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Suicide: A Public Health Issue

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Suicide is the eighth leading cause of death in the United States, resulting in the loss of approximately 30,000 lives per year.[1] Although suicide affects all populations, it is currently an epidemic among adults age 65 and older,[2] and is the third leading cause of death for people ages 15 to 24.[3] The American Association of Suicidology estimates that nine out of every 10 suicides are preventable.[4]

Effective suicide prevention requires that all providers involved in the care of a client be able to effectively identify risks and provide appropriate triage and support. Stigma contributes to the silence and shame associated with mental health issues such as suicide, and prevents many persons from seeking the care they require. As practitioners, we must first balance within ourselves our personal views, ethics and professional responsibilities. We must seek to build rapport while reducing risk. We must be vigilant that our words, body language and actions do not contribute to this stigma.

Scientific and technological advances have made it possible to extend life in many ways. Although these advances promise enormous benefit, they also present difficult and increasingly complex ethical choices for clients, their families, and health care professionals. Prolonged life expectancy for individuals living with debilitating illness may lead to a lessened quality of life or loss of dignity for our patients.

Many people use Asian medicine[5] for treatment of emotional and psychological complaints. What is the appropriate course of action for an acupuncturist to take when a patient confides he or she is considering suicide? In private practice as well as in public health clinics, and particularly with client populations dealing with substance abuse, terminal or chronic disease, an appropriate mechanism for suicide triage is critical.

The philosophy of Asian medicine promotes prevention. It is important to separate out our own beliefs and to remain nonjudgmental about the morality of end-of-life decisions. We can parallel the groundbreaking philosophy of the harm reductive movement[6] (used by the substance abuse treatment community) to assist us in developing principles to serve in these situations:

- Meet the client where he/she is without judgment.
- Affirm the right of the individual to determine the level of his or her care.
- Honor client self-determination. Choice should be intrinsic to all aspects of life and death.
- Strive to enhance the patient's quality of life.
- Encourage exploration of life options.
- Advocate for access to options (providing information and referrals).

Acupuncturists, unlike licensed mental health providers, are not typically mandated to report threats of suicide (although regulations may vary from state to state). However, if a client is considering his or

her choices, the practitioner does have an ethical obligation to, without judgment, work towards ameliorating any factors such as pain, depression, or need for medical treatment. Appropriate referral sources should be thoroughly reviewed with the client, including, but not limited to, pain management; counseling; hospitalization; hospice care; medical/pharmaceutical intervention for psychological issues; nursing home placement; and advanced health care directives. We must follow up on suicidal feelings with the same attention we would devote to any other life-threatening illness. We also have a professional obligation to refer clients to competent professionals who are available to address end-of-life issues.

All practitioners should have an informational handout that includes suicide prevention hotline numbers, psychiatric emergency room locations and mental health providers. Develop a list of specialty programs in your area that provide additional support in these cases. Document all discussion about this issue and all referrals made on your client's treatment sheet. Treatment records must not contain any personal assessment, only facts.[7] If the situation requires additional documentation, do so in the form of an incident report which is kept separate from the client's treatment record.

It is inappropriate and illegal for a practitioner to encourage, deliver, supply, or personally participate in the commission of an act of assisted suicide with a client. Doing so may subject the practitioner to criminal charges. The choice is the client's, not ours. It is our job to provide appropriate care and referral to resources.

In triaging a client who expresses thoughts of suicide, it is important to assess the client's risk. Question your client about what "feeling suicidal" means to him or her. Ask about previous thoughts or attempts, and if a clear plan exists as to how the client will commit suicide. Does the person have the means to carry out the plan? Do they possess the gun, rope, knife, pills, etc? Building rapport is essential to this dialogue.

You can triage your patient's risk for suicide by utilizing the SAD PERSONS Scale.[8] To use, assign one point for each positive risk factor, add your total points and review the recommended guidelines.

SAD PERSONS SCALE[9]
[Important Suicide Risk Factors]
Sex [Assign one point only if male]
Age [Assign one point only if <19 yrs or >45 years old]
Depression
Previous attempts
Ethanol abuse [alcohol or substance abuse]
Rational thinking loss
Social supports lacking [lack of family, friends, etc]
Organized plan [lethal, affairs in order, note]
No spouse [divorced, widowed, separated, single, no children]
Sickness [chronic, debilitating and severe]

Scale Score:
0-2: Typically not an acute situation, but make sure to follow up with the client by phone and document referral sources.
3-4: Closer follow up recommended. Ask the client to sign a release form to allow you to communicate with their mental health provider or primary care doctor.
5-6: Discuss the option of hospitalization with the client. Ask the client to sign a medical release and speak with their doctor. Ask the client to make a verbal or written contract that says they will see their therapist or go to the emergency room prior to attempting to take their life.
7-10: This may be a situation where hospitalization may be necessary with or without the client's consent. It is imperative in these situations to continue to validate the patient's feelings and call in the support of the patient's other providers and caretakers.

To be called upon to provide support to a patient struggling with end-of-life decisions is a credit to our importance as care providers. Ensuring appropriate triage, care and referrals is our duty. Embracing a harm reductive approach builds rapport and fosters a sense of greater connection for our patient. A triage tool, such as the SAD PERSONS Scale, offers us a first step in assessing and appropriately referring patients to the care they need, while operating within a professional standard of care and within the parameters of the law.

Our goal should be to meet our clients with open hearts and ears, where they are, not where we want them to be. By integrating our foundation in Asian medicine with proactive public health practice, we can nourish the shen and essence on every level.

Columnists' note: Upcoming Public Health columns will include global acupuncture initiatives and national public health acupuncture programs. If you are aware of programs or have experience in public health initiatives, we would welcome your input.

References

1. National Center for Injury Prevention and Control, Center for Disease Control.
2. *Suicide and Self-Inflicted Injury in Massachusetts, 1996-1998,* MA Department of Public Health.
3. Center for Disease Control and Prevention. *Suicide among Children, Adolescents and Young Adults, United States, 1980-1992*.
4. www.suicidology.org.
5. The authors will use the term "Asian medicine" as a culturally sensitive term in lieu of "Oriental medicine" and as a broader term in lieu of "Chinese medicine."
6. www.harmreduction.org.
7. American Health Information Management Association, 1992 Principles of Medical Record Documentation, Chicago.
8. Juhnke GA, Hovestadt AJ. Using the Sad Persons Scale to promote supervisee suicide assessment knowledge. *The Clinical Supervisor* 1995;13 (2):31-40.
9. Patterson W, et al. Sad Persons Scale. *Psychosomatics* 1983;24:343.

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