary artery disease) with consideration for the increased risk of anal HPV, anal cancer, domestic violence, mental health issues, and substance use.[79]

Healthcare for transgender individuals has been lacking in much of the US because of the insufficient number of healthcare providers with adequate training, because of discrimination, or negative behaviors experienced during healthcare utilization, and insufficient insurance or ability to pay for care.[80,81] Screening should be based on anatomy and behaviors that are present. Cervical and prostate screenings, for anyone with a cervix or prostate respectively, should be conducted at recommended intervals for trans and cisgender individuals. Transgender men may experience anxiety or distress during pelvic examinations, and healthcare providers should be sensitive to this possible reaction and attempt to maximize comfort during the examination.[81] Likewise, mammography is recommended for trans men who have not undergone chest reconstruction. Desire for birth control and fertility should also be discussed without assumptions by the provider.[81]

Recommendations

There are several additional suggestions in the literature to decrease disparity and improve access to care among LGBTQ persons. Although there has been some increase in acceptance of sexual minority individuals, there is still much work needed to reduce the health disparities and identify risks:

Seek resources for continuing education. An increase in knowledge and understanding on topics of concern for the LGBTQ population improves patient outcomes.

Effective communication. Using correct pronouns will increase a patient's comfort level. Do not gossip or joke about any patient. Encourage coworkers in their communication with patients. If you are uncertain, avoid the use of gender-related terms until you have confirmed this information with the patient. Apologize if you make an error and if there is a discrepancy with names or records. Ask what the name on the insurance card is or if the chart may have a different name. Confirm identity with date of birth.

Increase data collection on transgender individuals. As previously mentioned, there is minimal data available, lack of provider knowledge, and hesitancy to disclose this information to others. Four focus groups, with self-identified transgender individuals, explored the feasibility of asking about transgender identity in the Current Population Survey sponsored jointly by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics (BLS).[9] Feedback revealed some concerns about accuracy of responses since answers may be made by household proxy and because it would be difficult to create adequate response options to capture group diversity.[9] General recommendations were to develop and test a variety of questions to test with other trans focus groups.

Address one's own bias. Explicit bias is conscious; the person is aware of their feelings, which may be expressed in words or actions. Implicit bias is unconscious and can reflexively interfere with assessments, decision-making, and provider-patient relationships.[82] Both explicit (conscious) and implicit (unconscious) bias should not be in healthcare. The former will take significant time and effort to overcome. Implicit bias must be uncovered and identified by the individual who must then desire to change their thoughts and behavior.[81] Several versions of the Implicit Association Test[82] can be accessed online (https://implicit.harvard.edu/implicit /takeatest.html). Consider taking the Sexuality IAT, Transgender IAT, and Race IAT to assist with your self-evaluation.

Use of screening tools and guidelines. Guidelines and screening tools exist for general wellness in primary care practice and for specialty diagnosis in multiple settings. Additional research is needed to provide consistent care and optimize outcomes for our LGBTQ clients, including adequately developed guidelines that are evaluated and revised as information is updated.

BEFORE MOVING ONTO THE NEXT SECTION, PLEASE COMPLETE CASE STUDY 2 ON THE NEXT PAGE.

Resources

Many online sites provide education and CME credit related to sexual minority healthcare. The following list represents just a few of the hundreds of available resources. You can search by state and even locally to determine what is in your area

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The National LGBTQQ+ Health Education Center (https://www.lgbtqiahealtheducation.org/resources/) provides free publications, videos, webinars, and learning modules, many with continuing education credits, on multiple topics including providing inclusive healthcare, understanding disparities, and understanding health needs among others.

The CDC (https://www.cdc.gov/stophivtogether/hiv-prevention/) provides a variety of healthcare provider trainings along with some clinical care protocols and resources for HIV prevention and treatment.

The American College of Obstetricians and Gynecologists (https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/05/healthcare-for-lesbians-and-bisexual-women) provides recommendations for the healthcare of lesbian and bisexual women.

Case Study 2

Instructions: Please read through the case study below and consider the questions that follow.

(ANSWER KEY AND RATIONALE IS DISPLAYED AT THE BOTTOM OF THIS EXERCISE)

A new patient has presented to your primary care practice. Sarah M. is a 55 YO female without any known past medical history. You notice on her intake form that she is in a long-term, monogamous relationship with her female partner, Melissa, for 23 years. Sarah admits she has not seen a physician "in probably 25 years." She is not taking any medications or supplements. Sarah has a BMI of 34 and her vital signs are:

HR= 78 RR= 16 BP 155/92 T=98.8 F.

Sarah reports she did have a miscarriage at age 24 but no additional pregnancies. She states her periods had been regular until she completed menopause more than 3 years ago.

1. **Based on this limited information, you recognize that**
   a. Sarah does not require any specific gynecologic care since she is not sexually active with men.
   b. Sarah has a lowered risk for breast cancer compared to a heterosexual woman.
   c. Sarah may have been hesitant to seek medical care over the past several years because of negative interactions with healthcare professionals.
   d. Sarah should attempt to lower her BMI with weight loss supplements.

2. **Based on this limited information, you believe Sarah could be at risk for**
   a. Breast Cancer
   b. Metabolic disease
   c. Cervical cancer
   d. All of the above

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1. *Answer: C - Rationale: It is important that healthcare professionals recognize that a large number of individuals within the LGBTQ community have experienced negative interactions within the healthcare system. These negative interactions may result from explicit or implicit bias.*

2. *Answer: D - Rationale: Sarah has not received any medical care in more than 20 years. Based on her age, lack of prior screening and elevated BMI, she is at risk for all of the above disease processes. In fact, she has an elevated blood pressure at this visit, which could represent an indication of metabolic dysfunction.*

The Gay and Lesbian Medical Association: Health Professionals Advancing LGBTQ Equality (http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageId=534), founded in 1988 for physicians and medical students, is now open to members of other health specialties including nurses. Their mission is to ensure health equality for all sexual minority individuals.

On their resource page, there are links for both patients and providers. They also have free webinars and continuing education related to quality healthcare for LGBTQ people and assorted publications.

Familia es familia (https://www.familiaesfamilia.org/) provides information and links to topics such as family issues, immigration, school, community, discrimination, transgender, same-sex relationships, and student resources for LGBTQ individuals. Many of these are in Spanish and English.

The Safe Zone Project (https://thesafezoneproject.com/resources/) provides training resources in creating LGBTQ/Ally training and many other links to a variety of topics related to sexual minorities.

Campus Pride Index (https://www.campusprideindex.org/contactus/index) launched in 2007 and provides an assessment of colleges on eight LGBTQ-friendly aspects including safety, housing support, academic and student life, counseling and health, institutional support and commitment, and recruitment.

The Trevor Project (https://www.thetrevorproject.org/about/), founded in 1988, provides crisis intervention and suicide prevention 24/7 to LGBTQQ people under the age of 25. In addition to online and telephone service, individuals can chat confidentially via instant messenger or text a counselor any day any time. Text START to 678-678.

HealthSherpa (https://blog.healthsherpa.com/lgbtq-healthcare-resources/) helps individuals find quality, affordable health coverage under the Affordable Care Act. There are also links for people to become involved in political activism.

U.S. Office of Special Counsel (https://osc.gov/Pages/SearchResults.aspx?k=sexual%20discrimination) provides guidelines and factsheets related to complaints of employment-related discrimination in the federal workforce based on sexual orientation or gender.

The National Center for Transgender Equality (https://transequality.org/) was founded by transgender activists who desired to see policy changes. The site has multiple resources along with an FAQ section, issues relevant to transgender people and their advocates, legal rights information, and self-help guides.

Glossary

Unless otherwise stated, definitions are from New Jersey Institute of Technology.[65]

Ally: A person who supports and respects sexual diversity and acts to challenge homophobic or heterosexist remarks.

Cisgender: A person whose biological sex matches their gender identity.

Gender expression: The way a person presents and behaves.

Gender identity: How one perceives oneself (man, woman, or otherwise); this gender identity is internal and cannot be seen by others.

Healthcare disparity: Inequitable differences in healthcare resulting from differences in insurance coverage, access and availability of care, and quality of care received, leading to disparities (differences) in health and/or outcomes.

Healthcare provider: A person who is licensed, certified, registered, or otherwise authorized by the law of a state to provide healthcare in the ordinary course of business or practice of a profession.[83]

Heteronormativity: The assumption that all individuals are heterosexual or that heterosexuality is superior.

HIV+ (Human immunodeficiency virus positive): Having tested positive for a viral infection that affects CD4 cells, transmitted by contact with blood and body fluids infected with HIV.[84]

LGBTQ: Lesbian, gay, bisexual, transgender, queer (also may include additional Q for questioning).

MSM: Men who have sex with men.

Non-binary ("NB" or "enby"): a person who does not identify with gender binary of male or female.[85]

Pansexual: Person who is emotionally, physically, romantically, and/or sexually attracted to people regardless of those people's gender identity.

Queer: Individuals with non-normative gender identity, sexual orientation, or sexual anatomy (a term that has been used as a slur).

Sex assigned at birth: Determined by physical genital anatomy.

Sexual minority: "Those who identify as lesbian, gay, bisexual, or transgender or reported same-sex attraction."[50]

Transgender: Term for those whose gender identity does not match that assigned to their physical sex; may or may not use hormones or have had gender confirmation surgery.[86]

Transman FtM/F2M: Transgender person who lives as a male but was assigned female gender at birth.[87]

Transwoman MtF/M2F: Transgender person who lives today as a female but was assigned male gender at birth.[87]

Transition: The period of time during which a person begins to live according to their gender identity. This time frame varies by individual and may or may not include changes in clothing, appearance, identification, hormone therapy, and gender confirmation surgery.[87]

WSW: Women who have sex with women.

Ze: Non-gender pronoun used instead of "she" or "he"; ze (subject), hir (object), hirs (possessive pronoun), hirself (reflexive). Pronounced zee.[88]

Conclusion

As summarized in this learning activity, LGBTQ patients, in addition to having the same basic health needs as the general population, experience health disparities and barriers related to sexual orientation and/or gender identity or expression. LGBTQ health disparities exist throughout all age groups.

Youth have higher rates of homelessness, suicide, and mental health issues than their heterosexual peers. Many avoid or delay care or receive inappropriate or inferior care because of perceived or real homophobia, biphobia, transphobia, and discrimination by health care providers and institutions. Fear of and experiences with discrimination and stigma influence the decision whether to seek healthcare. Insurance coverage, cost, and lack of knowledgeable and experienced providers can cause a delay in seeking care.

Health care providers can take meaningful, positive steps to promote the health of their LGBTQ patients by examining their practices, offices, policies and staff training for ways to improve access to quality health care for LGBTQ people and by following the recommendations made in this activity. This course discussed methods to create a welcoming environment with a focus on primary care. Healthcare professionals can still identify ways to create a more inclusive environment and address instances of outright bias observed or encountered. Change is reliant on the identification of a situation in need of a different outcome.

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Self-Assessment

Choose the best possible answer for each question and mark your answers on the self-assessment answer sheet at the end of this book. There is a required score of 70% or better to receive a certificate of completion.

11. When obtaining a sexual history on all patients, it is important to do which of the following?
A. Avoid uncomfortable topics.
B. Limit discussion to the patient's current status.
C. Ensure confidentiality and remain nonjudgmental.
D. Obtain only if the visit pertains to reproductive matters.

12. Which of the following is a recommendation for decreasing bias related to LGBTQ healthcare needs?
A. Continuing education with a focus on sexual minorities.
B. Increased exposure to LGBTQ individuals.
C. Asking questions related to human sexuality.
D. Assume all individuals are LGBTQ.

13. Using an intake form that allows a patient to provide personal information in a nonjudgmental manner can do which of the following?
A. Avoid uncomfortable topics during the patient encounter.
B. Limit work for office staff.
C. Set the tone for provider-patient relationships.
D. Encourage them to refer other patients.

14. The National LGBTQ Health Education Center suggests posting which of the following?
A. Nondiscrimination policy.
B. Welcome sign.
C. Statement of purpose.
D. HIPPA facts.

15. A national survey in 2017 revealed which of the following?
A. Discrimination kept LGBTQ people from seeking care.
B. Discrimination may result in LGBTQ patients having trouble finding care if turned away.
C. Discrimination in healthcare still exists for those in the LGBTQ community.
D. All of the above.

16. Improved health outcomes are a direct result of which of the following?
A. Confrontation regarding unacceptable behaviors.
B. Avoidance of sexual topics for discussion when uncomfortable.
C. Risk identification, behavior modification, continued surveillance.
D. Limiting time spent in waiting rooms.

17. A health disparity:
A. Is a difference in health status, resulting from a form of disadvantage.
B. May be based on race, gender, immigrant status, disability, or sexual orientation.
C. May be overcome through education and understanding of healthcare providers.
D. Is all of the above.

18. Which of the following correctly defines health disparities?
A. Differences in healthcare providers' approaches to patient care.
B. Differing responses to a specific treatment among various patients.
C. Patients suffering from multiple disease processes.
D. Differences in health status of populations often as a result of some form of disadvantage.

19. In addition to common health risk factors, LGBTQ patients may experience social stressors contributing to all of the following EXCEPT:
A. Mental health issues.
B. Suicide.
C. Substance abuse.
D. Motor vehicle accidents.

20. One way to avoid negatively influencing the interaction and quality of healthcare provided is to:
A. Exclude personal belief systems from healthcare relationships.
B. Treat everyone differently.
C. Limit patient visits to only one topic for evaluation.
D. Avoid uncomfortable or difficult patient situations.

ASSESSMENT AND PREVENTION OF SUICIDE

COURSE DATES:	MAXIMUM CREDITS:	FORMAT:
Release Date: 2/2023 Exp. Date: 1/2026	*6 AMA PRA Category 1 Credit*™	Enduring Material (Self Study)

TARGET AUDIENCE

This course is designed for all physicians (MD/DO) and other health care practitioners.

HOW TO RECEIVE CREDIT:

- Read the course materials.
- Complete the self-assessment questions at the end. A score of 70% is required.
- Return your customer information/ answer sheet, evaluation, and payment to InforMed by mail, phone, fax or complete online at program website.

COURSE OBJECTIVE

The purpose of this course is to provide learners with the background and statistical data of suicide within the US, etiology of suicide, suicide risk, assessment, treatment, and management. Additional topics include the risk of imminent harm, communication strategies, and a special focus on the veteran population.

LEARNING OBJECTIVES

Completion of this course will better enable the course participant to:

1. Understand terminology and concepts related to suicide
2. Understand risk factors associated with suicide
3. Describe strategies for conducting a suicide assessment
4. Discuss appropriate treatment and management options for patients at risk of suicide

ACCREDITATION STATEMENT

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DISCLOSURE OF INTEREST

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COURSE SATISFIES

6

AMA PRA Category 1 Credits™

SPECIAL DESIGNATION

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DISCLAIMER

Introduction

The U.S. Centers for Disease Control [CDC] (2019) has identified suicide as one of the top ten leading causes of death in the 10-65 age group. According to the Suicide Prevention Resource Center (SPRC), suicide acts take a tremendous emotional and economic toll on the families and loved ones of those who engage in suicidal behaviors. Not only does the suicidal behavior of a loved one cause an emotional toll on family members and place others within the family unit at risk of dying by suicide, but it also results in increased medical costs for individuals and families, lost income for families, and lost productivity for employers and the community. This topic must be addressed throughout the healthcare community to prevent further avoidable loss of life.[1]

The financial benefits of implementing suicide preventative measures will, hopefully, convince policymakers and lawmakers that suicide prevention is not only the "right" thing to do, morally speaking, but is also an investment that has a financial benefit in addition to saving lives. A recent study by Shepard et al., in 2015 found that the total cost of suicide acts in 2013 was $93.5 billion, with an estimated average cost of $1,329,553 for a single suicide. Approximately 97% of this cost was attributed to lost wages from productivity, whereas the remaining 3% went to medical treatment. The study also estimated that every $1 spent on psychotherapeutic interventions and interventions that promoted linkages between different care providers saved $2.50 in suicides.[1]

Primary care providers may be able to prevent suicide due to their frequent interactions with suicidal patients. According to Schreiber and Culpepper,[2] 80% of individuals who die by suicide have had at least one contact with their primary healthcare provider within one year of suicide, whereas only 25 to 30% had contact with a mental health professional within that same period. And although it cannot be determined that routine screening for suicide has prevented any death, one behavioral healthcare program saw a 65% reduction in suicide rates 20 months after implementing a routine screening protocol.[3] Nevertheless, primary care providers are more likely to see patients experiencing suicidality than mental health professionals. A screening approach sensitive to risk factors, current stressors, and the presence of ideation, plan, intent, and preparatory behaviors, especially for patients experiencing depression, may alert providers to patients who may be at acute risk for suicide.[2]

Lastly, individuals discharged from a psychiatric facility have a suicide rate 300 times higher in the first week and 200 times higher in the first month compared to the general population.[4] Medical and allied healthcare professionals in emergency, behavioral health, and primary care settings thus, have a critical role in identifying patients at elevated suicide risk.

Suicide Terminology

In recent years, the societal vernacular on suicide has changed. Clinicians and researchers are encouraged not to say that an individual "tried to commit suicide" or "committed suicide" because the word "commit" has negative connotations. Instead of "committed" or "completed," it is currently recommended to use the phrase "died by suicide". Furthermore, suicide attempts are no longer categorized as "failed," "unsuccessful," or "successful."[5]

The following definitions are adapted from the CDC, and the American Psychiatric Association's Practice Guidelines for the Psychiatric Evaluation of Adults:[5]

- **Aborted or self-interrupted attempt:** When a person begins to make steps towards making a suicide attempt but stops before the actual act.
- **Affected by Suicide:** All those who feel the impact of suicidal behaviors, including those bereaved by suicide, friends, community, or the actions of celebrities.
- **Bereaved by Suicide:** Family members, friends, co-workers, others affected by the suicide of a loved one. They can also be referred to as survivors of suicide loss.
- **Interrupted Attempt:** When a person is interrupted from carrying out a self-destructive act by another person or outside circumstances.
- **Means/Methods:** The instrument, material, or method used to engage in self-inflicted injurious behavior.
- **Non-Suicidal Self Injury (NSSI):** The intentional injury of one's own body tissue without suicidal intent and for purposes not socially sanctioned, such as carving, cutting, or burning oneself, banging or punching objects or oneself, and embedding objects under the skin.
- **Protective Factors:** Factors that reduce the likelihood that an individual will engage in suicidal behavior.
- **Risk Factors:** Factors that increase the likelihood that an individual will engage in suicidal behaviors.
- **Safety Plan:** A collaborative plan between patient and clinician that contains a written list of warning signs, coping responses, supports, and emergency contacts that an individual may use to avert thoughts, feelings, or impulses or behaviors related to suicide.
- **Suicidal Behaviors or Preparatory Actions:** Acts or preparation toward making a suicide attempt that includes any evidence of intent to die.
- **Suicidal Ideation:** Thoughts of engaging in suicidal behaviors or serving as the agent of one's own death (active ideation), or preoccupation with death or being dead (passive ideation).
- **Suicidal Intent:** Expectation and desire for a self-injurious act to end in death.
- **Suicidal Plan:** Plan of the method, means, time, place, or other details for engaging in self-inflicted injurious behavior with any intent to die because of the behavior.
- **Suicidal Thoughts:** General nonspecific thoughts of wanting to end one's life.
- **Suicide:** Death caused by intentional self-directed injurious behavior with any intent to die.
- **Suicide Attempt:** A non-fatal, self-directed, potentially injurious behavior with any intent to die because of the behavior with or without injuries.

Healthcare Professional Consideration:
Healthcare professionals need to talk about suicide in a non-judgmental way and avoid stigmatizing terms. Hopefully, learning how to talk about suicide can encourage people to seek help.

Myths about Suicide

In society, there are many myths surrounding suicide that may prevent people from getting the help they need. Addressing common myths associated with suicide can help clinicians, researchers and the general population understand the importance of helping others address their mental health challenges by seeking treatment (see Table 1 on the next page).

Healthcare Professional Consideration:
Be prepared to hear suicide myths from patients or the general public. Addressing common myths surrounding suicide can help patients and others realize the importance of seeking treatment to address their mental health challenges.

Epidemiology

Global Suicide Data

The World Health Organization (WHO) recognizes suicide as a top health priority globally. However, it is estimated that more than 700,000 people die by suicide every year in the world. Suicide is the fourth leading cause of death among 15–29-year-olds globally in 2019. Given the sensitivity of suicide and the illegality of suicidal behavior in some countries, there is likely underreporting and misclassifications of deaths, making the availability and quality of suicide data poor.[7]

Suicide does not just occur in high-income countries but is a global phenomenon in all regions. Over 77% of suicides occurred in low and middle-income countries in 2019. Approximately 20% of global suicides result from self-poisoning with pesticides, most of which occur in low and middle-income countries. Other top methods are hanging and firearms.[7]

Table 1. Myths and Facts about Suicide	
Myth	**Fact**
Suicide only affects individuals with a mental health condition.	Many individuals with mental illness are not affected by suicidal thoughts and not all people who attempt or die by suicide have mental illness. Relationship problems and other life stressors such as criminal/legal matters, persecution, eviction/loss of home, death of a loved one, a devastating or debilitating illness, trauma, sexual abuse, rejection, and recent or impending crises are also associated with suicidal thoughts and attempts.
Once an individual is suicidal, he or she will always remain suicidal.	Active suicidal ideation is often short-term and situation-specific. Studies have shown that approximately 54% of individuals who have died by suicide did not have a diagnosable mental health disorder. And for those with mental illness, the proper treatment can help reduce symptoms.
Most suicides happen suddenly without warning.	Warning signs—verbally or behaviorally—precede most suicides. Many individuals who are suicidal may only show warning signs to those closest to them. These loved ones may not recognize what is going on, which may seem like the suicide was sudden or without warning. Therefore, it's essential to learn and understand the warning signs of suicide.
People who die by suicide are selfish and take the easy way out.	Typically, people do not die by suicide because they do not want to live—people die by suicide because they want to end their suffering. These individuals are suffering so deeply that they feel helpless and hopeless. Individuals who experience suicidal ideations do not do so by choice. They are not simply "thinking of themselves," but rather they are going through a severe mental health symptom due to either mental illness or a difficult life situation.
Talking about suicide will lead to and encourage suicide.	There is a widespread stigma associated with suicide, and as a result, many people are afraid to speak about it. Talking about suicide reduces the stigma and allows individuals to seek help, rethink their opinions, and share their story with others. We all need to talk more about suicide.[6]
Note. From Fuller, K. (2020, September 30). 5 Common myths about suicide debunked. National Alliance on Mental Illness. https://www.nami.org/Blogs/NAMI-Blog/September-2020/5-Common-Myths-About-Suicide-Debunked[6]	

United States Suicide Data

The American Foundation for Suicide Prevention (AFSP) similarly proposes that suicide is underreported, and there are challenges in collecting accurate data regarding the number of individuals who die by suicide each year.[8] The National Violent Death Reporting System (NVDRS) is a state-based surveillance system that gathers more than 600 unique data elements from death certificates, coroner/medical examiner reports, law enforcement reports, and toxicology reports.[9]

The AFSP estimates that 47,511 Americans die from suicide each year, making it the tenth leading cause of death in the U.S. This amounts to 130 suicides per day.[8] Suicide is the second leading cause of death in ages 10-24; the third leading cause of death in ages 35-44; and the fourth leading cause of death in ages 45-54. Over seven times as many people died by suicide in 2019 than in alcohol-related motor vehicle accidents.[10]

White, middle-aged males die by suicide at a greater rate than any other population. Males are 3.63 times more often to die by suicide than women. Females are 1.66 times more likely to attempt suicide.[8]

The number of people who think about or attempt suicide is even higher. In 2019, 12 million American adults seriously thought about suicide, 3.5 million planned a suicide attempt, and 1.4 million attempted suicides.[8,11]

The most common means of suicide in the United States is a firearm, followed by suffocation and poisoning. In 2019, up to 50% of suicides involved a firearm, 28% involved suffocation, and 13% involved poisoning.[12] Approximately 75% of firearm deaths were suicides, and 50% of all suicides were caused by firearms.[10] In men and women, firearms are the most common means of suicide. Firearms are the most common method of suicide used by men of all ages, and this is especially true among men aged 65 years and older.[12]

Suicide Risk Factors

Most suicides occur with individuals experiencing depression, substance use disorders, and psychosis.[13] Although research has identified that multiple factors can increase one's risk for suicide, no studies show that one factor or a set of factors is predictive of suicide. Factors that are positively associated with suicide risk include specific demographics, psychiatric illness and comorbidity, suicide-specific symptoms and attitudes, family history, personality disorder/traits, substance use/abuse, severe medical illness, life stressors, suicidal behavior, psychological vulnerability, and access to weapons.[5] Table 2 briefly outlines these risk factors.

Table 2. Risk Factors for Suicide			
Individual	**Relationship**	**Community**	**Societal**
• Previous attempts. • Mental illness, particularly clinical depression. • Social isolation • Criminal problems. • Financial problems. • Impulsive or aggressive tendencies. • Job problems or loss (relational, social, work, or financial). • Serious illness. • Substance use disorder.	• Adverse childhood experiences, such as child abuse or neglect. • Bullying. • Family history of suicide. • Relationship problems, such as a break-up, violence, or loss. • Sexual violence.	• Local epidemics of suicide. • Barriers to accessing mental health treatment. • Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal problem.	• Easy access to lethal methods (firearms, medications). • Stigma associated with mental illness or help-seeking. • Unsafe media portrayals of suicide.
Note. Adapted from U.S. Centers for Disease Control.[14]			

Demographics

Children

A well-characterized risk factor for death by suicide is exposure to early-life adversity, generally defined as parental neglect or childhood physical, sexual, or emotional abuse. Early-life adversity might also be transmitted through families, partly explaining the familial aggregation of suicidal behavior. Young people who die by suicide often have a high burden of adversity and a history of childhood abuse or neglect.[15]

Children are most vulnerable to influences that may eventually lead to suicide. The Adverse Childhood Experiences (ACE) study, first conducted in the mid-1990s, examined the long-term health effects of trauma exposure, violence, and loss during childhood. The higher the person's ACE score, the greater chance of a wide range of chronic health problems, including depression, anxiety, suicide, and PTSD.[16] A study of ACE data showed that ACEs were positively associated with reported suicide ideation and attempts, and the occurrence of at least three ACEs increased the likelihood of suicidal ideation and attempts threefold.[17]

Elderly

Eighty percent of suicide deaths in the U.S. are among men and women aged 45-54. However, the highest rate of suicides occurs among men aged 85 years and older[18] Death by suicide exists among the elderly and is directly linked to symptoms of depression and anxiety.[19] The developmental aspect of older Americans is often overlooked and considered a "natural part" of life; however, it is suspected that isolation, loss of loved ones, and untreated depression contribute to an increased risk of death by suicide in this age group.

Cultural and Geographic Factors

Immigrants

It is essential to recognize that immigrants are at a higher risk for suicide. Risk factors include language barriers, worrying about the family at home, and separation, often leading to hopelessness, depression, and anxiety. Additionally, the lack of information on the way the healthcare system works, loss of status, loss of social networks, as well as acculturation challenges are identified as other potential contributing factors.[13]

American Indian and Alaskan Native populations and Rural Areas

The U.S. suicide rate is highest amongst American Indian and Alaskan Native populations.[5] These ethnic groups tend to live in rural areas where suicide rates are higher compared to urban areas.[20] Rural areas often have lower availability of mental health services because of clinician shortages and social barriers, including stigma and lack of culturally competent care.[21] Geographic origin as a source of variation in the incidence of suicide underscores the importance of implementing suicide prevention strategies in rural areas.

Economic Factors

Suicide and suicide attempts are relatively equal in low-income and high-income countries, with some variance among gender and age groups. In high-income countries, such as the United States, suicide is most common among adults over the age of 45.[18]

Economic crises

Economic crises (e.g., unemployment and decreased personal income) have been positively associated with suicide. Poverty rates have been found to have a strong association with suicide death rates among men and women above the age of 20 years. While initial unemployment has been identified as a risk factor for suicide, it should also be noted that the subsequent poverty and reduced or persistent limited access to resources also contribute to the risk of death by suicide.[23]

Other studies have found that U.S. suicide rates are associated with economic cycles, with the rate decreasing during periods of economic expansion and increasing during contraction. These findings are supported by a study that found that, after controlling for depression, change in financial status was a more significant correlate of suicidal ideation than chronic poverty.[23]

Industry and occupation

Interestingly, suicide rates are also correlated with industry and occupation. The industry groups that have a higher rate of suicide are listed in Table 3.[24]

PLEASE COMPLETE CASE STUDY 1 ON THE NEXT PAGE.

Family and Home Factors

According to the Washington State Department of Health (WA DOH),[15] the emotional toll of a suicide within the family increases the risk of death by suicide in the surviving family members. The data also supports that the risk of suicide attempts is higher in relatives of people who have died by suicide, and that the risk of dying by suicide is higher in relatives of people with a history of suicide attempts.[21] Further, family conflicts, abuse, violence, lack of family connectedness and parents' mental health disorders can also increase an individual's suicide risk. Lastly, a history of foster care or adoption is also linked to higher suicide risk.[25]

Mental Health Factors

Depression and substance use disorders are the most common diagnoses among suicide victims. While depression is a strong risk factor for suicidal ideation and attempts, it lacks specificity as a predictor, and little is known about the specific characteristics that increase this risk. Comorbid psychiatric disorders also correlate with high suicide risk. A study examined comorbid disorders and suicide risk in severe depression/melancholia and found that the most common comorbidity was obsessive-compulsive behaviors, anxiety, and schizophrenia.[17]

Impulsivity is a tendency to act without thinking through a plan or its consequences. It has been linked to suicidal behavior because of its association with mental health disorders and/or substance abuse. Impulsivity also has been associated with aggression and other violent behaviors, including suicide.[26] Multiple other factors, such as alcohol- and drug-related disorders, are common in people who die by suicide and exacerbate underlying risks or interact with depression to increase suicidal behavior.[18]

Patients recently discharged from inpatient psychiatric units are at elevated risk for subsequent completed suicide, especially within the first week of discharge. Although rates decline relative to time after discharge, they do remain higher compared to the non-hospitalized population even several years after discharge, which provides a case for ongoing suicide safety assessments at discharge and several years after a discharge.[27]

Previous studies have shown that 90 to 95% of individuals who die by suicide also suffer from at least one severe psychological problem[5]; consequently, seeking and receiving psychological help is presumed to be a protective factor against suicide.

Table 3. Suicide Rates by Industry and Occupation Groups

Industry	Male	Female
Mining, Quarrying, and Oil and Gas Extraction	54.2	-
Construction	45.3	-
Other Services (such as automotive repair)	39.1	-
Agriculture, Forestry, Fishing, and Hunting	36.1	-
Transportation and Warehousing	29.8	10.1
Construction and Extraction	49.4	25.5
Installation, Maintenance, and Repair	36.9	-
Arts, Design, Entertainment, Sports, and Media	32.0	-
Transportation and Material Moving	30.4	12.5
Protective Service	-	14.0
Healthcare Support	-	10.6

Note. Numbers in Male/Female columns indicate suicide rates per 100,000.

Case Study 1

Instructions: Spend 5-10 minutes reviewing the case below and considering the question and discussion that follows.

You are working in a free clinic dedicated to a largely immigrant population. Your patient, Juan, is a 45-year-old construction worker who recently arrived from Mexico for work opportunities. He left Mexico due to financial hardship, and initially secured financial stability with his local construction position. Juan came in today in hopes of refilling a prescription for his anti-hypertensive medications since he has not yet established care in your area, and he does not have health insurance.

As you speak with Juan during his visit, he tells you that he is learning English, but for the most part, understands very little of the language and feels "lost" in his new surroundings so far. He has strong family and social bonds in Mexico but is alone here. He explains that he had been sending most of his salary back home and had taken great pride in his ability to provide for his family with this position. But, recently the housing market in the area has taken a steep downturn, with a significant decline in the number of new projects and Juan lost his job. Juan expresses dismay that he is having difficulty supporting not only himself in this new environment, but also that he is no longer able to support his family, and becomes tearful when discussing his situation. While Juan has no prior diagnosis of anxiety or depression, he admits to feelings of hopelessness since losing his job.

1. **Although you have just met Juan, take a moment to consider his current risk factors for suicide.** _____

_____

Discussion: While Juan has a strong network of friends and family at his home, his isolation in this country as an immigrant increases his suicide risk. In addition, his age and his profession, construction, have been associated with suicide risk. His recent, sudden, job loss also adds to the risk Juan faces. The feelings of hopelessness are concerning symptoms that warrant further exploration.

Those who do not receive adequate support are at increased risk for continued psychological problems, thereby increasing their risk of suicide.

Evidence-Based Practice:

In 2018, the Australian Rural Mental Health Study investigated the relationship between depression and suicidal behavior. Out of 1051 participants, 364 reported depression in their lifetime. Of these, 48% reported lifetime suicidal ideation, and 16% reported a lifetime suicide attempt. The severity of depression was a significant correlate of suicidality in both men and women, but suicide attempts were significantly more common among females with a younger age of depression onset and with a higher number of psychiatric comorbidities. No additional factors were found for males, making prediction difficult for men.[17]

Social Factors

Social isolation can be a significant risk factor for suicide.[15] Social isolation can occur for certain groups in specific geographic regions. For instance, in a small rural community, the LGBTQIA+ population may be isolated or marginalized, placing these individuals at a greater risk for death by suicide. In another example, questioning youth who are not connected with their family have a significantly higher suicide attempt rate than peers who have a supportive family.[15]

In a broader view, several social factors are associated with an increased risk of suicide: living alone, a high degree of introversion, traumatic events that had occurred in adulthood, and interpersonal stressors. Extreme hopelessness, helplessness, and worthlessness, which may or may not result from depressive disorders, have also been shown to contribute to increased risk.

Sexual Orientation

Sexual orientation has been shown to affect suicide risk. In the 2015-2019 National Surveys on Drug Use and Health, lesbian, gay, and bisexual adults are three to six times more likely than heterosexual adults to have suicidal thoughts, plans, or attempts. This demonstrates the importance of suicide prevention services that address the specific needs of lesbian, gay, and bisexual adults.[28]

Emotional Factors

Bereavement or loss of a close friend or relative, or a loved one can cause a significant amount of emotional distress, which can, in turn, lead to hopelessness and loneliness.[29] Within bereavement groups, those that are bereaved by suicide contribute to the highest risk for suicide.[30]

Physical Factors

Physical Health Conditions

While it is established that mental health disorders are risk factors for suicide, the relationship between poor physical health and suicide risk is unclear.[31] It is known that there is a close relationship between physical and mental health. Individuals with multiple physical health conditions tend to have a lower quality of life and a higher likelihood of a mental health disorder. Numerous studies have suggested that the type and number of physical illnesses are associated with suicide. However, most of the studies are based on small, non-representative samples of the population (e.g., U.S. military veterans).

A recent population-wide study of over one million people in Northern Ireland examined the relationship between physical health and suicide.[31] It showed that activity limitation is a significant factor for suicide risk, even after adjusting for chronic poor mental health. The effect of activity limitation was more pronounced for younger ages.

Sleep Disturbances

For a long time, experts believed that sleep disturbances were risk factors for suicidal ideations and suicidal behaviors.[32] However, a recent study published in 2020 showed that while sleep disturbances (insomnia, poor sleep quality, nightmares) are statistically significant risk factors for suicidal ideation, attempts, and death, these effects only weakly predict suicide. This finding is consistent with a growing body of evidence demonstrating this same relationship.

Traumatic Brain Injury

Athletes and veterans who have sustained multiple traumatic brain injuries (TBI) are vulnerable to suicidal behaviors and suicidal ideations. Regardless of gender, age or comorbidities, studies show that those with TBIs have more suicide attempts, and the risk of attempted suicide increases with the severity of the TBI.[33]

Stigma Surrounding Suicide

Public stigma is a social phenomenon in which members of society have negative attitudes about people with devalued characteristics. Stigma is a term that usually contains three elements: problems of knowledge (i.e., "ignorance"), attitudes (i.e., "prejudice"), and behavior (i.e., "discrimination"). Characteristics associated with suicide include emotional weakness, attention-seeking, selfishness, malingering, and immorality. Those who attempt or die by suicide are perceived to be impious (i.e., "not praying enough") or as betraying family and friends through a cowardly or selfish act.[34] The result of public stigma surrounding suicide can result in fewer observed help-seeking behaviors, and those that have survived suicide may internalize feelings of shame.[35]

Stigma also affects those bereaved by suicide. Research shows that those bereaved by suicide have higher rejection, shame, and blame levels than other bereaved people. This may partly be due to friends and family avoiding or feeling uncertain about approaching someone about their grief and loss. People bereaved by suicide may also find themselves avoiding the conversation about the cause of death due to anticipated stigmatized responses.[35]

Protective Factors in the General Population

According to the Center for Disease Control, there are several factors that can mitigate the risk in a person with a moderate to low risk for suicide. These include[14]:

- Effective coping and problem-solving skills.
- Self-esteem and a sense of purpose and meaning in life.
- Cultural and religious beliefs that discourage suicide.
- Connections to family, friends, and community support.
- Supportive relationships with care providers.
- Availability of physical and mental healthcare services.
- Limited access to lethal means among people at risk.

Healthcare Professional Consideration:
Safety planning and assessment of patients at increased risk for suicide should also include an examination of that patient's protective factors that serve to reduce suicidal acts.

Suicide Warning Signs

Since suicide is a relatively rare event, it is challenging to predict suicide based on risk factors. A recent meta-analysis found that predicting suicide is no better than chance and has not significantly improved over the last fifty years. The goal of identifying warning signs or clinical situations that warrant a suicide assessment is not a prediction but rather to determine an individual's suicide risk (i.e., "low", "medium", or "high") and to plan for informed interventions.[5]

Examples of clinical situations that warrant a suicide assessment include[5]:

- Crisis evaluations in the emergency department.
- Intake evaluations for all patients, especially those with severe mental illness.
- Patients with depression; someone who is either anticipating or experiencing significant loss or stress.
- Patients with certain physical illnesses, especially if life-threatening or associated with severe or chronic pain or loss of function.
- Significant clinical change (increase in suicide ideation, suicidal behavior, change in mental status, unstable mood, impulsiveness, trauma victimization)
- Regarding inpatient care settings, a change in privilege level, when there is a deterioration in mental status, and before discharge.

Warning signs are verbal expressions, changes in behaviors, or new behaviors that may indicate that a person is suicidal. The more of these warning signs a person displays, the greater the risk of suicide.[36]

Adult warning signs include[5]:

- Talking about wanting to die.
- Looking for a way to kill oneself.
- Talking about feeling hopeless or having no purpose.
- Talking about feeling trapped or being in unbearable pain.
- Talking about being a burden to others.
- Talking about great guilt or shame.
- Increasing the use of alcohol or drugs.
- Acting anxious, agitated, or reckless.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Daring or risk-taking behavior.
- Experiencing severe mental pain.
- Depression.
- Severe anxiety, panic attacks.
- Displaying extreme mood swings.
- Showing rage or talking about seeking revenge.
- Giving away prized possessions.
- Saying a final goodbye to family and friends.
- Putting affairs in order.
- Lack of interest in future plans.

Youth warning signs include[5]:

- Talking about or making plans for suicide
- Expressing hopelessness
- Displaying severe emotional pain or distress
- Showing worrisome behavioral cues or marked changes in behavior, such as:
  - Withdrawal from or change in social connections, including extracurricular activities and school performance
  - Changes in sleep
  - Anger or hostility that is out of character or out of context
  - Recent increased agitation or irritability
  - Risk-taking behavior or alcohol/drug use

Healthcare Professional Consideration:
It is important to note that the risk of suicide is greater if the warning sign is new, has increased, is after a perceived or experienced emotionally challenging event, or is associated with the acute onset of mental illness[5].

PLEASE COMPLETE CASE STUDY 2.

Case Study 2

Instructions: Spend 5-10 minutes reviewing the case below and considering the question and discussion that follows.

While seeing patients in your primary care office, you are happy to see that Laura is your next patient. She has recently returned to the area - you had been her physician for several years in the past. Laura is a veteran who recently was discharged from the military after serving for the last 10 years. During a training exercise, she suffered a traumatic brain injury for which she currently receives partial disability. You know from your previous relationship with Laura that she identifies as lesbian, and you have also cared for her partner in the past.

As you enter the room, you are somewhat surprised by Laura's appearance. She appears slightly disheveled, which is out of character for her. She tells you that recently, a close friend from her previous unit committed suicide. Laura does have a history of depression and recently has been having difficulty sleeping.

1. Which of Laura's risk factors is least likely to predict suicidal behavior?_____

_____

Discussion: Research has shown that insomnia is only weakly associated with suicide risk. Veterans, those with history of traumatic brain injuries, lesbian, gay, and bisexual, and those with a history of depression are shown to be at increased risk. Finally, those that are bereaved by suicide contribute to the highest risk for suicide among bereavement groups.

Suicide Screening

"Screening" and "assessment" are not synonymous. "Screening" is a method to identify those at increased risk for a specific condition or disorder and who could benefit from further evaluation[5]. "Suicide screening" is often a quick and standard procedure to identify individuals at risk for suicide. The method may be a standard form in a clinic, provider office, or the emergency department triage area. Often, suicide screening takes 15 minutes or less to conduct.

On the other hand, "assessment" is more comprehensive than screening and provides a more thorough conceptualization of an individual.[5] Assessments may include screenings, but these screening measures are used with other information to form an assessment or evaluation of the patient.

U.S. Preventive Task Force Recommendations

The U.S. Preventive Services Task Force (USPTF)'s most current recommendation for suicide screening is from 2014. As of September 2022, the USPTF is updating its current recommendation statement for suicide risk screening in adolescents, adults, and older adults. The existing recommendation states that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in a primary-care setting. It is important to note that this recommendation applies to individuals who do not have an identified psychiatric disorder.[37]

Joint Commission Recommendations

As of July 2019, the Joint Commission suggests that screening in some select environments for individuals with certain presenting complaints may indicate standard screening. The details of the recommendation are as follows[38]:

- Conduct an environmental risk assessment to identify features that could be used to attempt suicide.
- Screen all patients for suicide ideation using a brief and standardized screening tool.
- Use an evidenced-based process to perform a suicide risk assessment of those who have screened positive for suicidal ideation.
- Document an individual's overall level of risk for suicide and a plan to mitigate the risk.
- Follow policies and procedures regarding the care of individuals identified at risk for suicide. At a minimum, these should include:
    - Training and competence assessment of staff who care for patients at risk for suicide.
    - Guidelines for reassessment.
- Follow policies and procedures for counseling and follow-up care at discharge for patients identified at risk for suicide.
- Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide.

Suicide Risk Assessment Model

Individuals within the healthcare team must understand their role in suicide assessment and prevention within their organization. While each organization will differ, healthcare professionals should consider their role within the organization related to the Suicide Risk Assessment Model. The best practice would be for each role to flow to the following individual in the organization. As part of the routine screening, a behavioral health questionnaire should be given to each patient who presents to their primary healthcare provider to collect data regarding their psychological well-being.

A typical clinical protocol involves a healthcare team member deciding whether the Patient Health Questionnaire-9 (PHQ-9) or other behavioral health screening is indicated for a particular patient. Upon receiving the patient into the office, if they are identified as needing this screening, the medical assistant will ensure it is completed and scored. If the suicidality question on the PHQ-9 is positive, then the medical assistant will administer the Columbia-Suicide Severity Rating Scale (C-SSRS) questionnaire. Both assessment documents are then placed in the electronic medical record.

The primary healthcare provider will review the results with the patient and discuss the patient's present symptoms. The provider should contact a behavioral healthcare provider and, in the interim, conduct any needed safety planning and consider restricting access to lethal means. The primary healthcare provider will also engage the patient regarding strategies for managing depression symptoms. It is also vital to always encourage participation and facilitate a warm hand-off to the integrated behavioral health provider.

A licensed behavioral health provider needs to be available for urgent consultation of an acutely suicidal patient. The role of the behavioral health provider is to see patients for treatment or to determine if the patient is appropriate for specialty behavioral treatment. An integrated approach to behavioral health is imperative for the successful outcome of the patient who presents with depression symptoms or suicidal ideations.

Suicide Screening Tools

Screening an individual for suicidal risk involves several equally important factors:

1. Establishing rapport with the individual to determine an honest assessment.
2. Using an evidence-based screening tool that is appropriate for the individual and the situation.
3. Knowing what to do with the information collected.

Suicide screening tools are standardized and brief. Screening personnel may administer them and take less than 15 minutes to complete. The screener needs to ask all questions in a screening tool precisely. Should an individual show "at-risk scores or indicators," they require a full suicide assessment by a behavioral health provider.

ASQ – A Suicide Risk Screening Tool

The Ask Suicide-Screening Questions (ASQ) is a free resource for emergency departments, inpatient medical/surgical units, and outpatient clinics or primary care units by the National Institute of Mental Health (NIMH). This four-question tool takes about 20 seconds to administer[39]:

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?*

In addition to the screening tool, the NIMH designed a script for nursing staff that introduces the screening tool as well as what to say if a risk for suicide is identified. The script is located along with the tool on the following website: https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

The Patient Health Questionnaire 2

The Patient Health Questionnaire 2 (PHQ-2) is designed to screen as a first step approach for depression in the primary healthcare setting. The PHQ-2 is a simple tool containing two questions, enhancing routine inquiry about depression, the most prevalent and treatable mental disorder in the primary care setting. The PHQ-2 questions are the first two questions of the PHQ-9 tool[40]:

"*Over the past 2 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 indicates the frequency in which they experience these prompts on a 4-point scale of 0 ("Not at all"), 1 ("Several days"), 2 ("More than one-half of the days"), and 3 ("Nearly every day")[40]. One concern about this approach is that a patient may answer 'no' to the two questions but still have suicidal thoughts. Organizations should consider adding an additional question to the PHQ-2 assessing suicide risk, such as "Over the past 2 weeks, have you been bothered by: Thoughts you may want to kill yourself or have you attempted suicide?" Individuals who screen positive on the PHQ-2 need to be further evaluated with the PHQ-9 to determine their risk for a depressive disorder[40]. View the PHQ–2 at https://www.med-iq.com/files/noncme/material/pdfs/LI042%20IG%20tools.pdf

The Patient Health Questionnaire 9

The Patient Health Questionnaire 9 (PHQ-9) is a multipurpose tool for screening, diagnosing, monitoring, and measuring the severity of a patient's depression in the primary healthcare setting[41]. The tool rates the frequency of symptoms and then factors into the scoring severity index. The survey asks nine questions about depression and suicidal ideation over the past two weeks.

Question 9 on the tool screens for the presence and duration of suicide ideation. A follow-up questionnaire on the PHQ-9 assigns weight to the degree that the depressive problems are affecting the patient's level of function. The PHQ-9 is easily completed by the patient and quickly scored by the healthcare provider. It can be used repeatedly to determine improvement or worsening of depression in response to treatment.[41] View the PHQ -9 at https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf.

Suicide Assessment Five-Step Evaluation and Triage

The Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) interview contains more extensive items that may yield more detailed information about a patient's suicide risk.[40] This screening tool may be more useful in an outpatient behavioral health setting. It consists of the following five steps[42]:

1. Identify risk factors (suicidal behavior, current/past psychiatric disorders, key symptoms, family history of suicide, stressors, change in treatment, access to firearms)
2. Identify protective factors (both internal and external factors)
3. Conduct suicide inquiry

- Ideation: frequency, intensity, duration in the last 48 hours, past month, and worst ever
- Plan: timing, location, lethality, availability, preparatory acts
- Behaviors: past attempts, aborted attempts, rehearsals, non-suicidal self-injurious actions
- Intent: extent to which the patient expects to carry out the plan and believes the plan to be lethal versus self-injurious. Explore ambivalence of reasons to die versus reasons to live.

4. Determine the risk level of suicide with the appropriate intervention
5. Document the risk level, rationale, treatment plan, and a follow-up plan.

View the SAFE-T Pocket Card at https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432

Patient Safety Screener 3

The Patient Safety Screener 3 (PSS-3) is a three-item screening tool used in acute care settings where patients remain under constant care (Table 4).[43] It has been validated for use in the emergency department for patients 18 years and older and can be administered to all patients, not only those with a risk of suicide.

The PSS-3 is interpreted as follows[43]:

- Yes to question 1. This indicates depressed mood.
- Yes to question 2. This indicates active suicidal ideation.
- Yes to question 3. This indicates a suicide attempt.

Table 4. Patient Safety Screener

Over the past two weeks,	
…have you felt down, depressed, or hopeless?	— Yes. — No. — Patient unable to complete. — Patient refused.
…have you had thoughts of killing yourself?	— Yes. — No. — Patient unable to complete. — Patient refused.
In your lifetime,	
…have you ever attempted to kill yourself?	— Yes. — No. — Patient unable to complete. — Patient refused. — If yes, when did this happen? — Within the past 24 hours (including today). — Within the last month (but not today). — Between one and six months. — More than six months ago. — Patient unable to complete. — Patient refused.

View the Patient Safety Screener 3 (PSS-3) at https://sprc.org/micro-learning/the-patient-safety-screener-a-brief-tool-to-detect-suicide-risk

Columbia-Suicide Severity Rating Scale (C-SSRS)

The C-SSRS is one of the most used screening tools. This tool assists the screener in determining whether someone is at risk for suicide, the severity or imminence of that risk, and what level of support the individual needs. The screener will ask the individual if and when they have thought about suicide; which actions they had taken to prepare for suicide and when; and if and when they attempted suicide (whether it was interrupted or if they stopped on their own). Individuals and organizations establish criteria or thresholds that determine what steps need to be taken following the screening. A crisis plan and referral options are a part of the follow-up. The scale, as well as training on how to use the tool, is available free of charge for use in the community and healthcare settings and is available in 140 languages.[44] View the Columbia-Suicide Severity Rating Scale (C-SSRS) tool at https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/

Beck Depression Inventory-II (BDI-II)

The BDI-II depression screening evaluates the individual's characteristic attitudes and symptoms of depression over the previous two-week period.[45] The tool is widely used and has been validated for use with both adults and adolescents.

Beck Scale for Suicidal Ideation (SSI)

The SSI tool measures active and passive suicide desires and preparation steps that may have been taken.[45] Any positive responses indicate the need for further detailed questioning.

Beck Hopelessness Scale (BHS)

The BHS tool takes about five minutes to complete and is based on pessimism, hopelessness, and suicidal risk.[45] Hopelessness is a strong predictor and is a stronger indicator than the severity of depression. If the screening indicates a risk for hopelessness, the provider should conduct a more detailed suicide assessment. Unlike a screening, a full suicide assessment requires a skilled professional who has additional training for assessing at-risk individuals.

Using a tool is only half the assessment process. The evaluator must use the information from the screening and assessment tools, as well as the words, gestures, and non-verbal behavioral information from the individual, to evaluate the information and determine the individual's level of risk for carrying out the suicide action.

Suicide Assessment

A suicide assessment is a more comprehensive evaluation than screening and is performed by a clinician to confirm suspected suicide risk, estimate the imminent danger to the patient, and decide on a course of treatment. Although assessments can involve structured questionnaires, they also can include a more open-ended conversation with a patient and/or friends and family to gain insight into the patient's thoughts and behaviors (e.g., related to depression, suicide), risk factors (e.g., access to lethal means or a history of suicide attempts), protective factors (e.g., immediate family support), and medical and mental health history.

Establishing rapport

Establishing rapport with the at-risk individual may be the most challenging part of the assessment process. Being skilled and focused is an essential factor for the evaluator. It is important that the assessor gives the individual privacy, shows them concern, and makes them aware that they want to know what is currently happening. The act of asking about suicide can be therapeutic and can make a person feel understood, accepted, and connected to their clinician.[5]

The evaluator should use active listening and make eye contact with the individual (Table 5). Active listening is an important skill that requires time and practice. It is an essential component of a productive discussion because it allows for the respectful exchange of ideas.[46]

Here are some recommendations to improve active listening skills[46]:

- Listen to fully understand what is being said to you.
- Rephrase what you heard the person say so you can be sure you heard correctly.
- Ask questions that help you get more information (e.g., "What did you mean when you said ...?")
- Offer encouragement and support.
- Ask how the person feels. Be careful not to assume that you know how the person feels.

Structuring the assessment interview

If significant risk factors are present or any suicide warning signs are evident, the healthcare worker must conduct a suicide assessment. It is important to ask patients directly about suicide and obtain additional information from family members, friends, other clinicians, EMS personnel, and appropriate others. When conducting a suicidal inquiry, healthcare professionals must use a non-judgmental, non-condescending, matter-of-fact approach.

Individuals at elevated risk for suicide may be guarded during an interview or may respond with vague language prompting the interviewer to probe and inquire further. See Table 6 for examples of these statements as well as possible responses.

Healthcare Professional Consideration:

When assessing a patient for suicide, healthcare professionals need to demonstrate self-awareness of their emotional reactions, attitudes, and beliefs related to suicide.

BEFORE MOVING ONTO THE NEXT SECTION, PLEASE COMPLETE CASE STUDY 3 ON THE NEXT PAGE.

Understanding Levels of Suicide Risk

It is estimated that in 2019, 12 million Americans seriously thought about suicide (CDC, 2021d). Unfortunately, there is no specific way to predict who will attempt suicide, although we try and identify prognostic factors. According to the American Psychological Association (APA) , while the elderly makes up only 13% of the population, they account for 20% of individuals who die by suicide. In addition, 75% of older adults who die by suicide have seen their physician within the last month.[19]

Table 5. Active Listening Techniques[47]

Communication Blockers	Communication Enhancers
Blaming and attacking.	Asking for more information and problem solving together.
Being distracted or using other body language that is not-attentive.	Making eye contact, leaning toward the other person, giving full attention.
Dismissing or making light of someone's problems.	Showing empathy, validating the other person's feelings.
Interrupting.	Staying silent until the person is finished speaking.
Lecturing / memorializing.	Withholding judgment.
"Yes…but" statements.	"Yes…and" statements.

Note. Adapted from Tutu and Franklin: A Journey Toward Peace. (2000). PBS. https://www.pbs.org/journeytopeace/meethope/index.html[47]

Table 6. Common Individual Statements and Appropriate Responses[48]

The Individual's Statement	Possible Responses
Everyone will be better off without me.	Who would be better off? What would be better for those people? Where are you planning to go?
I just can't bear it anymore.	What is so hard to bear? What would make your life better? When did you begin to feel this way?
I just want to go to sleep and not deal with anything again.	What do you mean by "sleep?" What is it that you don't want to deal with anymore?
I want it to be over.	What is it that you want to be over? How can you make it be over?
I won't be a problem much longer.	How are you a problem? What is going to change in your life so that you won't be a problem any longer? When will you no longer be a problem?
Things will never work out.	What can you do to change that? What, then, do you propose to do?
It is all so meaningless.	What would make life more meaningful? What are some aspects of your life that make it worth living? What is happening in your life that makes it so meaningless?

Note. Adapted from Videbeck, S. L. (2017). Psychiatric-mental health nursing (7th ed.). Philadelphia, PA: Wolters Kluwer.[48]

Case Study 3

Instructions: Spend 5-10 minutes reviewing the case below and considering the question and disscusion that follows.

While working an evening shift in the Emergency Department, your next patient, Cindy, presents with a chief complaint of "Headache". While reviewing the chart, you noticed that during the suicide screening done at triage, the patient answered "Yes" to the question, "Over the past two weeks have you had thoughts of killing yourself?" Upon review of Cindy's records, you note that she has had a dozen visits for non-specific complaints like "weakness", "back pain", and "headache." Entering Cindy's room, you notice that she maintains little eye contact.

1. **What are some elements of Cindy's case that would increase your concern about her? Consider ways you might approach her to adequately evaluate her risk for suicide.** _____

Discussion: After evaluating her headache complaint, you ask "What did you mean when you stated you had thoughts of killing yourself?" You sit down, giving her your full attention. Although initially reluctant to explain, your empathetic yet persistent tone reassures her that assistance is available. She shares that she is severely depressed and has planned in the past to hang herself because she cannot bear the pain any longer. You persuade her that speaking with a mental health professional will help her start healing, and contact the psychiatrist on duty to perform a suicide assessment.

In recognizing the risk to all age groups, it is imperative that healthcare workers accurately assess for suicidal ideation. To do this, healthcare workers must:

- Identify individual risk factors.
- Use appropriate screening and/or assessment tools to determine suicide risk.
- Identify levels of risk.

Healthcare workers must be aware of risk factors that make a person vulnerable to suicidal ideation (SI). Suicidal thoughts and behaviors are linked to many different circumstances, including illness and life stressors—notably periods of crises, such as illness, chronic pain, financial stress (particularly sudden financial stress or loss, compared to chronic poverty), and relationship breakups.[15,19]

According to the WHO, the strongest predictor of suicide is one or more previous attempts.[7] Suicide and mental disorders, such as depressive disorders and substance use disorders, have been well-established as linked to death by suicide, particularly in high-income countries. Alcohol consumption is a significant risk factor associated with suicide and has been identified as the fifth-leading worldwide risk for disability-adjusted life year (DALY), a time-based measure that combines years of life lost due to premature mortality and disability. It remains the leading risk factor for suicide among individuals between the ages of 14 and 49 years.[15]

Often, patients who have attempted suicide are discharged with no community support or appropriate follow-up, making them vulnerable to reattempting suicide. In low-resource settings, geographic inaccessibility to healthcare facilities and the absence of trained professionals have been identified as potential obstacles.[15]

Evidence-Based Practice

A history of a previous suicide attempt places an individual at high risk for suicide and is the strongest predictor of suicide. A study examining medical records from 1987 to 2007 identified 1490 individuals with a first suicide attempt reaching medical attention. More than 59% died immediately from the first suicide attempt, and amongst those who survived, 85% killed themselves within one year.[2]

Classifying risks

There are various ways of classifying specific levels of risk. Zero Suicide identifies three levels of risk within the two categories of acute and chronic: low, intermediate, and high. The following algorithm to help clinicians identify and understand levels of risk based on acute or chronic SI (Table 7).[49]

Appropriate actions for different levels of risk

Zero Suicide offers the following guidelines for specific actions according to their respective levels of risk (See Table 8 on the next page).[49]

PLEASE COMPLETE CASE STUDY 4 ON THE NEXT PAGE.

Table 7. Levels of suicide risk

Acute	Chronic
High risk: Patients have suicidal ideation with the intent to die by suicide. They are unable to maintain safety without external support.	**High risk:** Patients with chronic suicidal ideation and an increase or change in baseline mood, behavior or talk about suicide/dying.
Intermediate risk: Patients have suicidal ideation, but no intent based on identified reasons for living (ie children) and ability to follow a safety plan and maintain safety. Preparatory behaviors are likely absent.	**Intermediate risk:** Patients with chronic suicidal ideation but have protective factors, coping skills, reasons for living and psychosocial stability suggesting the ability to endure future crisis without resorting to suicide.
Low risk: Patients are identified to be at low risk if they have suicidal ideation, but do not currently have a plan for suicide or suicidal behaviors. Another feature is collective high confidence (from patient, care provider, family member) in the ability of the patient to maintain safety independently.	**Low risk:** Patients with chronic suicidal ideation but have abundant strengths and resources. The following is generally NOT present: history of self-directed violence; chronic SI; highly impulsive; risky behaviors; marginal psychosocial functioning.

Note. Adapted from Zero Suicide. (2019). Therapeutic risk management – Risk stratification table.[49] https://zerosuicide.edc.org/sites/default/files/Risk%20Stratification%20Table%20MCHGM.pdf

Table 8. Actions according to level of suicide risk	
Acute	**Chronic**
High risk: Requires psychiatric hospitalization to maintain safety. These patients need to be observed on a secure unit and kept in an environment with limited access to lethal means.	**High risk:** These individuals require a calculated risk assessment; routine mental health follow ups; a safety plan; routine suicide risk screening; coping skills building; management of co-occurring psychiatric disorders, and evidence-based treatment for suicide.
Intermediate risk: Consider psychiatric hospitalization if related risk factors are responsive to inpatient treatment (i.e., psychosis). If patients are treated in an outpatient setting, there should be increased contact; regular re-assessment of risk; a safety plan in place.	**Intermediate risk:** These individuals require routine mental healthcare to maintain or enhance coping skills and protective factors; a safety plan; management of co-occurring psychiatric disorders, and evidence-based treatment for suicide.
Low risk: Outpatient treatment should include behavioral health services and a well-articulated safety plan.	**Low risk:** These individuals may seek treatment on a regular or an as needed basis. Some may be managed in primary care.
Note. Adapted from Zero Suicide. (2019). Therapeutic risk management – Risk stratification table.[49] https://zerosuicide.edc.org/sites/default/files/Risk%20Stratification%20Table%20MCHGM.pdf	

Case Study 4

Instructions: Spend 5–10 minutes reviewing the case below and considering the questions and discussion that follow.

(Rationale and discussion is displayed at the bottom of this exercise)

Mrs. B. is a 35-year-old married woman with two children (ages 10 and 15). She presents for an annual checkup at her primary care physician. She appears uncomfortable and refuses to make eye contact with the front desk nurse, with whom she is usually friendly. She has been seeing Dr. Duke, but she is scheduled to see his partner, Dr. Cook, this afternoon because Dr. Duke is on vacation. Dr. Cook's nurse, Joan, notices that Mrs. B. is not her usual self and appears "out of it" today and is somewhat irritable. She seems to have burn marks on her arms but is wearing a long-sleeved shirt and dismisses the marks saying: "I burned myself on the oven." When asked by the nurse, Mrs. B denies suicidal ideation; however, there was no additional follow-up with a screening or assessment tool to determine the appropriate level of risk. Mrs. B reports to the nurse that she has not been sleeping, doesn't have much appetite, and is struggling to get her husband to understand her needs "since he is so busy with his job and an affair" and her parents have moved 500 miles away. Mrs. B. has a history of depression diagnosed as postpartum depression after her second child was born. Her second child is now 10 years old, and she has no documented depressive symptoms. Of note, during the postpartum period, she had one suicide attempt. Dr. Cook is extremely busy today, and when Joan brings up Mrs. B.'s apparent depressed mood to his attention, he is extremely dismissive and remarks that her history of depression and prior suicide attempt was a thing of the past. Two weeks later, Mrs. B. is found by her older son after attempting to hang herself. She was admitted to the intensive care unit at the local hospital.

1. **Based on the information provided, Mrs. B. falls into the following category of risk:**
   - A. Low risk.
   - B. Moderate risk.
   - C. High risk.
   - D. None of the above.

2. **Which of the following is the strongest predictor of Mrs. B.'s current suicide attempt?**
   - A. Postpartum depression.
   - B. Previous suicide attempt.
   - C. Isolation.
   - D. Being married.

3. **Mrs. B. came to see her primary healthcare provider for her annual checkup. Based upon the previous reading, what percentage of individuals see their primary healthcare provider within one year of a suicide attempt?**
   - A. 80%.
   - B. 55%.
   - C. 65%.
   - D. 35%.

Rationale for Question 1: Patients at high risk most likely have a suicide plan with preparatory or rehearsal behavior.

Rationale for Question 2: While her history of postpartum depression and isolation are concerns that she may attempt suicide, the previous suicide attempt is the strongest predictor for the current suicide attempt.

Rationale for Question 3: According Schreiber and Culpepper2, 80% of individuals who die by suicide have had at least one contact with their primary healthcare provider within one year of dying by suicide.

Case Study 4 (Continued)

Discussion: Upon reviewing Mrs. B.'s history, the attending physician noted that she had reported that her husband had been engaged in an extramarital affair three months earlier. Mrs. B provided several "hints" in her discussion with the nurse, which were not included in her chart, and they included: her parents' relocation, lack of time spent with husband /affair of her husband, isolation, lack of sleep, and poor appetite. She had tried to cope with these stressors on her own, and although she saw a counselor monthly, she intentionally kept that information from the counselor at her last visit two months prior. Also, she had canceled her last two counseling sessions but did call a suicide hotline three weeks before her attempted suicide. The suicide hotline tried to follow up and check in with her, but she was dismissive and refused to take their calls. In addition to her primary care physician, she saw her gynecologist four weeks before her suicide attempt. Her gynecologist noticed that she was not her usual self, but when she pressed her, Mrs. B. reported that her therapist was adjusting her antidepressant dose and that she would be fine in a few weeks.

In conclusion, Mrs. B. had four interactions with healthcare professionals within the three months leading up to her suicide attempt. Although two of those providers recognized a change in her presentation, they did not fully appreciate the severity of her distress. The challenge with caring for patients who see multiple providers is that communication among providers in different health systems can be highly challenging. Often, providers have to rely on the patient's self-report for accurate communication of updates and pertinent findings.

In retrospect, her son—who knew that his mother had previously attempted suicide —was aware that she had contacted the suicide hotline before her second attempt, but he did not want to betray her confidence by reporting his suspicion to anyone who could have potentially intervened. Clearly, there is a need for continued education regarding mental illness and how it affects families. Also, patients with children who are old enough should be encouraged to share their diagnosis with families and encourage their families to use a support system as much as they feel comfortable.

Lastly, the nurse could have been more proactive and screened Mrs. B. for suicidal ideation and intent during her last visit. She had some context and a better understanding of Mrs. B.'s history than the physician filling in. She chose to defer to Dr. Cook's authority and failed to act on her clinical judgment. In addition, she could have reported her suspicions to Dr. Duke when he returned from his vacation four days after her visit.

Documentation

Careful documentation of assessing and managing a patient's illness is part of legal and ethical psychiatric care.[50] It also allows communication about changes of a patient's risk level that can inform their treatment plan.[5]

Documentation of Risk Assessment

Documentation must be thorough and objective. Healthcare providers should never express opinions or make judgments, such as, "Patient is completely irrational." Instead, inputting the patients' exact words in quotation marks (e.g., Patient states, "You are the ones who are crazy, and I am going to kill myself to get away from everyone and everything.") is recommended.

Sadek details the important components of documentation, which includes[50]:

- The date of an assessment.
- The reasons for the assessment.
- Risk factors for suicide.
- Protective factors that may reduce suicide risk.
- The patient's suicide risk level.
- Basis for the risk level and plan.
- Action taken regarding firearms and other means of suicide.
- The steps put in place given the patient's specific constellation of risk and protective factors.
- Contact details for the patient, relatives, and treating professionals.

Documentation is a clinical tool critical to the initial assessment and periodic reassessment informed by the patient's risk level. Because risk fluctuates over time, suicide assessment should not be seen as a one-time, isolated event. If an individual is determined to be at elevated risk for suicide, appropriate consultation, referral, and follow-up is important to continue to monitor across time.

Healthcare Professional Consideration:

When documenting a patient's risk for suicide, the healthcare professional should also document their communication to the treatment team and appropriate persons (i.e., on-duty doctor, nursing supervisor).

Treatment and Management of Suicide

The treatment and management of suicide are complex, and clinicians must develop a biopsychosocial treatment plan which is critical for the appropriate management of patients at elevated risk for suicide. A thorough biopsychosocial assessment can help inform the healthcare worker's conceptualization and facilitate a discussion on social support resources available to the patient. Under some circumstances, it can be beneficial for the healthcare worker to include family members or other supportive resources in the patient's treatment plan.

Patients seen in any medical setting who present as imminent harm to themselves or others must be immediately referred to a psychiatrist, psychologist, or other qualified healthcare provider. As an example, first responders and emergency room staff should be appropriately trained to care for patients at elevated risk for suicide. An empathic approach is indispensable in this case. Emergency room staff and first responders must be aware of any biases toward persons living with suicidal thoughts or behavior, including religious or philosophic beliefs, lack of formal psychiatric training, or limited resources, including time or staffing shortages. The challenge is identifying patients safe enough to be discharged without hospitalization in an emergency setting. Some emergency departments have mental health professionals on call to help evaluate patients identified as at risk of suicide and determine those safe enough to return home.[51]

When an individual attempts suicide, medical stabilization at a hospital is the priority. If the patient experiences physical trauma, the appropriate surgical service should be contacted. If the attempt involves drug ingestion, the patient must undergo detox and receive antidotes.[5]

Levels of Care

There are four levels of care for a patient with varying levels of suicidality as it pertains to ideation, plan, intent, preparatory behaviors, and previous attempts[5]:

- Outpatient.
- Intensive outpatient program.
- Partial hospital program.
- Inpatient hospitalization.

Outpatient Treatment

The appropriateness of outpatient treatment is contingent on a thorough assessment of a patient endorsing suicidality to include current stressors in a safety plan. Patients who are eventually discharged from the inpatient setting must have an appropriate outpatient follow-up with mental health providers.[51] Follow-up should be set up as soon as possible, within a few days of discharge. Given that compliance with follow-up appointments may be low, family members' use in helping patients comply is greatly encouraged. Family members and friends can also be engaged to help reduce a patient's access to lethal means of suicide. Particular attention should be paid to the patient's documented suicide plan, and appropriate interventions should be implemented. These strategies include removing potential means of suicide from the home—guns, medications, or other toxic substances—as appropriate. Finally, proper documentation of the patient's progress in the inpatient setting will help guide and inform decisions in the outpatient setting.[51]

Treatment of patients at risk for suicide should be chosen based on their underlying mental illness and the manifestation of suicidal behaviors.[51] For example, chronic suicidal behaviors should be treated with interventions based on psychotherapy, whereas acute suicidal behaviors should be treated with more aggressive interventions (i.e., increased frequency of therapy and/or psychopharmacologic medications).

Partial Hospitalization and Intensive Outpatient Care

Partial hospitalization programs (PHPs) and intensive outpatient programs (IOPs) are structured mental health treatment programs that are a step down from 24-hour care in an inpatient hospital. The main difference between PHPs and IOPs is the length of time. Partial hospitalization programs are at least four hours a day and at least five days a week; IOPs are a few hours per day and a few days per week. Patients who have an elevated risk of suicide that is not imminent but require aggressive treatment would benefit from these programs.[51]

Inpatient Hospitalization

Any patient at imminent risk for suicide, including a recent suicide attempt, should be referred to psychiatric inpatient hospitalization. Inpatient care offers medically supervised care in a hospital setting 24 hours a day, seven days a week, and an average stay for a patient usually ranges from 48 hours to ten days.[4] The goal of inpatient hospitalization is to conduct an evaluation, initiate therapy and/or medications, and stabilize the patient until they are safe and eligible for a lower level of care.[2]

Factors that can place a patient at high risk of suicide include[2]:

- Suicide attempt with a highly lethal method (firearm or hanging).
- Suicide attempt that includes steps to avoid detection.
- Ongoing moderate-severe suicidal ideation or disappointment that a suicide attempt was not successful.
- Inability or reluctance to honestly discuss the suicide attempt and what precipitated it.
- Inability or reluctance to openly discuss safety planning.
- Lack of alternative interventions for monitoring and treatment.
- Agitation.
- Hopelessness.
- Impulsivity.
- Poor social support.
- Psychiatric disorders: anxiety disorders, bipolar disorder, personality disorder, PTSD, psychotic disorders, and substance use disorders.

If a patient cannot be immediately hospitalized in a psychiatric inpatient unit, they should be kept in a room where all sources of potential harm are removed, and a staff member should be providing constant supervision.[2] Patients identified with suicidal thoughts and behaviors in most clinical settings are assigned a dedicated "safety attendant" to watch them. This intervention often decreases the need for restraints for most patients. The use of family members is highly discouraged because family members may connive with patients to make plans to leave against medical advice or violate a legal hold, or if they see a patient leaving, they may not try to stop them.[53] Security staff may be necessary if the patient insists on leaving.[2]

Mechanical and chemical restraints should be used judiciously in suicidal patients. The use of restraints should be minimized when possible. However, the use of restraints may be essential and potentially lifesaving for situations wherein the patient is combative or otherwise uncooperative. All restrained patients must be assessed per hospital protocol. Often, documentation of the neurovascular status of the restrained patient must be performed. Finally, a re-evaluation of the need for restraints should be performed per hospital protocol.[51]

If the patient needs to be transferred to a hospital on a psychiatric hold, an ambulance should be used, and the paramedics should be aware of the suicide risk.[2]

Involuntary Hospitalization

If a patient refuses to be hospitalized despite being a risk to themselves or others, involuntary hospitalization may be necessary. The process of committing a patient to hospitalization varies from state to state in the U.S.[2] If a patient is admitted involuntarily, they maintain autonomy to consent for treatment. The only medications that can be administered without consent are those that are required to stabilize the patient during a behavioral crisis. If other medications are deemed necessary, a clinician must obtain court-ordered treatment.[2]

Transition from Inpatient to Outpatient Care and Continuity of Care

In the U.S., one out of seven people (or 14%) who died by suicide had contact with inpatient mental health services in the year before their death (National Action Alliance for Suicide Prevention, 2019). The transition from inpatient to outpatient behavioral care is a critical time for patients who are at risk for suicide. In the month after a patient is discharged from inpatient care, the suicide death rate is 300 times higher (in the first week) and 200 times higher (in the first month) than the general population. The suicide risk remains high for up to three months, and sometimes up to a year, after discharge.[4]

The following evidence-based recommendations guide care for an individual with elevated suicide risk during the transition from inpatient to outpatient care[4]:

- **Work as a collaborative team.** Both inpatient and outpatient teams should work as a unified team and employ a patient-centered approach that involves the providers, the patient, and the family. This collaboration can help patients navigate the gap between care settings.
- **Cultivate human connection.** Encourage contact between the outpatient provider and the patient prior to discharge. Make use of certified peer specialists and others who have lived experiences to support both the patient and the family.
- **Build bridges.** Establish and follow protocols to triage appointments and arrange for rapid referrals for patients. Write formal agreements between inpatient and outpatient provider organizations to clarify their roles, responsibilities, and commitments to rapid referrals. Develop strategies for narrowing the gap in the care transition. Lastly, maintain good communication between organizations to provide optimal patient care.

Recommendations for Inpatient Providers

Due to the nature of increased suicide risk following an inpatient discharge, it is crucial that patients receive an outpatient appointment or other mental health services as soon as possible after discharge. Prior to discharge, inpatient providers should do the following[4]:

1. **Develop relationships, protocols, and procedures for safe and rapid referrals.**
   - **Begin discharge planning upon admission.** Discharge planning begins within 24 hours of admission and sets an expectation that hospitalization is a brief period of treatment, and that post-discharge care will be needed.
   - **Develop collaborative protocols.** Work with outpatient organizations to ensure a safe and rapid referral post-discharge.
   - **Negotiate a memorandum of understanding (MOU) or memorandum of agreement (MOA).** Partner with an outpatient organization and write a formal agreement detailing care coordination expectations. These partnerships are the key to developing a smooth transfer with minimal barriers.
   - **Electronically deliver copies of essential records.** Send the following information to the outpatient provider: current course of illness and treatment; transition/discharge plans; treatment plans; medication list; crisis/safety plan; release of information; and emergency contacts list. Send the records at the time of discharge.
2. **Involve family members and other supports.**
   - **Encourage family participation.** Family members and other individuals (relatives, spouses, partners, friends) can provide a source of support for the patient upon discharge. Providing education to these supports can increase the efficacy of the support network for the patient.

- **Include peer specialists.** Certified Peer Specialists offer unique support due to their own personal experience with managing their own mental health challenges and can connect with the patient and provide additional social and emotional support, answer questions about post-discharge life, and offer hope for recovery.
- **Engage school and community support.** For children, reach out to the school counselor or school psychologist to discuss support resources and safety needs at school.

3. Collaboratively develop a safety plan.
   - **Work collaboratively.** Work with the patient and their family members and supporting community to develop a patient safety plan. Ensure that staff has the training to develop safety plans with the patient. Specific to children, with consent, share the safety plan with the school counselor.
4. Connect with the outpatient provider.
   - **Schedule an outpatient appointment.** Secure an outpatient appointment ideally within 24-72 hours after discharge, but no later than seven days after discharge. Identify any potential barriers to attending the appointment prior to discharge (e.g., transportation, childcare, housing, insurance, additional time away from work).
   - **Offer step-down care.** Some patients may benefit from an intermediate level of care in a less restrictive environment but with more frequent services than offered in outpatient care (e.g., IOPs and PHPs).
   - **Partner with the outpatient provider.** Complete any necessary release documents and speak directly to the outpatient provider. Provide background on the patient's presenting problem, course of treatment, details of the safety plan. A short conversation with the outpatient team prior to discharge can build a bridge across services. This initial contact can be in-person, over the phone, or via videoconferencing.
   - **Connect the patient with the outpatient provider.** Arrange an in-person meeting or a video conference to allow a therapeutic alliance to begin prior to discharge.

After discharge, inpatient providers should follow up with the patient and outpatient provider. A recently discharged patient should receive a phone call within 24 hours to assess the patient's recovery, and communication should be maintained until the patient's first outpatient appointment to ensure bridge support.[4]

Recommendations for Outpatient Providers

A patient discharged from a psychiatric inpatient unit may be referred to a clinic, mental health center, day treatment program, or private practice. Before discharge from the inpatient setting, the provider should connect with the patient to build a therapeutic alliance. This pre-discharge contact triples the odds of a patient engaging in outpatient services post-hospitalization. The following are steps an outpatient provider should follow prior to their patient being discharged[4]:

1. Develop relationships, protocols, and procedures that allow for safe and rapid referrals.
   - **Establish relationships through effective communication.** Cultivate a relationship with inpatient facilities to ensure smooth transitions for future patients.
   - **Establish policies and procedures.** Review policies and procedures for referral acceptance and triage appointments. A patient's heightened risk for suicide in the first week after discharge prioritizes them for an intake appointment.
   - **Accept shared responsibility.** Work with the inpatient facility, the patient, and their family to coordinate a safe and effective care transition.
   - **Negotiate a memorandum of understanding (MOU) or memorandum of agreement (MOA).** Work with inpatient facilities to ensure timely communication and promote the release of records for care continuity.
   - **Obtain copies of essential documents.** Obtain releases of information, transition plan, treatment plans, medications, and collaborative crisis/safety plan
   - **Arrange a conference call.** Schedule a call with the inpatient providers in order to gather as much information as possible prior to your patient intake.
   - **Train all staff.** Staff members can influence a patient's impression of the outpatient office. Greeting patients with compassion and warmth will help the patient feel more comfortable and can influence the patient's willingness to engage in treatment.

2. **Reach out to their family members or other supports**
   - Meet the patient and family members at the inpatient psychiatric setting. If an in-person meeting with the patient is not feasible, consider connecting through telemedicine. At a minimum, call the patient prior to discharge to begin fostering a therapeutic alliance.

After discharge, an outpatient provider may contact the patient by phone if the initial appointment is not within 24 hours. Following up by phone following discharge can be helpful to confirm the intake appointment, re-assess suicide risk, and build rapport. It is also important to involve family members and other supports by providing psychoeducation and community resources. A healthy family support system improves the health and well-being of the patient.[4]

Pharmacotherapy

Each patient should be individually assessed to evaluate the discharge environment for safety. In these circumstances, psychopharmacologic interventions are often employed. If psychopharmacologic interventions are used for patients discharged home, the patient and family members must understand the possible side effects associated with the drugs being administered, especially the use of antidepressants in patients who are depressed and suicidal.[51]

Antidepressants

Several studies using randomized controlled trials have shown that the treatment of depression using drug therapy, such as antidepressants, has been associated with decreased suicidal ideation in individuals of ages 25 years and older.[51] Some studies suggest that the use of selective serotonin reuptake inhibitors (SSRIs) (i.e., Lexapro, Prozac) results in a more significant reduction of suicide ideation compared to selective serotonin and norepinephrine reuptake inhibitors (SNRIs) (e.g., Cymbalta, PRISTIQ) or norepinephrine-dopamine reuptake inhibitors (NRDIs) (e.g., Wellbutrin)[51]. Interestingly, in patients younger than 25 years old, antidepressant therapy has not been shown to decrease suicidal ideation and behaviors, although it does reduce signs and symptoms of depression.[51]

Black box warning of increased SI on antidepressants.

In 1999, concerns were raised about antidepressants causing suicidality (Rush, 2021). There were concerns about patients developing intense suicidal ideation while taking fluoxetine (Prozac) as prescribed. In response to these concerns, the manufacturer conducted a meta-analysis of 3,065 patients and found no significant difference in suicidal behavior in patients taking fluoxetine versus placebo.[52]

In 2003, similar concerns re-emerged as the United States Food and Drug Administration (FDA) issued a warning regarding the risk of increased suicidality associated with antidepressant use in young people under 26 years of age seen in clinical trials. In 2005, The FDA issued another warning about suicidality in adults being treated with antidepressants.

In 2007, the FDA did not advise withholding antidepressants for approved indications, but they did emphasize the following[52]:

- Individuals 18 to 24 years old should be informed of the risk of developing suicidality when initiating antidepressant treatment (usually in the first one to two months).
- Clinicians should monitor patients closely during antidepressant treatment.
- Depression and other psychiatric conditions are themselves associated with an increased risk of suicidality.

There is no clear evidence that antidepressant use in patients with depression symptoms increases the risk of suicidality in adults. Some trials show a negative association between antidepressant use and suicide attempts. On the other hand, evidence strongly suggests an age-specific effect of antidepressants and suicidality. Among young adults, adolescents, and children, the onset of suicidality is greater when compared to placebo, especially during the few weeks of psychopharmacological treatment. However, it is important to weigh the small risk of suicidality against the risk of suicidality with untreated depression.[52]

Lithium

For patients with unipolar depression or bipolar and related disorders, maintenance treatment with lithium has been shown to prevent suicide. The exact mechanism of action through which lithium works to reduce suicidal behaviors remains unknown; however, it has been theorized that it may function by reducing mood disorder episodes or by decreasing impulsive and aggressive behaviors.[2]

Evidence-Based Practice:

Buprenorphine, the treatment for opioid use disorder, is currently being investigated as a treatment for severe suicidal ideation. A four-week randomized trial compared adjunctive buprenorphine with a placebo in 62 patients with severe suicidal ideation. The patients had various diagnoses (unipolar major depression, borderline personality disorder, adjustment disorder) and were treated with antidepressants and/or benzodiazepines. The study found an improvement in suicidal ideation with adjunctive buprenorphine that was independent of treatment with antidepressants.[2]

Overdose Concerns with Medications

Of note, tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) may be lethal if taken in high doses and thus should be avoided in patients at risk for suicide. In addition, the SNRI venlafaxine may be dangerous in overdose and should be avoided. By contrast, SSRIs are generally safe in overdose and should be the first-line treatment in patients with thoughts and behaviors of suicide.[2] While acute toxicity is believed to be less severe in the setting of SSRI overdose compared to TCAs and MAOIs, fatal overdose and successful suicide attempts have been reported with SSRIs.[53]

Suicide management strategies include non-pharmacologic interventions, such as individual psychotherapy, behavioral therapy, family therapy, and cognitive therapy. The following are proven psychotherapies for treating patients with thoughts and behaviors of suicide: cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), collaborative assessment and management of suicidality (CAMS), and problem-solving therapy (PST), and attachment-based family therapy (ABFT).

Many psychotherapies are rooted in the principle that the therapist is an empathic partner who forms a strong alliance with the patient and acknowledges the patient's suicidal thoughts and behaviors as a response to pain or distress. The following components are necessary for any approach to treating suicidal thoughts or behaviors[54]:

- **Lethal means reduction:** This is one of the most important interventions to reduce suicide attempts. It is vital to assess a patient's access to firearms or other lethal means and to work with them to restrict access to those means.
- **Safety planning:** This strategy involves a plan to keep a patient safe until skills can be learned or other solutions put into place.
- **Developing reasons for hope**: Many treatments approach patients with thoughts and behaviors of suicide by managing hopelessness. The goal is to connect patients to core values and attachments that inspire them to manage their current pain.
- **Inspiring delay:** Generally, the impulse to engage in suicidal behaviors is fleeting. By having the patient delay action on the impulse, it could save their life. One strategy includes having the patient reflect on things they may miss if they die, year by year.

Psychotherapies

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) for Suicide Prevention (CT-SP) is an evidence-based cognitive-behavioral treatment for adults with suicidal ideation and behaviors. Although this protocol was initially developed for patients who had recently attempted suicide, it has applications for patients who are more acutely suicidal. The CT-SP treatment is based on the cognitive-behavioral theory that a person's biopsychosocial vulnerabilities can interact with suicidal thoughts and behaviors to produce a "suicide mode".[55] By targeting those suicide-related thoughts and behaviors, suicide risk can be decreased.

Dialectical Behavior Therapy

Dialectical Behavioral Therapy (DBT) was initially developed to treat patients diagnosed with borderline personality disorder who are also chronically suicidal. It is based on the biosocial theory of emotion dysregulation. Dialectical Behavioral Therapy promotes the belief in one's own ability to succeed, the ability to emotionally self-regulate, and interpersonal effectiveness.[56]

Its cornerstone is the idea that patients must build a life worth living, even if they have many problems in their life and wish to die.[54]

Collaborative Assessment and Management of Suicidality

Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based suicide-focused treatment that quickly reduces suicidal ideation in six sessions, lowers distress and hopelessness, improves hope, and improves clinical retention to care. The therapist and patient work closely to keep the patient stable and identify "drivers" that compel the patient to take their life.[57]

Problem-Solving Therapy

Problem-Solving Therapy (PST) is a brief, evidence-based approach that teaches and empowers patients to solve their here-and-now problems contributing to their depression and helps increase their self-efficacy. It is effective with a majority of the population, including people from different cultural backgrounds.[58]

Attachment-Based Family Therapy

Attachment-Based Family Therapy (ABFT) is a family therapy model designed to treat family and individual processes associated with adolescent suicide and depression.[59] Based on interpersonal theories, adolescents' depressive symptoms and suicidality can be exacerbated or buffered against by the quality of interpersonal relationships with families. Attachment-Based Family Therapy aims to repair attachment relationships or establish a secure base for adolescent development.

Other therapies

Non-pharmacological interventions for the treatment of suicide include electroconvulsive therapy (ECT). For severely suicidal patients, ECT provides a quick response that may be lifesaving in the short-term. The ECT treatment can be administered in an inpatient or outpatient setting but requires anesthesia and the delivery of an electric current to the brain.[10]

Some preliminary evidence has suggested that high doses of repetitive transcranial magnetic stimulation might rapidly decrease suicide ideation and suicidal behaviors. This intervention is potentially useful in emergency or crisis scenarios to expeditiously address a patient's ideations and intent[44].

Safety Planning Strategies

The first National Strategy for Suicide Prevention was put forth in 1999 by then-Surgeon General David Satcher, MD.[60] It was a landmark document that helped officially organize the strategies to prevent suicide across the country.

Since then, research and clinical evidence have continued to refine various approaches to protect at-risk individuals. Some well-known interventions are Crisis Hotlines and the use of the Safety Planning Intervention.

Crisis Hotlines

Crisis telephone helplines, or crisis hotlines, are a valuable resource in suicide prevention on a public health level. There is substantial information that helplines reduce distress and suicidal behaviors in many callers. Crisis lines, available 24 hours a day, provide immediate access to crisis intervention, particularly to those unwilling or unable to have a face-to-face interaction with a mental healthcare provider. Crisis lines, such as those in Washington State, are heavily used. Between October 1, 2014, and September 30, 2015, 46,633 calls to the National Suicide Prevention Lifeline came from individuals in Washington State. Of those 46,633 calls, 22,936 were from individuals who used the Veterans Crisis Line for help[15].

Raising awareness of such crisis resources needs to begin in K-12 schools and higher education and be displayed in multiple public locations, including billboards, public transportation, and media outlets.[15] In addition, crisis line information and materials should be available in primary health care, behavioral health care, and emergency department settings.

There are no randomized controlled trials of suicide crisis lines, partly due to the difficulty of conducting such studies ethically; however, an evaluation conducted in 2018 of the Substance Abuse and Mental Health Services Administration (SAMHSA) Lifeline found that 80% of callers interviewed six to twelve weeks after their initial call said the follow-up calls kept them from dying by suicide, provided them with hope, made them feel cared about, and connected them to other mental health resources.[61]

Crisis hotlines play a significant role in intervening during an individual's crisis. Hotlines, which provide 24-hour service with referrals and resources, have demonstrated reducing suicide attempts while connecting the individual with community resources for follow-up. Suicide hotlines provide the connectedness that research shows is an influential protective factor in preventing suicide.[15]

Safety Planning Intervention

The second highly effective approach to prevent suicide is implementing a Safety Planning Intervention (SPI). This plan is a brief 30-to-45-minute clinical intervention conducted when an individual is identified with a risk for suicide. It is a collaborative effort between a treatment provider and a patient and results in a written list of warning signs, coping strategies, and resources to use during a suicidal crisis.[62]

The premise of this intervention is that if individuals are provided tools that enable them to resist or decrease suicidal urges for brief periods, the risk for suicide is likely to decrease. The target population for an SPI evaluation is those at increased risk for suicide but do not need immediate rescue.

Patients at this level of risk may have[62]:

- History of suicidal behavior (e.g., plans/ preparations for suicide, suicide attempts, aborted attempts,).
- Recent history of SI.
- Otherwise determined to be at-risk for suicide.

This intervention aims to provide people who are experiencing suicidal ideations with a specific set of concrete strategies to use to decrease the risk of suicidal behavior. The safety plan includes a collaboratively identified coping strategy and a list of individuals or agencies that may be contacted during a crisis. It prioritizes relying on internal, individual resources and expands to include resources that include the participation of others or other external resources.[62]

In 2018, Stanley and Brown published an article in JAMA Psychiatry comparing SPI with follow-up versus usual care of a suicidal patient in the emergency department. They found that SPI with follow-up resulted in 45% fewer suicidal behaviors over a period of six months.[62]

See Table 9 for an in-depth review of each of the Safety Planning Intervention Steps.

Table 9. Safety Planning Intervention Steps

STEP	GOALS	COMMUNICATION
1. **Recognizing the warning signs of an impending suicidal crisis:**	• Identify warning signs that may indicate the beginning of worsening of a crisis. • Understand how identifying warning signs provides an opportunity to cope before acting on suicidal urges.	• Ask "What were the warning signs that you experienced during the crisis?" or "How will you know you are in a crisis and the safety plan should be used?" • If the warning signs are vague, ask the patient to be more specific so they are more likely to recommend the beginning signs of a crisis.
2. **Using your own coping strategies:**	• Explain the purpose of coping strategies is to: 1) help take the individual's mind off of their problems to prevent worsening of suicidal thoughts; and 2) prevent the individual from making a suicide attempt without contacting other people. • Help the individual recognize internal coping strategies. • Identify barriers and ways to overcome them.	• Ask "What have you done in the past to take your mind off your suicidal thoughts without contacting another person? What activities could you do by yourself to help take your mind off of your problems even if it is for a brief period of time?" • If the individual cannot think of any distracting activities, provide suggestions. • Ask "How likely do you think you would be able to do this during a time of crisis?" or "Is it feasible?" If there is doubt, ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"
3. **Contacting others in order to distract from suicidal thoughts:**	• Instruct the individual to use Step 3 if Step 2 does not lower risk. • Identify other people and social settings that provide distraction. • Obtain feedback from the individual about the likelihood of doing these activities. • Identify barriers and problem-solve ways to overcome them.	• Ask "Who can you contact who helps you take your mind off your problems or helps you feel better? You don't need to tell these people that you are feeling suicidal. We just want to identify people who can take your mind off your problems even for a brief time." • Ask, "What public places, groups, or social events help you to take your mind off your problems or help feel better?" • Ask, "Sometimes when people are feeling really upset, they don't want to talk to other people. However, sometimes just getting out and being in a place around other people can help. Can you think of places you could go where you wouldn't have to be alone?" • For each response, ask, "How likely do you think you would be able to talk with someone/go somewhere during a time of crisis?" "Is it feasible and safe?"

Table 9. Safety Planning Intervention Steps (continued)		
4. **Contacting family members or friends who may help to resolve the crisis:**	• Instruct the individual to use Step 4 if Step 3 does not resolve the crisis or lower risk. • Explain that this step involves contacting a trusted family member or friend for support. • Obtain feedback from the individual about the likelihood of doing these activities. • Identify barriers and problem-solve ways to overcome them.	• Ask "Among your family or friends, who do you think you could contact for help during a crisis?" or "Who is supportive of you and who do you feel that you can talk with when you're under stress or feeling suicidal?" • Ask, "How likely do you think you would be able to reach out to each person?" • If doubt is expressed about contacting others, ask, "What might get in the way of reaching out to this person?
5. **Contacting mental health professionals or agencies:**	• Instruct the individual to use Step 5 if Step 4 does not resolve the crisis or lower risk. • Explain that Step 5 consists of professionals who can provide assistance to the individual during a crisis.	• Ask "Who are the professionals and community workers that we should identify to be on your safety plan? • Ask, "What is the likelihood that you would contact these professionals or agencies?"
6. **Making the environment safe and reducing the availability of means to complete suicide:**	• Explain that having access to lethal means places the individual at greater risk for suicide and does not allow enough time to use the coping strategies or sources of support listed on the Safety Plan. • For each method that is identified, determine the individual's access to the lethal means and collaborate to find voluntary options that reduce access to the lethal method and make the environment safer.	• Express concern about the patient's safety and explain that making the environment safer will help to lower risk of acting on suicidal feelings. For some individuals who attempt suicide, the interval between thinking about and acting on suicidal urges is usually a matter of minutes. • For each lethal method, ask "What can we do to make the environment safer?" • Ask, "How likely are you to do this? What might get in the way? How can we address the obstacles?" • If doubt is expressed about limiting access, ask, "What are the pros of having access to this method and what are the cons? Is there an alternative way of limiting access so that it is safer?"

Note. Adapted from Stanley, & Brown (2018). The safety planning intervention to reduce suicide risk for people with SMI [PowerPoint slides]. Substance Abuse and Mental Health Services Administration.[62] *https://www.nasmhpd.org/sites/default/files/SAMHSA%20SPI%20SMI%20PPT%20final_2.pdf.*

The basic steps of SPI involve more tasks than simply completing a safety plan form. These include[62]:

- Identify and assess suicide risk.
- Obtain the patient's subjective crisis narrative.
- Provide psychoeducation around suicide and introduce safety planning.
- Identify warning signs that may indicate the beginning or escalation of a crisis and explain how to follow the steps that allow them to cope with the crisis before acting on suicidal thoughts.
- Complete the safety plan (see Figure 1 on the next page for the safety planning document).
- Implement the safety plan.
- Follow up with the patient to continuously assess their risk for suicide.

This plan should be developed collaboratively with the individual. Whenever possible, the patient should complete the form themself, and the healthcare professional should be available to provide clarification and ensure that the plan is achievable.

Once the safety plan is completed, review the entire plan with the patient.[62] Inform the patient that it is not necessary to follow all the steps before reaching out for help. The clinician should provide a copy of the safety plan to the patient and discuss its location. At follow-up visits, periodically review the safety plan.

Suicide Prevention Strategies

Suicide is preventable with early and timely low-cost interventions. Any efforts to thwart the daunting number of suicides worldwide must be thorough and multifaceted; suicide is complex and multifactorial in its etiology. Given that the etiology of suicide is multifactorial, combining multiple strategies to reduce risk and strengthen protective factors at the individual, relationship, community, and societal levels are required.[60] No single approach is impactful enough to decrease the incidence of suicide.

For any suicide prevention strategy to succeed and for the suicide prevention interventions to be appropriately tailored to address each individual's need, it is critical to fully understand the methods used to attempt suicide. All suicides are preventable. Appropriately implemented interventions at the state, community, and individual levels can help prevent suicides and suicide attempts. Some of these interventions include responsible media reporting, assessing the community for barriers to mental healthcare access, introducing alcohol policies to reduce the irresponsible consumption of alcohol, and educating various groups to reduce the stigma of the topic.[15]

Early identification of mental health and substance abuse disorders is critical to any suicide prevention strategy. Additionally, training non-specialized healthcare workers in the identification, assessment, and management of suicide is an effective strategy to prevent suicide.[15]

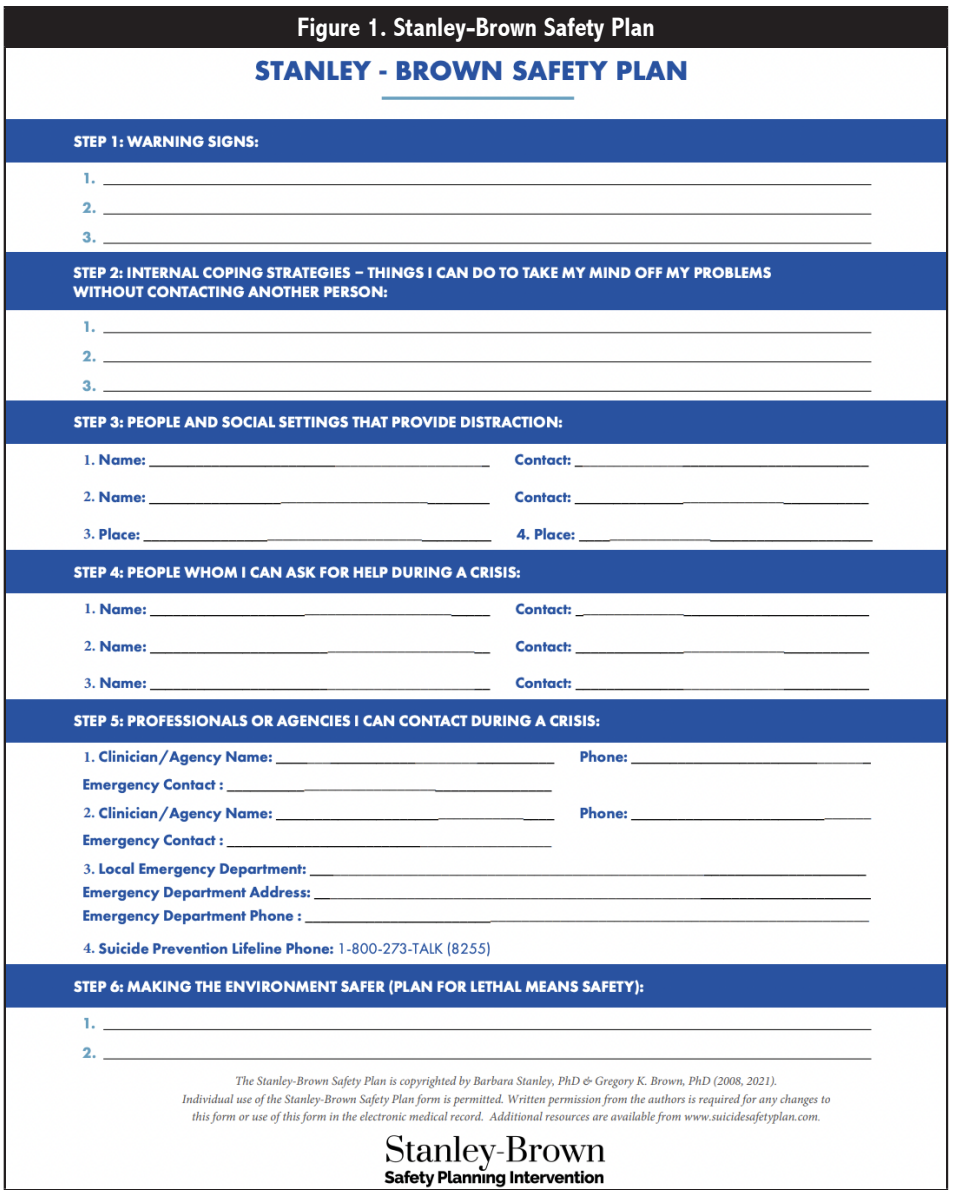
In many cultural and religious groups, mental illness is still considered taboo. Many people who contemplate taking their lives are too afraid to seek help for fear of being ostracized. The lack of public awareness concerning suicide in particular, and mental illness as a whole, only potentiates the problem.[15]

Suicide prevention strategies should be unique to the target population and should address differences in patient characteristics, methods of suicide, socioeconomic status, age, and gender. Given that suicide is a complex issue, multiple professionals must be involved in any applied strategies. These stakeholders include policymakers, professionals in health education and law, media, and community members.

Caring Contacts

One evidence-based intervention that has been shown to support individuals following a crisis event is the "Caring Contacts" program. Caring Contacts is an effective suicide prevention strategy that may be used post-discharge for high-risk individuals and may be scaled to the community's needs.[64] It is low-cost, and once established, volunteers can manage it. The program involves a clinician or other caring individuals who send eight or more messages of care, support, and connection to an individual with suicidal risk over a year. It may consist of postcards, letters, emails, or even text messages. It helps to keep patients engaged, provides a follow-up for individuals who are challenging to engage, and extends the connection between provider and patient after treatment has ended.[64]

Figure 1. Stanley-Brown Safety Plan



STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Place: _____ 4. Place: _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
2. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
3. Local Emergency Department: _____
Emergency Department Address: _____
Emergency Department Phone : _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

Note. From Stanley, B., & Brown, G. K. (2021, August 6). Stanley-Brown safety plan [Graphic]. Stanley-Brown Safety Planning Intervention. https://bgg.11b.myftpupload.com/wp-content/uploads/2021/08/Stanley-Brown-Safety-Plan-8-6-21.pdf[63]

Zero Suicide

Zero Suicide is a framework that takes a systemic approach to identifying suicide risk across healthcare and behavioral healthcare systems.[40] The foundational belief of Zero Suicide is that the suicide deaths of individuals under care within healthcare and behavioral health systems are preventable. The Zero Suicide website provides a wide variety of resources available to community leaders, including the Zero Suicide Toolkit, to help implementors put the Zero Suicide framework into practice.

Primary, Secondary, Tertiary Prevention

If a suicide act has not occurred, it is important to determine the best prevention strategies. Strategies range from referral to prevention resources to immediate hospitalization and prescribed interventions to keep the individual from self-harm. The public health model of primary, secondary, and tertiary prevention is a valuable model for suicide.

Primary Prevention

Primary prevention strategies for suicide are geared toward the general population and include activities and information that educate the community about strategies to decrease suicide. Primary prevention aims to reduce the number of new suicide cases in the general population.[65] These general suicide programs and information are appropriate for schools, homes, clinics, clubs, and social groups.

Secondary Prevention

Secondary prevention strategies for suicide aim to decrease the likelihood of a suicide attempt in high-risk patients.[66] This level of prevention includes the activities of crisis intervention programs and crisis hotlines. Secondary prevention comprises specific measures used to care for individuals in an active suicidal crisis. Crisis care is usually provided by hospitals, clinics, and hotlines.

Tertiary Prevention

Tertiary prevention strategies for suicide occurs in response to completed suicides and suicide attempts.[65] Tertiary prevention also provides interventions and care for individuals who had personal connections to someone who died from suicide. The goal of tertiary prevention is to help survivors grieve and to understand why the person killed him or herself.

Service Members and Veterans

Suicide is a national public health concern, and this claim is especially true among veterans and active military members. The U.S. Department of Veterans Affairs (VA) leads efforts to understand suicide risk factors for veterans, develop evidence-based prevention programs, and prevent veteran suicide by utilizing a public health approach.[67] The VA analyzes suicide data at the national and state levels to better guide these strategies.

The U.S. Department of Defense (DoD) also publishes quarterly and annual suicide reports presenting suicide data on service members and their families. It describes intentional efforts to combat suicide, reduce the stigma associated with seeking help, and share program evaluation and policy review.[67]

Service Member and Veteran Suicide Deaths in the U.S.

Service Members

According to the 2020 Department of Defense Suicide Event Report (DoDSER), 580 members died by suicide. Key findings included[67]:

- Active component: The suicide rate increased from 2015 to 2020.
- Reserve: There was no significant change in the suicide rate from 2015 to 2020.
- National Guard: There was no significant change in the suicide rate from 2015 to 2020.
- Service members who died were largely enlisted, male, and younger than 30 years old.

Table 10 shows the suicide counts and rates per 100,000 Service members in the military.

Veterans

According to the most recent National Veteran Suicide Prevention Annual Report, the Veteran suicide count and the rate decreased in 2019 from 2018 and 2017. There were 399 fewer Veteran suicides in 2019 than in 2018, reflecting the lowest raw count of Veteran suicide deaths since 2007. In 2019, the number of suicide deaths among the U.S. population was 45,861, of which 6,261 (13.7%) were Veterans[67].

Despite a decrease in Veteran suicide deaths in 2019, the Veteran population remains at a significantly higher risk for suicide than non-Veterans in the U.S.[67] The Veteran suicide rate is 52.3% (i.e., 1.5x) higher than non-Veterans.[67,69]

Table 10. Military Suicide Counts and Rates		
Military Population / Service	**2020 Count**	**2020 Rate**
Active Component	384	28.7
Army	175	36.4
Navy	66	19.3
Marine Corps	62	33.9
Air Force	81	24.3
Reserve	77	21.7
Army	142	22.2
Navy	13	-
Marine Corps	10	-
Air Force	12	-
National Guard	119	27.0
Army	103	30.9
Air Force	16	-

Note. Adapted from U.S. Department of Defense, Under Secretary of Defense for Personnel and Readiness. (2021). CY 2020 annual suicide report. https://www.dspo.mil/Portals/113/Documents/CY20%20Suicide%20Report/CY%202020%20Annual%20Suicide%20Report.pdf[68]

From 2001 to 2019, there were increases in the percentage of Veteran suicide deaths involving firearms and suffocation, as well as decreases for those due to poisoning or "other means". In 2019, firearms were used in 70% of male Veteran suicides and 50% of female Veteran suicides.[67]

Veteran Risk Factors

The Veteran population has unique risk factors that contribute to the higher suicide rates.[69] Multiple studies have shown that the following factors increase the risk of suicide for Veterans[69,71,72,73]:

- Anger, rage, mood swings, and episodes of anxiety and agitation.
- Expressing feelings of having no reason to live.
- Seven adverse social determinants of health are strongly associated with SI and suicide attempts in Veterans: violence, housing instability, financial or employment problems, legal problems, familial or social problems, lack of access to health care and transportation, and nonspecific psychosocial needs.
- A chart review conducted in 2012 found that approximately half of Veterans who died by suicide had a sleep disturbance such as insomnia.
- Sexual dysfunction is common in people with post-traumatic stress disorder (PTSD). In male Veterans, decreased sexual pleasure and frequency of sexual intercourse is linked to more suicidal thoughts. In female Veterans, increased sexual frequency is linked to increased suicidal thoughts.
- Mental health conditions like anxiety disorders, manic-depressive disorders, depressive disorders, and PTSD. Research at the Syracuse Medical Center found that 40% of Veterans with anxiety had at least one risk factor for suicide. They also found that Veterans with a positive depression screen were at high risk for suicide.
- Research has established links between TBIs and suicidality. Veterans who sustained a deployment-related TBI are at greater risk for suicide than those without TBI diagnoses.
- Substance abuse, especially heavy binge drinking. In general, individuals who abuse drugs or alcohol are more likely to be depressed, have financial or social issues and engage in impulsive and high-risk behaviors. In 2017, researchers found that Veterans who abuse drugs or alcohol are twice as likely to die by suicide than other Veterans.
- Veterans and Service Members who have been exposed to suicide are at elevated risk for suicide themselves.
- Over 40% of Veterans experience difficulty when transitioning from military life to civilian life. Studies show these individuals are five times more likely to experience SI.

Evidence-Based Practice:

A study in 2020 examining VA patient data determined that social determinants of health, including violence, housing instability, and financial problems, increased the risk of suicide in Veterans.67 Each adverse factor increased a Veteran's odds of suicidal ideation by 67% and a suicide attempt by 49%.

Protective Factors Related to Veterans and Military Personnel

Protective factors within a population reduce the probability amidst the increased risk. Protective factors are less frequently investigated and, therefore, lack empirical support as risk factors; however, several research studies report encouraging results.

Like in the general population, social support is a significant protective factor. Relationships with family and friends can prevent individuals from considering suicide to solve their problems. Studies show that Veterans who had good social support during and post-deployment had more positive mental health outcomes, including lower rates of SI. However, even with solid social support, individuals must have the social skills to ask for help when they need it. Given that social supports mitigate suicide risk, it is vital to assess Veterans for the presence of social connections.[74]

Research also shows that Veterans with a greater sense of purpose have more resilience, which reduces the odds of suicidality. In addition, engagement in religion or spirituality has also been associated with decreased risk for SI in Veterans. Other protective factors include employment, meeting basic needs, self-care, living stability, social support, resilience, and self-determination).[71]

An approach to clinical interviewing should include questions about protective factors. Not only do these questions carry less stigma than questions about suicide or self-harm behavior, but identifying protective factors for suicide in Veterans encourages the healthcare provider to focus on the individual's competence in various domains of basic functioning.[71]

Service Members and Veteran Intervention Strategies

As a healthcare worker, knowledge regarding available resources is important for referrals and resources to individuals we meet. The Veterans Administration Health Service Department has implemented several programs to aid Veterans at risk for suicide or who have attempted suicide previously. The VA's mission is to end Veteran suicide by implementing a public health approach that combines community-based and clinically based strategies across prevention, intervention, and postvention areas of focus.[68]

Suicide Prevention 2.0 (SP 2.0). Suicide Prevention 2.0 is comprised of a dual effort, intervening on the community level and in the clinical care setting. The community-based intervention component reaches Veterans inside and outside the VA system by collaborating with other agencies.[72] It aims to: 1) identify Service members, Veterans, and their families and screen everyone for suicide risk; 2) promote connectedness and improve care continuity; and 3) decrease lethal means and safety planning. The clinical approach focuses on disseminating evidence-based psychotherapies to Veterans in need. The VA is currently hiring over 100 clinicians across 140 healthcare systems to provide mental health services to Veterans.[68]

Now Initiative. The Now Initiative's goal is to initiate evidence-based interventions to impact Veterans most efficiently at high-risk of suicide within one year. Its areas of focus include 1) lethal means safety; 2) suicide prevention in medical populations; 3) outreach to prior Veteran Health Administration (VHA) users; 4) suicide prevention program enhancements; and 5) paid media.[67]

The President's Roadmap to Empower Veterans and End the National Tragedy of Suicide (PREVENTS). On March 5, 2019, Executive Order 13861 was signed establishing a 3--year effort known as PREVENTS. Its three main areas of focus include: 1) National Suicide Prevention Campaign; 2) improving suicide prevention research, and 3) building partnerships.[68]

988 / Veterans Crisis Line. The Veterans Crisis Line is a confidential resource that connects Veterans in crisis and their family members with qualified and trained responders in the VA.[72]Veterans and loved ones can connect via phone by dialing 988 or via online chat through http://www.veterancrisisline.net. Alternatively, Veterans can send a text message through their cellphones to 838255. Once the crisis line is contacted, Veterans and family members can receive confidential support 24 hours a day, 7 days a week.[68] It is important to note that Veterans can seek help via this confidential resource even if they are not registered with the VA system. The responders on the crisis line are trained to assist veterans with mental health problems and those struggling with the transition to civilian life or relationships. Many of the responders are Veterans themselves and understand what Service members have been through and the challenges they and their families face.[68]

Hannon Act of 2019 (P.K. 116-171). In October 2020, the Hannon Act was signed into law. Section 201 of the Hannon Act established the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP), a $174 million, three-year program to enable VA to provide resources for community-based suicide prevention efforts. It also provides the VA with opportunities to expand suicide prevention efforts. One of its goals is to improve local community capacity to conduct outreach to Veterans and families, provide them with suicide prevention services, and connect them to resources within the community.[68]

The Veterans COMPACT Act of 2020 (P.L. 116-214). The Veterans COMPACT Act was signed into law in December 2020. It enables the VA to implement programs, policies, and reports related to transitioning Service members, suicide prevention, and crisis services; mental health education and treatment; and improvement of services for women Veterans.[68]

Veterans Benefit Administration. The suicide prevention efforts within this administration are focused on improved data sharing toward enhanced suicide risk prediction and identification; increased coordination for Veterans with financial insecurity; and implementation of suicide training for the Veterans Benefits Administration personnel.[68]

Domestic Policy Council. This interagency group creates and amplifies suicide prevention efforts across various agencies related to suicide prevention for Veterans.[68]

In summary, the VA believes that every veteran's suicide is a tragedy. The VA relies on multiple sources of information to identify deaths due to or are most likely due to suicide. It has undertaken the most comprehensive analyses of veteran suicide rates in the United States. The VA has examined over 50 million veteran records from 1979 to 2014 from every state. In addition, the VA has expanded current initiatives and developed new ones to help veterans and their families and reduce the rate of suicide among veterans. The ongoing collection of data and strategic initiative development, such as the #BeThere campaign, highlights the VA's ongoing commitment to the mental health and well-being of our veterans.

BEFORE MOVING ONTO THE NEXT SECTION, PLEASE COMPLETE CASE STUDY 5 ON THE NEXT PAGE.

Risk of Imminent Harm Through Self-Injurious Behaviors

Not every self-injury is a suicide attempt. Non-suicidal self-injuries (NSSI) are defined as "behaviors engaged in with the purposeful intention of hurting oneself without intentionally trying to kill oneself". Other terms used are self-injurious behavior, self-mutilation, cutting, deliberate self-harm, delicate self-cutting, self-inflicted violence, parasuicide, and auto aggression. Forms of NSSI include scratching, plucking hair, interfering with wound healing, cutting, burning, or hitting.[50]

Evaluating between Non-Suicidal Self-Injury and a Suicide Attempt

To accurately predict suicide risk and identify those at the highest risk for suicide is an important task. It is imperative to differentiate between Non-Suicidal Self-Injury (NSSI) and a Suicide Attempt (SA). While both behaviors are injurious to the body, it is necessary to determine the individual's injury intent. Clinicians must understand the distinction between NSSI and SA to make a sound decision regarding treatment and hospitalization.

An NSSI is not a suicide attempt. It is most often used to try to regulate emotional pain or self-soothe – not as a means of ending one's life.[75] Usually, NSSI behaviors are performed to feel better and/or deal with significant negative feelings. Other reasons for NSSI include tension reduction, emotion regulation, anger expression, self-punishment, or a decrease in dissociation. Suicidal behaviors, however, are more lethal (e.g., gunshot wounds, handing).[50]

Evidence-Based Practice:

A review of 22 empirical studies found that the adolescent lifetime prevalence of self-injury is 13 to 23%. The typical age of onset is between 12 and 14 years of age. Risk factors for NSSI include a history of sexual abuse, a higher number of adverse childhood events (ACEs), depression, anxiety, eating disorders, alexithymia, hostility, low self-esteem, antisocial behavior, smoking, and emotional reactivity.[52]

Tattoos and body piercings are not considered NSSI, unless they are created with the specific intention to self-harm. Often NSSI is inflicted on the hands, wrists, stomach, or thighs but can occur anywhere on the body.[76]

While self-injury is a risk factor for suicide, they differ in several important ways, including but not limited to[75]:

- Expressed intent: The expressed intent of NSSI is almost always to feel better, whereas for suicide, it is to end feeling (and subsequently, life) altogether.
- The method used: Methods for NSSI typically cause damage to the surface of the body only; suicide-related behaviors are potentially lethal. Notably, it is uncommon for individuals who engage in NSSI and who are also suicidal to identify the same methods for each purpose.
- Level of damage and lethality: NSSI is often carried out using methods designed to damage the body, but not to injure the body sufficiently enough to require medical intervention or to end life. Suicide attempts are always more lethal than standard NSSI methods.
- Frequency: NSSI can vary in frequency, often contingent on experience of stress and other difficult emotions; suicide-related behaviors are much rarer.
- Level of psychological pain: The amount of distress experienced when engaging in NSSI is often significantly lower than that which gives rise to suicidal thoughts and behaviors. Moreover, NSSI tends to reduce arousal for many of those who use it and, for many individuals who have considered suicide, is used as a way to avoid attempting suicide.
- Presence of cognitive constriction: Cognitive constriction is black-and-white thinking – seeing things as all or nothing, good or bad, one way or the other. It allows for little ambiguity. Individuals who are suicidal often experience high cognitive constriction; the intensity of cognitive constriction is less severe in individuals who use NSSI as a coping mechanism.
- Aftermath: The aftermath of NSSI and suicide can be strikingly different. Although unintentional death does occur with NSSI, it is not common. After a typical NSSI incident, well-being and functioning improve for a short amount of time. The aftermath of a suicide-related gesture or attempt is precisely the opposite.

Despite the different intentions associated with NSSI and suicidal thoughts and behaviors, it is important to note that they share common risk factors. These include but are not limited to[75]:

- History of trauma, abuse, or chronic stress.
- High emotional perception and sensitivity.
- Few effective mechanisms for dealing with emotional stress.
- Feelings of isolation (this can be true even for people who seem to have many friends or connections).
- History of alcohol or substance abuse.
- Presence of depression or anxiety.
- Feelings of worthlessness.

Case Study 5

Instructions: Spend 5–10 minutes reviewing the case below and considering the questions that follow.

(Rationale and discussion is displayed at the bottom of this exercise)

Jack is a 65-year-old retired Lieutenant Colonel in the Army. He was on active duty flying helicopters during the Vietnam War, airlifting casualties to medical centers. He enjoyed a 45-year marriage to his high school sweetheart. They have three grown children with a dozen grandchildren. Jack has enjoyed a post-military career as a consultant to the Department of Defense at the Fort Lewis military base in Tacoma, Washington. He retired 2 years ago so that he and his wife could enjoy traveling and visiting the children and grandchildren.

Jack's wife became ill last year and struggled with ovarian cancer that she succumbed to after a 6-month battle while undergoing chemotherapy. Jack's connectedness to social events was primarily through his wife. She was actively engaged in her church. When Jack's wife died, he withdrew and lost much of that connectedness. His daughters and friends attempted to get him into grief counseling or to attend a bereavement group with the Hospice who took care of her. He had participated in group meetings a couple of times and then brushed off any further contact. He had a couple of months where he seemed to "bounce back;" however, he has begun to struggle with nightmares and flashbacks since her death. He is barely sleeping. He has attempted to connect with his war buddies; however, that has stirred many memories from the long-ago war.

In addition to his wife's death, many of the repressed feelings from the war have begun to plague Jack, and he has become more despondent, reclusive, and depressed. His children live hundreds of miles away and do not realize the changes in their Dad. Based on their contact, they believe that he is still attending the bereavement group. His daughters call once a week. At the time of her weekly phone call, his oldest daughter could not get a hold of him…. She persists without an answer and calls the neighbor, who admits not having seen Jack for a few days. The police perform a welfare check and find Jack lying on the floor of his house with an apparent self-inflicted gunshot wound and a suicide note.

1. **Based upon the information provided, which of the following strategies would be least effective in Jack's scenario?**
   - A. Refer Jack to a behavioral health provider.
   - B. Direct Jack to the Veterans Crisis Hotline.
   - C. Connect Jack with a support group for veterans struggling with grief.
   - D. Report the situation to the local parish.

2. **Veterans with a _____ are at a greater risk of suicide.**
   - A. Traumatic brain injury.
   - B. Poor diet.
   - C. Back pain.
   - D. Migraine disorder.

3. **In Jack's case, considering the discussion regarding reducing access to lethal means, which action by family or friends may have been taken?**
   - A. Educating Jack regarding what to do when he has suicidal thoughts.
   - B. Call the police and have them do a welfare check.
   - C. Remove any firearms from the house.
   - D. Call the local parish for assistance.

Rationale for Question 1: The best option is D. The Veterans Crisis Hotline is available 24/7 for veterans who are in a crisis or struggling with depression, despondency, or feelings of suicide. Grief counseling and support groups both for veterans and in this case, Jack's loss of his wife is a critical intervention through a crisis moment. Grief counseling and support groups and the Veteran's Crisis Hotline can provide crisis intervention and mental healthcare support.

Rationale for Question 2: The best option is A. Studies support that traumatic brain injury coupled with other risk factors found in the general population (substance abuse, depression, etc.) can increase the veteran's risk of death by suicide.

Rationale for Question 3: The best option is C. Family members concerned with a veteran's safety can request a gunlock from their local VA suicide prevention coordinator. In addition, at minimum the weapon should be locked and unloaded and, if necessary, a temporary off-site storage may be advisable.

Discussion: While Jack's family may not have been fully aware of his severe depression, Jack had many risk factors for suicide. These included: his age (the elderly are at higher risk for suicide); the recent death of his wife and subsequent loneliness; social isolation; a history of trauma during his military career, and current symptoms of PTSD (nightmares, flashbacks); sleep disturbances; and untreated depression. All of these risk factors place Jack at a higher risk for suicide. In the aftermath of Jack's death by suicide, his friends and family members should receive grief to help them cope with the loss of their daughter.

Communication Strategies with Patients and Supporters about Lethal Means

The CALM (Counseling on Access to Lethal Means) program helps clinicians work with patients and families to reduce access to lethal means to prevent suicide. Highlights of this program include the following actions[77]:

- Speak with the patient and family, friends, or with other key persons in his/her support system. If the patient is an adult, be sure to obtain releases for permission to speak with members of the patient's support system.
- Discuss suicide risk and how escalation of such risks may lead to a suicide attempt.
- Ask the patient whether there are firearms in the home and if the patient has access to firearms outside the home as well.
- Recommend that all firearms be removed from the home and from patient's access until such time as the situation improves.
- If handling firearms is too dangerous for the patient, enlist the support of others to remove the firearms. Law enforcement may temporarily hold firearms and most will dispose of such weapons upon request.
- If the family is unwilling to remove firearms from the home, the firearms should be unloaded and locked in a place that is not easily accessible. Ammunition should be stored in a separate locked container.
- Potentially lethal prescription medications and alcohol should be removed from the home, and only left in small amounts, if at all.
- Monitor the patient's reactions to the reduction plan. Opposition may suggest a strong commitment to using lethal means to die by suicide. If the patient is overly eager to comply it may indicate that he/she has chosen another means (e.g., deliberate car accident) to attempt suicide.

Strategies to Reduce Access to Lethal Means

Limiting or reducing a person's access to lethal means effectively prevents suicides. The conceptual model of reducing access includes means restriction, which results in the individual either substituting or delaying the attempt. This substitution or delay results in fewer fatal attempts, and often the suicidal crisis may even pass, ultimately resulting in a drop in the overall suicide rate[15].

Individuals at risk for suicide need firearms, medications, means to hang themselves, or poisonous substances restricted or made less accessible. Statistically, an individual who does not have access to lethal means is more likely to delay the attempt, and fewer attempts with less lethal means will prove less fatal. The individual who attempts suicide generally does so during a crisis; if that attempt is delayed, generally, the crisis is averted, and 89-95% of attempters do not go on to die by suicide[15]. If lethal means are restricted, the suicide rate will decline over time.

Creating a safe environment within a healthcare facility is essential to reduce access to lethal means to suicidal patients. Hospitals, prisons, and detention facilities can prevent suicide by using collapsible shower heads, light fixtures, doorknobs, and specially designed bedding that does not tear.[78]

Healthcare providers should educate patients on how to make their family members and homes safer by reducing access to medications and firearms[78]:

Medications:

- Never keep lethal doses of any medication on hand.
- Consider keeping medications locked in a safe place.
- Properly dispose of medications that are no longer needed.

Firearms:

- Keep firearms locked and unloaded in a safe and ammunition stored in a separate location.
- Ask a friend or family member to store a firearm for a while.
- Unloaded firearms can also be secured with a gun-locking device making them unusable.

PLEASE COMPLETE CASE STUDY 6.

Case Study 6

Instructions: Spend 5-10 minutes reviewing the case below and considering the questions that follow.

(Rationale and discussion is displayed at the bottom of this exercise)

Ella is a 16-year-old high school student. She requests to see a school counselor after a difficult breakup with her boyfriend of three months. During her initial consultation with the counselor, she reports that she has had suicidal ideations and a plan and intent. She reports that she has a plan to swallow a bottle of Tylenol to "make the pain go away." When asked if she had access to Tylenol, she reported that she bought a bottle a few days ago and was waiting to find the right time. The school counselor promptly contacts Ella's parents, who come in to meet with her. Ella's mom reports that Ella tended to be dramatic and that she had made such threats after her previous three breakups and all Ella needed to do was stop being distracted by boys and focus on her future. At the counselor's insistence, the mother promised to report the counselor's findings to her pediatrician. The following week, Ella was found dead by her best friend on her bathroom floor.

1. **What was the trigger that led to the death by suicide in this case?**
   A. Ella's mom not listening.
   B. Romantic Breakup.
   C. Ella has always had suicidal ideations.
   D. School counselor's confrontation.

2. **Based on the information regarding restricting access to lethal means, which action could have been taken by an individual in the scenario to reduce the risk of suicide?**
   A. Notify the pediatrician.
   B. Meet with the parents and Ella together.
   C. Ask Ella to meet with her regularly.
   D. Remove access to the Tylenol.

3. **Based on the information provided regarding lethal means, who does not need education to raise awareness of Ella's risk for suicide?**
   A. Educators.
   B. Mother.
   C. Lay gatekeeper.
   D. The school counselor.

Case Study 6 (continued)

Rationale for Question 1: The best option is B. The stressor in Ella's life was the breakup with her boyfriend of three months.

Rationale for Question 2: The best option is D. Removing the bottle of Tylenol from Ella's possession and ensuring that she does not have access to other means of poisoning could have reduced the potential for follow-through by Ella.

Rationale for Question 3: The best option is D. Although there is no definitive means of absolutely ensuring that a suicide can be prevented, conducting an appropriate assessment, and developing a plan that includes patient and family is mandatory. In addition, ongoing follow-up is essential as well. Patients at risk for suicide must receive follow-up, as well as extensive education. Family members must also receive education and training on an ongoing basis.

Discussion: Managing and treating suicidal ideations can be challenging, especially in children whose parents are dismissive of the warning signs in their children. The counselor, in this case, reacted appropriately by promptly reporting her findings and suspicions to Ella's parents. However, Ella's mom's denial regarding the challenges her daughter faced was a particular hindrance in securing the right help for Ella.

Education regarding lethal means is imperative for all involved. Limiting or reducing Ella's access to lethal means (Tylenol) could have effectively prevented her death by suicide. This restriction to access may have resulted in her using a substitute or delaying the attempt. Either the substitution or delay would have provided time to pass and potentially the crisis to pass, which would have resulted in an unsuccessful attempt or no attempt at all.

The counselor should have tried to contact Ella's father and convey her sense of urgency regarding the immediacy of Ella's needs. This was especially important, given that her mother was so resistant to getting Ella the help she needed. After Ella's death, her friends and classmates should receive counseling. Additionally, Ella's parents should receive grief counseling to help them cope with the loss of their daughter.

Conclusion

Death by suicide is one of the top ten leading causes of death in the United States for people ages 10-65.[11]Suicidal behavior takes a huge emotional toll on family and friends and an economic toll on society. Therefore, suicide prevention and treatment must be addressed throughout the healthcare community to prevent the further loss of life. Healthcare professionals are in a unique position to prevent suicide due to their frequent contact with patients and should use a multi-factorial approach to screen patients for suicidality to assess their risk level, conduct a thorough assessment, and to appropriately refer patients to appropriate services.

Resources

Below is an extensive resource list borrowed from the National Action Alliance for Suicide Prevention of suicide-related resources filtered by topic[4]:

1. **Suicide Care**
   a. National Action Alliance for Suicide Prevention. This organization lists recommended standard care practices for people with suicide risk. https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf
   b. U.S. Department of Veterans Affairs (VA) /U.S. Department of Defense (DoD). The VA and DoD have created their own guidelines for the assessment and management of patients at risk for suicide. https://www.healthquality.va.gov/guidelines/MH/srb/
   c. Zero Suicide. This organization has created a toolkit to help transition individuals through care. https://zerosuicide.edc.org/toolkit/transition#quicktabs-transition=1
   d. Zero Suicide. Universal Health Services Inc, Behavioral Health Division has a detailed suicide care management plan template for inpatient hospital settings. https://zerosuicide.edc.org/sites/default/files/UHS%20Inpatient%20Suicide%20Care%20Management%20Plan%20Template.pdf
2. **Suicide-Specific Therapy Approaches**
   a. Dialectical Behavioral Therapy (DBT). https://behavioraltech.org/
   b. Cognitive Behavioral Therapy (CBT). https://sprc.org/event-training/cognitive-behavioral-therapy-for-suicidal-behavior/
   c. Collaborative Assessment and Management of Suicidality (CAMS). https://cams-care.com/
   d. Problem-Solving Therapy (PST). https://aims.uw.edu/training-support/behavioral-interventions/problem-solving-treatment-pst
   e. Attachment-Based Family Therapy (ABFT). https://drexel.edu/familyintervention/attachment-based-family-therapy/overview/
3. **Involving family and other supports**
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   b. Family-to-Family Educational Program. https://www.nami.org/Support-Education/Mental-Health-Education/NAMI-Family-to-Family
   c. Suicide is Different. https://www.suicideisdifferent.org/
4. **Safety planning**
   a. Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version. https://sprc.org/online-library/safety-plan-treatment-manual-to-reduce-suicide-risk-veteran-version/
   b. Patient Safety Plan. https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf
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   d. SAMHSA Suicide Safe Mobile App. https://store.samhsa.gov/product/suicide-safe
5. **Lethal means counseling**
   a. Recommendations for Clinicians. https://www.hsph.harvard.edu/means-matter/recommendations/clinicians/
   b. Recommendations for Families. https://www.hsph.harvard.edu/means-matter/recommendations/families/
   c. Counseling on Access to Lethal Means (CALM). https://dev.sprc.org/resources-programs/calm-counseling-access-lethal-means
   d. Firearm Safety and Injury Prevention. https://www.acep.org/patient-care/policy-statements/firearm-safety-and-injury-prevention/
6. **Rapid referrals**
   a. HelpPRO Therapist Finder. https://www.onlinetherapy.com/
   b. Therapy Finder. https://suicidepreventionlifeline.org/help-yourself/
7. **Discharge planning**
   a. Strategy 4: Care Transitions from Hospital to Home: IDEAL Discharge Planning. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklst_508.pdf
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9. **Follow-up**
   a. Follow-Up Matters. https://followupmatters.suicidepreventionlifeline.org/#one-month
   b. Re-engineered Discharge (RED) Toolkit; Tool 5: How to Conduct a Post discharge Follow up Phone Call. https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool5.html
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    b. Zero Suicide, Contact after Leaving Care. https://zerosuicide.edc.org/toolkit-taxonomy/contact-after-leaving-care

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ASSESSMENT AND PREVENTION OF SUICIDE

Choose the best possible answer for each question and mark your answers on the self-assessment answer sheet at the end of this book. There is a required score of 70% or better to receive a certificate of completion.

21. _____% of individuals who die by suicide have had at least one contact with their primary healthcare provider within one year of dying by suicide.

A. 10.
B. 80.
C. 45.
D. 60.

22. The American Foundation for Suicide Prevention estimates that suicide is the _____ leading cause of death in the U.S.

A. 2nd.
B. 5th.
C. 10th.
D. 12th.

23. Healthcare workers must accurately assess for suicidal ideation. To do this, they must do all of the following EXCEPT:

A. Identify individual risk factors.
B. Use appropriate screening tools.
C. Identify levels of risk.
D. Manage the patient's medications.

24. Warning signs of suicide could include all of the following, EXCEPT:

A. Talking about feeling trapped.
B. Talking about having no purpose.
C. Decreasing the use of alcohol.
D. Extreme mood swings.

25. Which of the following individuals would be most likely at risk for suicide?

A. Linda, a 20-year-old black female.
B. Jerry, a 45-year-old white male.
C. Victoria, a 15-year-old white female.
D. Carl, a 26-year-old Hispanic male.

26. Stigma is a term that contains the following elements EXCEPT for:

A. Tolerance.
B. Prejudice.
C. Ignorance.
D. Discrimination.

27. All of the following are protective factors for suicide EXCEPT:

A. Belongingness.
B. Sense of purpose or meaning in one's life.
C. A high yearly income.
D. Religiosity.

28. The practitioner needs to inquire of the patient regarding suicidal thoughts, ideations, and plans. Which of the following would be an appropriate way to word the question?

A. "You are not thinking about dying by suicide, are you?"
B. "Have you ever tried to kill yourself or thought about suicide?"
C. "People who are moody like you often think about hurting themselves; you aren't thinking that way, are you?"
D. "Have you ever tried to attempt suicide to get attention?"

29. The important components of documenting a patient's suicide risk includes all of the following EXCEPT:

A. Risk factors for suicide.
B. Protective factors for suicide.
C. A patient's occupation.
D. The patient's suicide risk level.

30. Restricting access to lethal methods can result in all of the following EXCEPT:

A. Provide more suicide options.
B. Substitute planned method for less lethal one.
C. Delay a suicide from occurring.
D. Reducing the number of suicides.

31. The following statements are true EXCEPT for the following:

A. The higher the person's Adverse Childhood Experiences (ACE) score, the greater chance of a wide range of long-term health problems.
B. Compared to individuals without ACEs, the odds of suicide ideation or attempts in adulthood increased more than tenfold among individuals with 10 or more ACEs.
C. The ACE study first conducted examined the long-term health effects of trauma exposure, violence, and loss during childhood.
D. The higher the individual's ACE score, the greater chance of developing depression, anxiety, suicide, and PTSD.

32. In the month after a patient is discharged from inpatient care, the suicide death rate is:

A. 5 times higher in the first week after discharge.
B. 50 times higher in the first week after discharge.
C. 100 times higher in the first week after discharge.
D. 300 times higher in the first week after discharge.

33. One of the goals of psychiatric inpatient hospitalization for a suicidal patient is to:

A. Initiate long-term therapy only.
B. Conduct a psychiatric evaluation and initiate therapy and/or medications.
C. Exclusively conduct a medical evaluation.
D. Immediately refer a patient to intensive outpatient care.

34. The basic steps for a safety plan intervention include all of the following EXCEPT:

A. Identify warning signs that may indicate the beginning or escalation of a crisis.
B. Obtain crisis narrative in which the individual can "tell their story" about a specific suicidal or personal crisis.
C. Provide psychoeducation and introduce safety planning.
D. Immediately provide psychopharmacological intervention for the patient.

35. The Beck Depression Inventory-II assessment evaluates which of the following:

A. An individual's feelings and behaviors over the past 2 weeks.
B. An individual's feelings and behaviors over the past 2 days.
C. Active and passive suicide desire.
D. Gestures and non-verbal behavioral information.

36. After a suicide attempt, the first priority for a patient should be:

A. Alerting family and friends.
B. Medical stabilization at a hospital.
C. Providing medication.
D. Providing therapy.

37. Involuntary hospitalization is necessary when:

A. A patient refuses to attend appointments consistently.
B. A patient discloses passive suicidal ideation.
C. A patient has missed their medication(s).
D. A patient is a risk to themselves or others and refuses to be hospitalized.

38. A patient with an acute and high-risk for suicide:

A. Is unable to maintain safety without external support.
B. Has chronic suicidal ideation and an increase or change in baseline mood, behavior or talk about suicide/dying.
C. Has suicidal ideation, but does not currently have a plan for suicide or suicidal behaviors.
D. Has protective factors, coping skills, reasons for living and psychosocial stability suggesting the ability to endure future crisis without resorting to suicide.

39. As a result of public stigma surrounding suicide, survivors of suicide may:

A. Internalize feelings of shame.
B. Discuss suicide freely and openly.
C. Seek help from a therapist.
D. Alert their family members during a mental health crisis.

40. In regards to suicide, the American Psychiatric Association defines the term "Aborted or self-interrupted attempt" as:

A. When an individual is interrupted from self-destructive behavior by another person or outside circumstance.
B. When an individual formulates a plan for self-inflicted injurious behavior.
C. When an individual takes steps towards making a suicide attempt but stops before the actual act.
D. A non-fatal, self-directed, potentially injurious behavior with any intent to die.

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Final exam questions are located at the end of each chapter.

Tennessee Guidelines for Managing Chronic Pain

	A	B	C	D
1	○	○	○	○
2	○	○	○	○
3	○	○	○	○
4	○	○	○	○
5	○	○	○	○
6	○	○	○	○
7	○	○	○	○
8	○	○	○	○
9	○	○	○	○
10	○	○	○	○

Improving Access to Care for LGBTQ Patients

	A	B	C	D
11	○	○	○	○
12	○	○	○	○
13	○	○	○	○
14	○	○	○	○
15	○	○	○	○
16	○	○	○	○
17	○	○	○	○
18	○	○	○	○
19	○	○	○	○
20	○	○	○	○

Assessment and Prevention of Suicide

	A	B	C	D
21	○	○	○	○
22	○	○	○	○
23	○	○	○	○
24	○	○	○	○
25	○	○	○	○
26	○	○	○	○
27	○	○	○	○
28	○	○	○	○
29	○	○	○	○
30	○	○	○	○

	A	B	C	D
31	○	○	○	○
32	○	○	○	○
33	○	○	○	○
34	○	○	○	○
35	○	○	○	○
36	○	○	○	○
37	○	○	○	○
38	○	○	○	○
39	○	○	○	○
40	○	○	○	○

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TN23CME

7099078842

Book expires: 2/28/2025

Program: TN23CME
Course 1: TN23CME-50
Courses 1 & 2: TN23CME-55
Course 2. TN23CME-30
Course 3. TN23CME-60

LEARNER RECORDS: EVALUATION

You must complete the program evaluation and applicable activity evaluation(s) in order to earn *AMA PRA Category 1 Credit*™, MOC points, or participation in MIPS. For each of the objectives determine if the activity increased your:

A Competence B Performance C Outcome D No Change

COURSE 1 - TENNESSEE GUIDELINES FOR MANAGING CHRONIC PAIN:

		A	B	C	D
1.	Apply recommended guidelines for the appropriate use of controlled substances	○	○	○	○
2.	Recognize substance use disorder and advise patients on appropriate treatments	○	○	○	○

3. Please identify a specific change, if any, you will make in your practice related to safe prescribing of opioid analgesics.

_____

_____

4. What do you see as a barrier to making these changes? _____

_____

COURSE 2 - IMPROVING ACCESS TO CARE FOR LGBTQ PATIENTS:

		A	B	C	D
5.	Implement strategies to improve healthcare access of the LGBTQ population	○	○	○	○
6.	Apply strategies to address health risks in the LGBTQ community.	○	○	○	○

7. Please identify a specific change, if any, you will make in your practice related to caring for LGBTQ patients.

_____

_____

8. What do you see as a barrier to making these changes? _____

_____

COURSE 3 - ASSESSMENT AND PREVENTION OF SUICIDE:

		A	B	C	D
9.	Identify risk factors and utilize appropriate screening tools for patients at risk of suicide	○	○	○	○
10.	Use appropriate strategies for the assessment and treatment of patients at risk of suicide	○	○	○	○

11. Please identify a specific change, if any, you will make in your practice related to assessment and prevention of suicide.

_____

_____

12. What do you see as a barrier to making these changes? _____

_____

OVERALL PROGRAM:

		Yes	No	If no, please explain:
13.	The program was balanced, objective & scientifically valid	○	○	_____
14.	Do you feel the program was scientifically sound & free of commercial bias or influence?	○	○	_____

15 How can this program be improved? _____

_____

16 Based on your educational needs, please provide us with suggestions for future program topics & formats. _____

_____

17. For which activities would you like to use your participation as a clinical practice improvement activity (CPIA) for MIPS?

○ Course 1 ○ Course 2 ○ Course 3 ○ None

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- If you already have an account created, sign in to your account with your username and password. If you do not have an account already created, you will need to create one now.
- Follow the online instructions to complete your self-assessment. Complete the purchase process to receive course credit and your certificate of completion. Please remember to complete the online evaluation.

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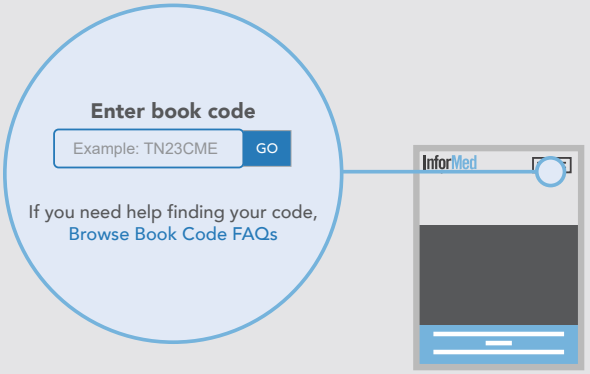

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BOOK CODE: TN23CME
BOOK EXPIRES: 2/28/2025

2023 Tennessee Medical Licensure Program

- **2 Hours**
  Controlled Substance Prescribing*
- **10 TOTAL**
  AMA PRA CATEGORY 1 CREDITS™

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*Mandatory CME Requirement

Tennessee physicians must complete two (2) hours of CME in controlled substance prescribing in accordance with board rules.

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