Suicide Risk Assessment Toolkit for the Primary Care Setting

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The views expressed in this Capstone are those of the author and do not reflect the official policy or position of the United States Air Force, Department of Defense, or the U.S. Government.

Abstract

Introduction: The Centers for Disease Control and Prevention reported that suicide is the 10th leading cause of death for all ages and the cost associated with lost wages and medical expenses was estimated to be $34.6 million with over 38,000 successful suicides and an additional 487,000 cases of self-inflicted wounds being treated in emergency rooms (CDC, 2012, 2013). In addition, 77 percent of U.S. counties have experienced a shortage of mental health providers and mental health prescribers (Thomas, Ellis, Konrad, Holzer & Morrissey, 2009) which can lead to many patients being seen by their primary care provider (PCP) for mental health management. Cattell & Jolley (1995) studied suicide and depression in the elderly and reported that 43% of elderly patients were being seen by their PCP prior to their suicide and mental health referrals were not done consistently.

Purpose: Develop and evaluate a Suicide Risk Assessment Toolkit based on the current evidence and clinical practice guidelines (CPG) for utilization in a primary care setting.

Method: This SRA Toolkit was submitted to a panel of six subject matter experts in various health care specialties to review and provide suggestions for improvement with possible implementation in a family practice or primary care setting as a long term goal.

Discussion: All except one panel member rated the SRA Toolkit as "Likely" or "Very Likely" to be utilized in a primary care setting. The dissenting panel member who rated it "Unlikely" for use in a primary care cited time as a major constraining factor. Suggestions to improve the SRA Toolkit included simplification and single page quick reference for easy use during patient visits.

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Suicide Risk Assessment in Primary Care

Introduction

Overview of Problem

Suicide is not only a leading cause of death in the United States, it is a significant cost to the economy as well. According to a Center for Disease Control and Prevention report, in 2010 suicide had become the tenth leading cause of death for all ages (CDC, 2013), costing $34.6 million dollars in lost work and medical expenses (CDC, 2012). In addition, there were 38,364 suicides in the United States with an additional 487,700 cases of self -inflicted injuries requiring emergency treatment (CDC, 2012). The suicide rate for 2010 was more than twice the 14,748 murders in the United States (Federal Bureau of Investigation, 2010). The CDC (2013) reported suicide rates had increased by 28.4% from 1999 through 2010. The three most common methods of suicide were firearms, suffocation, and poisoning. Firearms were the most common method for men while poisoning was the most popular method for women (CDC, 2013). To counter the alarming rate of suicide in 2007 of 11.3 per 100, 000, the U.S. government established a goal to reduce suicide by 10% (U.S. Department of Health and Human Resources, 2014). During 2008-2009, approximately 8.3 million adults or 3.7% of the adult population in the United States reported having a suicidal thought, 2.2 million reported having developed a suicide plan and approximately one million adults reported making a suicide attempt (Crosby, Han, Ortega, Parks, & Gjroerer, 2011).

Suicide is not a specific mental illness but rather a symptom that is associated with several different mental health diagnoses. Some specific mental disorders associated with elevated suicide rates are Major Depressive Disorder (MDD), Bipolar Disorder, and Schizophrenia (Sadock & Sadock, 2010).

MDD is a mental illness that at times can be debilitating such that up to 50% of people who commit suicide had previously reported having depressive symptoms (Sadock & Sadock, 2010, pg 334). The Diagnostic and Statistical Manual of Mental Disorders 4th edition Text Revision reports 15% of individuals with a diagnosis of MDD will eventually commit suicide. Individuals with MDD who are admitted to a nursing home have an increased likelihood of dying in the first year. Those with MDD report more pain and physical illness when being seen by their primary care provider (American Psychiatric Association, 2005). Almost two-thirds of individuals who reported having a mental illness considered suicide while 77.5% of individuals with a mental illness develop a suicide plan, 79.6% make a suicide attempt, and 83.4% with a mental illness made a planned suicide attempt (Nock, Hwang, Sampson, & Kessler, 2010).

The American Psychiatric Association is changing its attitudes toward suicide and suicidal behaviors. The newly released Diagnostic and Statistical Manual of Mental Disorders 5th Edition includes a proposal for the diagnosis of Suicidal Behavior Disorder with recommended diagnostic criteria and specific risk factors to address the issue of suicide (American Psychiatric Association, 2013).

Due to the shortage of mental health providers in the United States, individuals with mental illness who may be having suicidal thoughts have no access to a mental health specialist and are being seen by their primary care provider (PCP) or in an emergency department (ED). In 2009, 77% of U.S. counties had a "severe" shortage of both mental health providers and mental health prescribers while 96% of U.S. counties had some level of shortage in mental health prescribers (Thomas et al., 2009) which can lead to PCP's treating patients with self-harm thoughts and mental health issues. Despite the high correlation between depression and suicide (Cooke, Gotto, Mayorga, Grant, & Lynn, 2013), many patients with depressive symptoms are

evaluated, treated, and have been medically managed by their PCP instead of a mental health specialist. McDowell, Lineberry, & Bostwick (2011) reported that PCP's write antidepressant prescriptions more often than mental health providers and lack additional psychopharmacological training that would allow them to expertly prescribe psychotropic medications. Pratt, Brody, & Quipping (2011) reported antidepressants were the third most commonly prescribed medication in the United States between the years of 2005 and 2008. While this statistic is imposing, Pratt et al. (2011) also reported less than 50% of patients on multiple antidepressants visited a mental health provider in the past 12 months. Finally, McDowell, et al., (2011) also reported persons who were successful in their suicide were more likely to have seen their PCP during the final 30 days of their life. Additionally, studies indicate that 75% of patients who completed suicide had contact with their PCP within 12 months of committing suicide and 45% had contact with their PCP within one month of successful suicide (Bostwick & Rackley, 2012). In the elderly population there is an even higher rate of patients completing suicide who have seen their PCP within one month of their suicide (Luoma, Martin & Pearson, 2002).

Legal liability associated with treating a person who successfully commits suicide is another issue for a health care provider in today's litigious society. A commonly accepted medical legal concept is malpractice has occurred if an accepted standard of care is not followed and results in a negative outcome to the patient (Knapp, & Vandecreek, 1983). A thorough assessment is required in any clinical situation and as mentioned earlier in this paper, treating suicidal patients was a common experience in many healthcare professions (Palmieri et al., 2008). A study on the legal aspects of SRA, (Smith at al., 2008) reported that psychiatrists, psychologists, and other mental health providers were not routinely conducting an adequate SRA

due to lack of time, belief that documentation will make them more liable, anxiety about suicide, and not being properly trained in conducting a SRA. Not conducting a SRA does not relieve a health care provider of legal liability if a patient successfully commits suicide (Smith, et al., 2008).

Performing a SRA does not imply that the PCP assumes responsibility if a patient commits suicide. The therapeutic relationship between a health care provider and a patient is complicated and should be based on honesty and trust. In actuality, lying in the clinical setting is fairly common by both parties for multiple reasons (Palmieri & Stern, 2009). Patients may deny suicidal intentions to their PCP in order to avoid embarrassment or hospitalization (Simon, 2008). The results of an on-line survey by WebMD in 2004 found that 13% who responded stated they had lied to their doctor while an additional 32% reported they had "stretched the truth" with their doctor (DeNoon, 2004). In a study of persons who had committed suicide, Fawcett (2001) noted only 18% had communicated suicidal thoughts to a health care provider, despite inquiries being made by the provider and that 77% of in-patients who had committed suicide denied any suicidal intent within a week of suicide (Fawcett, 2001).

In certain cases suicide is an impulsive act with only a brief period between the suicidal ideation and the suicidal act. This impulsiveness makes it difficult to accurately predict who will commit suicide despite conducting a thorough SRA. Deisenhammer et al. (2008) reported 47.6% of suicide attempters had less than 10 minutes from their first thoughts of committing suicide to the actual attempt. In a study of 158 persons who attempted suicide, 24% had less than five minutes from the decision to attempt suicide to their initial attempt (Simon et al., 2001).

This evidence suggests a significant number of patients with depressed mood are either not receiving any mental health treatment from a specialist or are receiving mental health

treatment from their PCP who may lack adequate clinical knowledge to manage them. One source (Mann et al, 2005) reported that mental illness, specifically depression, is not correctly diagnosed and therefore undertreated in the primary care setting, and that suicide reduction programs should include educating PCP's. Feldman et al. (2007) reported that a PCP would only ask about suicidal ideation approximately 27% of the time unless prompted by a request for antidepressants by the patient and assessment of suicidal thoughts was inconsistently conducted. Cattell & Jolley (1995) studied suicides in the elderly and found only 14% of those who committed suicide had been seen by specialty care, 43% were seen by their general practitioner and referrals to mental health in the elderly prior to committing suicide were inconsistent. In a study of Italian health professionals including psychiatrists, general practitioners, psychiatric nurses, emergency room physicians, emergency room nurses, and medical students, Palmieri et al., (2008) found that treating suicidal patients was a common experience across the spectrum of health care specialties while training for suicide risk assessment (SRA) training was inconsistent. Graham, et al., (2011) concluded a PCP's willingness to treat suicidal patients was dependent on the training the provider had received and female PCPs had less self-perceived competency for treating suicidal patients.

Purpose of the Capstone

The purpose of this capstone was the development and evaluation of an evidence based SRA Tool kit to provide appropriate evidence based and timely information to all staff employed in a primary care setting.

<div align="center">**Review of Literature**</div>

The electronic data bases CINHAL, PubMed, Ovid MEDLINE, ERIC, and PsychArticle were searched to identify studies that were relevant to the issue of SRA. The search terms used

were suicide, suicide risk assessment, training, education, primary care, and family practice. Pertinent articles were limited to studies that were published in peer reviewed English language journals. The subjects were limited to patients who were aged 19 or older. Journal articles were excluded if they were opinion pieces, editorial articles, or non-peer reviewed articles. The initial search identified 104 articles. A review of titles and abstracts was completed and 15 articles were selected for full review. One additional article was included after conducting a review of references for a total of 16 articles for this part of the literature review.

Accomplishing a SRA in the ED is a challenging procedure, the patient may deny any suicidal intention to avoid hospitalization and collateral information from the therapist or family members may not be available (Simon, 2008) so the ED practitioner must rely on their own observations and clinical judgement. In a literature review of 51 articles about suicide and ED's it was reported that emergency physicians, not mental health, conduct up to 90% of suicide evaluations that took place in the ED (Hickey et al., 2000). In another study, up to 58.9% of patients who were brought to the emergency department (ED) for deliberately committing self-harm were discharged from the hospital without being seen by mental health for an assessment (Hickey et al., 2000).

The completion of a SRA based on current clinical evidence is a critical issue in the treatment of patients with suicidal thoughts. There have been efforts to improve the quality of training in professional graduate health care programs on suicide risk assessment. Schmitz et al. (2012) reviewed SRA practices in a graduate mental health training program and found that only one half of psychology trainees had any didactic training on suicide. Schmitz, et al., (2012) recommended the inclusion of suicide assessment education in mental-health training programs, SRA continuing education requirements for state licensure, credentialing bodies verify SRA

training, and non-SRA trained providers have a supervised clinical practice while treating suicidal persons. Cramer, et al., (2013) conducted a literature review to evaluate the effectiveness of SRA and to propose an evidence-based training program for SRA. The authors found that it was difficult to measure SRA training in graduate health care programs and identified 10 competencies when completing an SRA. The competencies that Cramer, et al. (2013) suggested were: 1) to know and manage your own attitudes toward suicide, 2) develop and maintain a collaborative relationship with the patient, 3) know and elicit evidence-based risk and protective factors, 4) focus on the current plan and intent, 5) determine level of risk, 6) develop a collaborative evidence-based treatment plan, 7) notify and involve other persons, 8) document risk plan and reasoning, 9) know the law regarding SRA, 10) and engage in a debriefing and self-care. Granello (2010) identified and suggested 12 similar core principles to guide a health care provider in performing a SRA that should be included in educational programs. These principles are: 1) the SRA of each person is unique, 2) understand that SRA is a complex process, 3) be aware that SRA is an ongoing process, 4) be cautious when doing a SRA, 5) be collaborative, 6) use your clinical judgment, 7) take all risks, threats, and warning signs serious, 8) ask difficult questions, 9) realize that SRA is treatment, 10) uncover underlying messages, 11) use cultural context when conducting a SRA, 12) thoroughly document the SRA (Granello, 2010). Wyman et al. (2008) reported that the staff perceptions on management of suicidal persons was higher after receiving SRA training.

In a retrospective study of 198 successful suicides in England, Saini, While, Chantler, Windfuhr, & Kapur (2014) reported a relative lack of a SRA being conducted prior to a successful suicide in the primary care setting and current SRA and suicidal assessment scales have a poor predictive value. Consequently, Saini et al., (2014) recommended PCP's take into

account additional factors such as various demographic and clinical factors when conducting a SRA.

A PCP's previous training in suicide prevention and SRA was predictive of an increased willingness to treat suicidal persons and lower training levels correlated with lower perceived competency among PCPs in treating suicidal persons (Graham, Rudd, & Bryan, 2011). In a study of a one hour educational program on suicidal risk conducted at a Veterans Administration hospital for 71 employees, Matthieu, Chen, Schohm, Lantiga, & Knox (2009) reported that referrals to mental health increased after suicide prevention gatekeeper training and there was additional interest in ongoing training for SRA. At a hospital in Japan, Takahiro et al. (2010) evaluated a two-hour SRA brief educational program for 44 first-year medical students and showed an immediate improvement in provider's confidence and attitudes of SRA but those improvements were limited at the six month follow up.

There are several articles that assessed the efficacy of educational programs in SRA and the treatment of suicidal persons with mixed results. Milton, et al., (1999) conducted a retrospective study of SRA and PCP attitudes after a patient's successful suicide and found that a SRA was recorded for only 38% of successful suicides. In addition, psychiatric training for a general practitioner did not predispose them to conducting a SRA and length of practice time reduced the likelihood of an SRA being conducted. Berlin, Perizzlo, Lejderman, Fleck, & Joiner (2006) conducted a brief evaluation of a suicide prevention program for frontline hospital staff in Brazil and found that after training, short-term knowledge on suicide prevention improved and the staff felt more capable of helping suicidal individuals. In contrast, Morriss, Gask, Webb, Dixon, &Appleby (2005) evaluated 103 frontline healthcare workers after a brief educational skills training on SRA and found the training did not reduce the rate of successful suicides.

In a study evaluating an 18 hour suicide prevention program, Chan, et al. (2009) found nurses felt more competent to conduct a SRA after an 18 hour educational program but positive results may not be significant at the six-month point. After a 60 minute seminar on suicide prevention PCPs reported improved confidence and knowledge regarding suicidal persons and the training resulted in an increase number of SRA's being conducted (Falluco, Conlon, Gale, Constantino, & Glowinski (2011). Oordt, et al. (2009) conducted a 12 hour educational program for newly trained mental health providers and found 43% had little or no prior SRA training and 97% agreed the training would change their practice. A 6 month follow up showed 83% reported making a change in their practice and improved overall confidence in treating suicidal persons. Pasco Wallack, Sartin, & Dayton, (2012) evaluated the efficacy of a three-hour training program for university residential advisors and found crisis skills in self-efficacy had increased after the training. See Appendix B for a review process of selected articles.

Summary of research articles

Suicide rates have been increasing so that it is now is the 10th leading cause of death in the U. S. (CDC, 2012) and there is a shortage of mental health providers (Thomas, et al., 2009). This can lead to a significant amount of individuals with significant risk factors for suicide being treated by their PCP (Bostwick & Rackley, 2012, Cattell & Jolley, 1995, Luoma, et al., 2002). There have been several brief educational programs that have demonstrated effectiveness at improving a healthcare provider's knowledge and perceived efficacy in treating suicidal persons (Graham, et al., 2011, Matthieu, et al., 2009, Takihiro, et al., 2010).

Based on the research parameters used for the literature review, there were no evidence-based SRA Toolkits for frontline healthcare providers to utilize when treating suicidal persons. The research also indicates there are inconsistencies in the training of healthcare professionals in

conducting a SRA and treating suicidal persons. The quality of SRA's conducted in the primary care, family practice, and ED setting are inconsistent (Aflague & Ferszt, 2010) and formal training in suicide prevention and SRA is not standardized in graduate training programs with didactic training social worker, psychology, and child psychiatry programs in SP ranging from 29% to 94% (Matthieu, et al., 2009).

The lack of formal training in SRA and suicide risk management is not only an issue in the primary care field. Mental health specialties also lack consistency between training programs regarding SRA and suicide risk management training. Oordt, Jobes, Fonseca, & Schmidt (2009) conducted a study of SRA training with 82 active duty USAF mental health providers in San Antonio, Texas and in the preliminary needs assessment found most had "little or no" training in their post graduate training programs on SRA. Additionally, most of the mental health professionals had some experience treating patients with suicidal patients while 74 % reported being only "somewhat or moderately" experienced with suicidal patients (Oordt, et al., 2009).

In an effort to increase SRA training for medical personnel the State of Washington mandated six hours of continuing education in the assessment, treatment, and management of suicidal patients every six years for psychologists, occupational therapists, mental health counselors, marriage and family therapists, advanced social workers, chemical dependency professionals, certified counselors, and certified advisors (Stuber & Quinnett, 2013, pg.). Ironically, primary care physicians and nurses objected to this new law and were excused from the mandate, thus not benefiting from additional training in suicide risk assessment (Stuber & Quinnett, 2013). In a pre-post study of additional training in suicide assessment and management, Oordt et al. (2009) reported psychiatrists and psychiatric nurse's confidence in conducting a SRA improved after a 12 hour training program.

Although conducting a SRA with some type of a risk estimate is the current standard of care if the provider has any concerns, the predictive value of a SRA is questionable (Homaifar, Matarazzo, & Wortzel, 2013). In addition, the value of the risk assessment to the patient in mitigating suicidal thoughts is unclear and may only be done to mitigate organizational liability in case of a successful suicide thus wasting the providers time (Mulder, 2011). Even when a SRA is conducted there is very little standardization of what is required and how it should be conducted. Cramer, Johnson, McLaughlin, & Rauch (2013) reported there were no clear standards in psychological doctoral programs for education about SRA and they recommended the development of specific SRA training to be included in doctoral education programs. Aflague & Ferszt (2010) studied psychiatric nurses and found there was no standardization of conducting a SRA and in fact there was significant variability in the performance of a SRA among the nurses who were in the study.

Ronquillo, Minassian, Vilke, & Wilson (2012) conducted a literature review on suicide assessment in the emergency department and recommended training in SRA due to the number of patients who were seen at the emergency department with suicidal ideation. Despite the research indicating the need for training in SRA for those working the primary care settings and the existence of clinical practice guidelines there are multiple reason that implementation of evidence based practices are delayed being implemented into clinical practice.

Cabana, et al. (1999) identified both patient related and environmental barriers to the implementation of best practices. A study of oncology nurses and their knowledge of suicidal risk factors found that most rated themselves as having "little to some skill" with suicidal evaluation and had difficulty identifying demographic factors associated with suicidal thoughts (Valente, 2010).

A barrier to changing a physician's behavior identified by Bain (2007) was not having the necessary information at the point of care. Mann, et al. (2005) conducted a literature review with experts from 15 countries of suicide prevention strategies. This study identified physician education and restricting access to lethal means to suicide as promising strategies for reducing suicide rates.

Rationale for Capstone Based on Literature Review

There are a significant number of health care consumers who are experiencing suicidal ideations and are being seen by either family health or primary care providers. PCP's do not get consistent training in conducting a SRA. Several brief educational programs have demonstrated effectiveness at improving a healthcare provider's knowledge and perceived efficacy in treating suicidal persons (Graham, et al., 2011, Matthieu, et al., 2009, Takihiro, et al., 2010). The development of an evidence based SRA tool kit that could be reviewed by primary care providers could be beneficial and enhance provider confidence and skills at conducting a SRA.

Theoretical Framework

A goal of this capstone was to develop an evidence-based SRA Toolkit to be utilized in a primary care setting. The Theory of Planned Behavior (TPB) was developed out of the Theory of Reasoned Action, is based on social behavior theory, and used to explain the rationale behind planned behaviors (Armitage & Conner, 2001). See Appendix A. The TPB has been thoroughly studied and a meta-analysis conducted by Armitage & Conner (2001) found support that the TPB is efficacious as a predictor of an individual's behavior and their intentions to engage in that behavior. In a recent review of the TPB, Ajzen (2011) reported that it can be used to accurately predict behavior.

According to the TPB the intention to perform a behavior is preceded by attitudes, subjective norms, perceived behavioral control, and intention toward that behavior (Ajzen, 2002). The definitions for the primary concepts of the TPB are;

1. Attitudes; the behavioral belief regarding possible consequences of a specific action (Ajzen, 2002).

2. Subjective norms; the individual's perception about a specific behavior and the likelihood that important groups in the individual's life either approve or disapprove of a given behavior (Ajzen, 2002).

3. Perceived behavioral control; the individual's perception on how easy or difficult the specific behavior will be. This is composed of perceived self-efficacy and perceived controllability regarding the behavior (Ajzen, 2002).

4. Intention; the intention to perform the behavior itself.

5. Behavior; The individual's observable reaction in a specific situation (Ajzen, 2002).

Research Question

Would a panel of clinical healthcare experts find a resource kit designed for the primary care environment about suicide risk assessment and treatments based on current clinical practice guidelines to be an effective tool to improve the frequency and quality of a SRA?

Methods

The literature suggests health professionals who work in the primary care setting are seeing a significant percentage of those who successfully commit suicide in the period before they take their lives. The literature also shows that a health care provider may not have received any training or inconsistent training in SRA while in their educational programs. A SRA Toolkit

in the primary care setting would be a valuable resource for a PCP to assist them in treating suicidal persons.

Study Design

This capstone was designed as a descriptive study to determine whether the SRA Toolkit is a useful resource for health care professionals working in primary care.

Purpose

The purpose of this capstone was the development and assessment of an information tool kit about SRA to be used by healthcare professionals who practice in the family practice or primary care arena.

Definition of Terms

SRA Toolkit: A resource developed by the author that included an introduction to the subject, on-line resources on the assessment and treatment of suicidal persons, the most recent versions of clinical practice guidelines on SRA available, examples of assessment questions, as well as proper documentation of a SRA based on current standards of care.

Suicide: Death from injury, poisoning, or suffocation where there is evidence (explicit or implicit) that the injury was self-inflicted and the decedent intended to kill themselves (O'Carroll et al., 1996).

Suicide Attempt with Injuries: An action resulting in nonfatal injury, poisoning, or suffocation where there is evidence that the injury was self-inflicted and the intent was to die (O'Carroll et al., 1996).

Suicide Attempt: A potentially self-injurious behavior with a nonfatal outcome for which there is evidence that the person intended at some level to kill themselves. A suicide attempt may or may not result in injuries (O'Carroll et al., 1996).

Suicidal Act: A potentially self-injurious behavior for which there is evidence (explicit or implicit) that the person intended at some level to kill themselves. A suicidal act may result in death, injuries, or no injuries (O'Carroll et al., 1996).

Instrumental Suicide-Related Behavior: Potentially self-injurious behavior for which there is evidence that the person did not intend to die **and** the person wished to use the appearance of intending to die in order to attain some other goal (seek help, punish others, attention seeking. (O'Carroll et al., 1996).

Suicide-Related Behavior: Potentially self-injurious behavior for which there is explicit or implicit evidence either that the person intended at some level to kill themselves or the person wanted to use the appearance of intending to kill themselves in order to attain some other end. Suicide-related behavior compromises suicidal acts and instrumental suicide-related behavior (O'Carroll et al., 1996).

Suicide Threat: Any interpersonal action, verbal or nonverbal, stopping short of a directly self-harmful act, that a reasonable person would interpret as communicating or suggesting that a suicidal act or other suicide related behavior might occur in the near future (O'Carroll et al., 1996).

Suicidal Preparatory Behavior: Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (buy a gun, collect pills) or preparing for one's death by suicide (note, give things away) (O'Carroll et al., 1996).

Suicidal Ideation: Any self-reported thoughts of engaging in suicide-related behavior (O'Carroll et al., 1996).

Suicidal Risk Factors: Factors that increase the likelihood of suicidal behavior and include both modifiable and non-modifiable indicators. (VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, 2013).

Suicidal Protective Factors: Capabilities, qualities, environmental and personal resources that increase resilience and drive individuals toward growth, stability, health, and increase coping with different events and decrease the likelihood of suicidal behavior (VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, 2013).

Setting

The SRA Toolkit and structured review questions were sent electronically to the panel members. They were provided four weeks for reviewing the SRA Toolkit and completing the review questions. The setting for the review as well as the completion of the structured questions was determined by the personal preferences of each panel member.

Description of Sample

Inclusion criteria were the health care providers were known to the DNP student and were currently practicing in their specialty.

Criteria for exclusion was providers who were not known to the DNP student.

The resulting review panel consisted of six health care providers; All providers were known to this DNP student. The specific training of the panel members was DNP Psychiatric Mental Health Nurse Practitioner, DNP Family Practice Nurse Practitioner, Psychologist, Family Practice Physician, Psychiatrist, and a BSN prepared Registered Nurse who had worked in a primary care setting.

Measures

The evaluation measures constructed for this study is provided in appendix C. Question #1 evaluated their likelihood of using the SRA Toolkit in a family practice or primary care setting clinical practice in a Likert scale with answer ranging from "very unlikely" to "very likely". The Likert format has given similar results to other measures and in some situations is desirable since it requires only one response (Maurer & Pierce, 1998). Simple descriptive statistics were used to describe the most common answer to question one.

Questions #2 through #6 were qualitatively analyzed by the DNP student determining patterns or themes among the panel members on specific questions. These themes were reviewed for bias by a non-interested party.

Procedure

The SRA Toolkit was developed after a literature review for current guidelines for the assessment and treatment of suicidal persons. The following electronic data bases were searched to identify relevant SRA clinical practice guidelines; CINHAL, PubMed, Ovid MEDLINE, ERIC, PsychArticle, and the U.S. Department of Health & Human Resources National Guideline Clearinghouse. The search terms used were suicide, suicide risk assessment, and clinical practice guidelines. Pertinent articles were limited to clinical guidelines that were published in peer reviewed English language journals. Links to three Clinical Practice Guidelines were chosen for inclusion in this SRA Toolkit. The author included the Air Force Guide for Suicide Risk Assessment, Management, and Treatment (2013) with its appendices.

The SRA Toolkit was explained to each panel member and after they agreed to participate, the SRA Toolkit was electronically submitted to each member of the panel for review and critique. The panel members were able to review the SRA Toolkit at any setting of their choosing and were able to contact the DNP student for clarification about the material and

expectations. They were provided up to four weeks for review of the material and to formulate comments. At the end of this period all six panel members had returned the completed questionnaire. Only one individual had questions that required telephonic communication.

Human Subject Protection

The study was approved by the University of Virginia, Institutional Review Board (Appendix E). No personal identifying information was gathered from panel members. No financial compensation was offered to panel members.

Data Analysis

The numerical answers to the first Likert scale question were tabulated and a mean was computed. The answers to the comments gathered from the structured interview questions were collected and qualitatively analyzed for common themes and suggestions. These themes were reviewed for bias by a two non-interested party. No investigator bias was identified.

The identified themes and suggestions will be incorporated in the completed SRA Toolkit for future testing in clinical settings.

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Results

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This descriptive study examined the appropriateness of the SRA Toolkit for utilization in a primary care setting.

Question # 1: How likely do you feel that the information provided in the SRA Toolkit would be utilized in a family practice or a primary care practice?

The six raters' scores on the first Likert scale question were averaged. Both the average and mode was four or likely to be utilized.

Five of the six panel members reported that this SRA Toolkit would be either "Likely" or "Very Likely" to be utilized in a primary care setting. Both the FNP and the PMHNP identified

the SRA Toolkit as "Very Likely" to be utilized in a primary care setting while the psychiatrist, family practice doctor, and the psychologist identified the toolkit as "Likely" to be utilized in a primary care setting. Only one panel member rated the toolkit as "Unlikely" to be utilized in a primary care setting citing time restrictions as the primary reason for not being utilized.

Question # 2: What suggestions would you like to offer for improving the SRA Toolkit?

A common theme for question #2 was to shorten or condense the toolkit. One respondent specifically discussed the time limitations when a PCP is seeing a patient. The recommendations from all respondents were to either limit the toolkit to a single example of a risk assessment or to provide a single page that combines the best from all the example risk assessments.

Question #3: What information was the least helpful in the SRA Toolkit?

The length of the SRA Toolkit and the repetitive nature of the risk assessment examples were identified as being least helpful. The purpose of being a broadly usable tool and including three example risk assessments was not identified in the introduction to the toolkit and the one respondent identified this as an attempt to be all inclusive in the toolkit. Including information that was exclusively for mental health use was another piece of information that was identified as being not helpful. The use of the high interest log utilized in the USAF assessment example was identified as not being useful in a primary care setting.

Question #4: What information did you find most helpful in the SRA Toolkit.

The example of sample questions to ask during a SRA was identified as helpful by all the respondents. Respondents preferred different SRA examples based on their area of expertise. Three respondents specifically identified the second example SRA as the most helpful, which is also the briefest.

Question #5: In what clinical setting do you think this instrument would be most useful?

All respondents reported that they believed the toolkit would be of use in a primary care setting. One respondent, who was a provider in the USAF system, identified flight medicine and pediatrics as additional areas that would find the SRA Toolkit useful. Flight medicine is a clinic that provides primary care to persons who are in career fields that involve flying and their families. One respondent stated that the SRA should be conducted in all clinical areas. Another respondent added that a SRA would work in a primary care setting if staff were provided adequate time to conduct assessments.

Question #6: Are there any additional comments you would like to make?

One respondent suggested adding the pocket guide and decision tree while another suggested adding information about head injuries. One respondent stated that this type of training would be helpful since training received thus far, only extended to asking about thoughts of harming themselves, which did not include what to do or ask afterwards. Another respondent felt the SRA Toolkit had potential to be helpful after further corrections. One respondent suggested adding information about the impulsive nature of suicide, correcting the mistaken belief that all suicides are preventable and avoiding adding an additional responsibility to the PCP.

Discussion

There have been reports of suicide since mankind began keeping records and cultural attitudes about suicide have changed over the years. The term suicide was first used in the year 1642, prior to that suicide was considered self-murder and a crime punished by burial in the highway (Shneidman, 1998). In historical Greek culture, suicide was seen as an act against the gods and persons who committed suicide were denied a funeral. In Roman culture suicide was criminalized and all personal property belonging to the individual who committed suicide was forfeited to the state after a person committed suicide to eliminate any legacy for the family

(Crone, 1996). During the middle-ages, suicide was seen as an unnatural act that violated Gods power over mankind, since God gave life, only God should have the right to take life (Crone, 1996).

In recent years attitudes toward suicide have changed such that suicide is no longer seen as a crime where the individual is punished or incarcerated but rather a symptom of a mental illness that deserves treatment and care. Both the United States (U.S. Department of Health and Human Services, 2014) and the World Health Organization (2014) have identified suicide as a mental health problem that needs to be reduced.

Several CPG's have been developed regarding the assessment and treatment of suicidal persons. The American Psychiatric Association (2003), The Registered Nurses' Association of Ontario (2009), The USAF (2013), and the Department of Veterans Affairs (Assessment and Management of Risk for Suicide Working Group, 2013) have all published evidence based guidelines for assessing and treating suicidal persons.

Despite the existence of multiple guidelines for the assessment of suicidal persons, suicide risk assessments in primary care setting are being inconsistently implemented (Oordt et al., 2009). Additionally, there are evidence based CPG's on the assessment and treatment of suicidal persons, educational programs have been inconsistent with standardizing training in suicide risk assessment (Cramer et. al., 2013).

Perceived behavioral control (PBC) is one of the concepts of the TPD and has an effect on a person's intention to engage in a behavior as well as an independent predictor of a persons' intention and engage in certain behaviors (Armitage & Conner, 2001). Increasing an individual's PBC through increasing knowledge and necessary skills will increase the likelihood of the

behavior. In this study descriptive study the majority of the panel members identified the SRA Toolkit as likely or very likely to be utilized in practice.

Strengths and Weaknesses

Strengths: The recommendations from the expert panel provides the basis for further review and implementation of a SRA Toolkit in primary healthcare. An additional strength is the diverse clinical experience among the panel members who provided a wide range of feedback.

Limitations: A major limitation of this study is the small size of expert subject panel and the limitation of evaluation questions. The panel members were not equally experienced in patient care and suicide assessment standards so their individual feedback may vary in relevance based on their education and experience.

Nursing Practice Implications

Luoma et al. (2002) reported that a significant percentage of suicidal persons were being treated and managed by their family practice or primary care provider within a year of a successful suicide. As nursing responsibilities expand at both nurse practitioner and RN levels, nurses are frequently the frontline contact when dealing with potentially suicidal persons. An evidence-based SRA Toolkit with specific information on the facts regarding suicide and how to conduct an effective SRA made available in the primary care setting could improve the confidence and consistency in assessing risk of suicidal persons.

Implications for further Research

There were several valuable suggestions for improvements to the SRA Toolkit that are worthy of consideration in conducting future research. All panel members recommended modifying the toolkit to make it shorter and including a one page assessment example that the PCP could refer to during a patient appointment. A pocket guide that synthesizes and

summarizes the major points of a SRA could be developed to help the practitioner remember important aspects of a SRA while meeting with a patient.

This SRA Toolkit was reviewed by clinical practitioners who practice in different specialties and patient populations. The future development of a SRA Toolkit that focuses on specific patient populations such as predominantly military or civilian populations that the PCP treat could be beneficial. Further study with larger samples of providers is needed to better understand the SRA Toolkit rating as "very unlikely" to be utilized when the other members of the panel rated it more likely to be utilized.

Capstone Products

The final products of this capstone are:

- Suicide Risk Assessment Toolkit for the Primary Care Setting

- Typed structured interview notes

- Report of the project

- Completed structured questions

- Manuscript appropriate for publication in *Military Behavioral Health*

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Appendix A

Theory of Planned Behavior (Armitage & Connor, 2001)
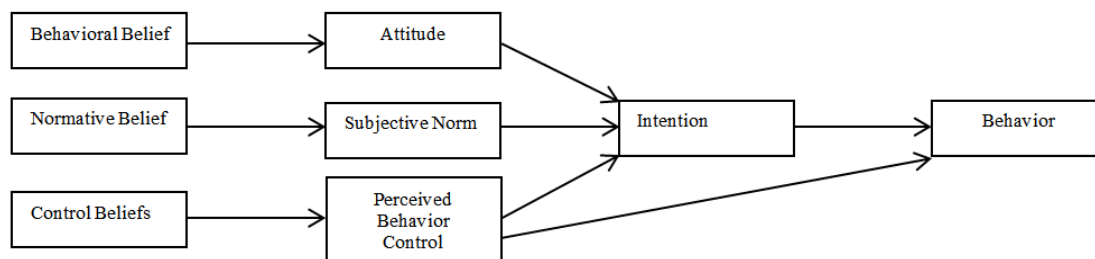
Appendix B

Suicide Risk Assessment Toolkit

Table of Contents

Section I

Introduction

Overview of Problem

   Suicide, not only a leading cause of death in the United States it is a significant cost to the economy. According to the Center for Disease Control and Prevention report, in 2010 suicide had become the tenth leading cause of death for all ages (CDC, 2013), costing $34.6 million dollars in lost work and medical expenses (CDC, 2012). During 2010 there were 38,364 suicides in the United States with an additional 487,700 cases of self -inflicted injuries requiring emergency treatment (CDC, 2012). The suicide rate for 2010 was more than twice the 14,748 murders in the United States (Federal Bureau of Investigation, 2010). The CDC (2013) reported suicide rates had increased by 28.4% from 1999 through 2010. The three most common methods of suicide were firearms, suffocation, and poisoning. Firearms were the most common method for men while poisoning was the most popular method for women (CDC, 2013). To counter the alarming rate of suicide in 2007 of 11.3 per 100, 000, the U.S. government established a goal to reduce suicide by 10% (U.S. Department of Health and Human Resources, 2014). During 2008-2009, approximately 8.3 million adults or 3.7% of the adult population in the United States reported having a suicidal thought, 2.2 million reported having developed a suicide plan and approximately one million adults reported making a suicide attempt (Crosby, Han, Ortega, Parks, & Gjroerer, 2011).

   Suicide is not a specific mental illness but rather a symptom associated with several different mental health diagnoses. A specific mental disorder commonly associated with elevated suicide rates is Major Depressive Disorder (MDD) (Sadock & Sadock, 2010, pg 334). MDD is a mental illness that at times can be debilitating such that up to 50% of people who commit suicide

had previously reported being depressed (Sadock & Sadock, 2010). The Diagnostic and Statistical Manual of Mental Disorders 4th edition Text Revision reports that 15% of individuals with a diagnosis of MDD will eventually successfully commit suicide. Individuals with MDD who are admitted to a nursing homes have an increased likelihood of dying in the first year. Those with MDD report more pain and physical illness when being seen by their primary care provider (American Psychiatric Association, 2005). Almost two-thirds of individuals who reported having a mental illness considered suicide while 77.5% of individuals with a mental illness develop a suicide plan, 79.6% make a suicide attempt, and 83.4% with a mental illness made a planned suicide attempt (Nock, Hwang, Sampson, & Kessler, 2010). The American Psychiatric Association has changed its position on suicide and suicidal behaviors in the newly released Diagnostic and Statistical Manual of Mental Disorders 5th Edition. A proposal for new diagnostic criteria and specific risk factors is recommended for a new diagnosis of Suicidal Behavior Disorder (American Psychiatric Association, 2013).

Due to the shortage of mental health providers in the United States, individuals with mental illness who may be having suicidal thoughts have no access to a mental health specialist and are being seen by their primary care provider (PCP) or in an emergency department (ED). In 2009, 77% of U.S. counties had a "severe" shortage of both mental health providers and mental health prescribers while 96% of U.S. counties had some level of shortage in mental health prescribers (Thomas et al., 2009) which can lead to PCP's treating patients with self-harm thoughts and mental health issues. Despite the high correlation between depression and suicide (Cooke, Gotto, Mayorga, Grant, & Lynn, 2013), many patients with depressive symptoms are evaluated, treated, and have medications managed by their PCP instead of a mental health specialist. McDowell, Lineberry, & Bostwick (2011) reported that PCP's write antidepressant

prescriptions more often than mental health providers and PSP's lack additional psychopharmacological training that would allow them to expertly prescribe these medications. Pratt, Brody, & Quipping (2011) reported that antidepressants were the third most commonly prescribed medication in the United States between the years of 2005 and 2008. This statistic is imposing, in that Pratt, et. al. (2011) also reported that less than 50% of patients on multiple antidepressants visited a mental health provider in the past 12 months. McDowell, et. al. (2011) reported that persons who were successful in their suicide were more likely to have seen their PCP during the final 30 days of their life. While Bostwick & Rackley (2012) reported that 75% of patients completing suicide had contact with their PCP within 12 months of committing suicide and 45% had contact with their PCP within one month of successful suicide). In the elderly population there is an even higher rate of patients completing suicide who have seen their PCP within one month of their suicide (Luoma, Martin & Pearson, 2002).

This evidence suggests a significant number of patients with depressed mood are either not receiving any mental health treatment from a specialist or are receiving mental health treatment from their PCP who may lack the adequate clinical knowledge to manage them. Mann et al. (2005) reported that mental illness, specifically depression, is not adequately diagnosed and undertreated in the primary care setting, and that educating PCP's is a component of suicide reduction. Feldman et al. (2007) note that a PCP would only ask about suicidal ideation approximately 27% of the time unless prompted by a request for antidepressants by the patient and that assessment of suicidal thoughts were inconsistently conducted. Cattell & Jolley (1995) studied suicides in the elderly and found that only 14% of those who committed suicide had been seen by specialty care, 43% were seen by their general practitioner and referrals to mental health in the elderly prior to committing suicide were inconsistent. In a study of Italian health

professionals that included psychiatrists, general practitioners, psychiatric nurses, emergency room physicians, emergency room nurses, and medical students Palmieri et al. (2008) found that treating suicidal patients was a common experience across the spectrum of professional training while suicide risk assessment (SRA) training was inconsistent. Graham, et al. (2011) concluded a PCP's willingness to treat suicidal patients was dependent on the provider training and that female PCPs had less self-perceived competency for treating suicidal patients.

The lack of formal training in SRA and suicide risk management is not only an issue in the primary care field as the mental health field has also noted a lack of consistency between training programs regarding SRA and suicide risk management training. Oordt, Jobes, Fonseca, & Schmidt (2009) conducted a study of SRA training with 82 active duty USAF mental health providers in San Antonio, Texas and in the preliminary needs assessment found most had "little or no" training in their post graduate training programs on SRA. Additionally, most of the mental health professionals had experience with suicidal patients while 74 % reported being only "somewhat or moderately" experienced with suicidal patients (Oordt, et al., 2009).

In an effort to increase SRA training for medical personnel the State of Washington mandated six hours of continuing education in the assessment, treatment, and management of suicidal patients every six years for psychologists, occupational therapists, mental health counselors, marriage and family therapists, advanced social workers, chemical dependency professionals, certified counselors, and certified advisors (Stuber & Quinnett, 2013, pg.). Ironically, primary care physicians and nurses objected to this new law and were excused from the mandate, thus avoiding additional training in suicide risk assessment (Stuber & Quinnett, 2013). In a pre-post study of additional training in suicide assessment and management, Oordt et.

al. (2009) reported psychiatrists and psychiatric nurse's confidence in conducting a SRA improved after twelve hour training.

Although conducting a SRA with some type of a risk estimate is the current standard of care if the provider has any concerns, the predictive value of a SRA is questionable (Homaifar, Matarazzo, & Wortzel, 2013). In addition the value of the risk assessment to the patient in mitigating suicidal thoughts is unclear and may only be done to mitigate organizational liability in case of a successful suicide thus wasting the providers time (Mulder, 2011). Even when a SRA is conducted there is very little standardization of what is required and how it should be conducted, for example Cramer, Johnson, McLaughlin, & Rauch (2013) reported there were no clear standards in psychological doctoral programs for education about SRA and they recommended the development of specific SRA training to be included in doctoral education programs. Aflague & Ferszt (2010) studied psychiatric nurses and found that there was no standardization of conducting a SRA and in fact there was significant variability in the performance of a SRA among the nurses who were in the study.

Legal liability associated with treating a person who successfully commits suicide is another issue for a health care provider in today's litigious society. A commonly accepted medical legal concept is malpractice has occurred if an accepted standard of care is not followed and results in a negative outcome to the patient (Knapp, & Vandecreek, 1983). A thorough assessment is required in any clinical situation and as mentioned earlier in this paper, treating suicidal patients was a common experience for many healthcare professions (Palmieri, at al., 2008). In a study on the legal aspects of SRA, Smith et al. (2008) reported psychiatrists, psychologists, and other mental health providers are not routinely conducting an adequate SRA due to lack of time, belief that documentation will make them more liable, anxiety about suicide,

and lack of proper training in conducting a SRA. Of note, not conducting a SRA does not excuse a health care provider from legal liability if a patient successfully commits suicide (Smith, at al., 2008).

Cabana et al. (1999) identified both patient related barriers and environmental related barriers to the implementation of best practices. A study of oncology nurses and their knowledge of suicidal risk factors found that most rated themselves as having "little to some skill" at suicidal evaluation and had difficulty identifying demographic factors associated with suicidal thoughts (Valente, 2010). One of the barriers to changing a physician's behavior identified by Bain (2007) was not having the necessary information at the point of care. Mann et al., (2005) also identified physician education as an intervention that reduced suicide rates, while pharmacotherapy, Gatekeeper education, means restriction, screening, psychotherapy, chain of care, and media programs were identified as evidence based suicide reduction interventions.

Methodology

In one study, up to 58.9% of patients who were brought to the emergency department (ED) for committing deliberate self-harm behaviors were discharged from the hospital without being seen by mental health for an assessment (Hickey et al., 2000). In a literature review of 51 articles about suicide and ED's it was reported emergency physicians conduct up to 90% of suicide evaluations happening in the ED. Safety contracts are still used despite the evidence that these safety contracts do not provide adequate legal protection for the provider nor the facility (Ronquillo et al., 2012).

The completion of a SRA based on current clinical evidence is a critical issue in the treatment of patients with suicidal thoughts. There have been efforts to improve the quality of training in professional graduate health care programs on suicide risk assessment. Schmitz et al.

(2012) reviewed SRA practices in a graduate mental health training program and found only one-half of psychology trainees had any didactic training on suicide. Schmitz et al., (2012) recommended that suicide education be incorporated in mental-health training programs, SRA continuing education be required for state licensure, credentialing bodies verify SRA training, and providers who have not been trained in SRA have a supervised clinical practice while treating suicidal persons.

In a retrospective study of 198 successful suicides in England, Saini et al. (2014) reported a relative lack of a SRA being conducted prior to a successful suicide in the primary care setting and current SRA and suicidal assessment scales have a poor predictive value. Consequently, Saini et al. (2014) recommended the PCP take into account additional factors such as various demographic and clinical factors when conducting a SRA.

A PCP's previous training in suicide prevention (SP) and SRA was predictive of an increased willingness to treat suicidal persons and lower training levels correlated with lower perceived competency among PCPs in treating suicidal persons (Graham, Rudd, & Bryan, 2011). In a study of a one hour educational program on suicidal risk conducted at a Veterans Administration hospital for 71 employees, Matthieu, Chen, Schohm, Lantiga, & Knox (2009) reported referrals to mental health increased after suicide prevention gatekeeper training and there was additional interest in ongoing training for SRA. At a hospital in Japan, Takahiro et al. (2010) evaluated a two-hour SRA brief educational program for 44 first-year medical students and showed an immediate improvement in provider's confidence and attitudes of SRA but those improvements were limited at the six month follow up.

There are several articles that assessed the efficacy of educational programs in SRA and the treatment of suicidal persons with mixed results. Milton et al. (1999) conducted a

retrospective study of SRA and PCP attitudes after a patient's successful suicide and found a

SRA was recorded for only 38% of successful suicides. In addition, psychiatric training for a

general practitioner did not predispose them to conducting a SRA and length of practice time

reduced the likelihood of an SRA being conducted. Berlin, Perizzlo, Lejderman, Fleck, & Joiner

(2006) conducted a brief evaluation of a suicide prevention program for frontline hospital staff in

Brazil and found short-term knowledge on suicide prevention improved and the staff felt more

capable of helping suicidal individuals after training. In contrast, Morriss, Gask, Webb, Dixon,

&Appleby (2005) evaluated 103 frontline healthcare workers after a brief educational skills

training on SRA and found the training did not reduce the rate of successful suicides.

In a study evaluating an 18 hour suicide prevention program, Chan et al. (2009) found

that nurses felt more competent to conduct a SRA after an 18 hour educational program but that

positive results may not be significant at the six-month point. After a 60 minute seminar on

suicide prevention PCPs reported improved confidence and knowledge regarding suicidal

persons and that the training resulted in an increase number of SRA's being conducted (Falluco,

Conlon, Gale, Constantino, & Glowinski (2011). Oordt, et al. (2009) conducted a 12 hour

educational program for newly trained mental health providers and found 43% had little or no

prior SRA training and 97% agreed the training would change their practice. A 6 month follow

up showed 83% reported making a change in their practice and improved overall confidence in

treating suicidal persons. Pasco Wallack, Sartin, & Dayton (2012) evaluated the efficacy of a

three-hour training program for university residential advisors and found that crisis skills in self-

efficacy had increased after three-hour training.

Summary

Suicide rates have been increasing to the point that it is now is the 10th leading cause of death in the U. S. (CDC, 2012) and there is a shortage of mental health providers (Thomas, et al., 2009). This translates into a significant amount of individuals with multiple risk factors for suicide being treated by their PCP (Bostwick & Rackley, 2012, Cattell & Jolley, 1995, Luoma, et al., 2002).

PCP's do not get consistent training in conducting a SRA. Several brief educational programs have demonstrated effectiveness at improving a healthcare provider's knowledge and perceived efficacy in treating suicidal persons (Graham et al., 2011, Matthieu et al., 2009, Takihiro et al., 2010). The development of an evidence based SRA tool kit that could be periodically reviewed by primary care providers would be beneficial and enhance provider confidence and skills at conducting a SRA.

This SRA Toolkit is a collection of existing evidence based practices that are available. It is an effort to simplify current information for a PCP and includes example assessments, risk factors, protective factors and relevant on-line websites.

Section 2

SRA Toolkit Development

The literature suggests that health professionals who work in the primary care setting are seeing a significant percentage of those who successfully suicide in the period before they take their lives. The literature also shows that a health care provider may not have received any training in SRA in their program. A SRA Toolkit in the primary care setting would be a valuable resource for a PCP to assist them in treating suicidal persons.

The electronic data bases CINHAL, PubMed, Ovid MEDLINE, ERIC, PsychArticle, and the U.S. Department of Health & Human Resources National Guideline Clearinghouse were initially searched to identify relevant SRA clinical practice guidelines. The search terms used were suicide, suicide risk assessment, and clinical practice guidelines. Pertinent articles were limited to clinical guidelines that were published in peer reviewed English language journals. Three Clinical Practice Guidelines were chosen for inclusion in this SRA Toolkit and from personal knowledge the Air Force Guide for Suicide Risk Assessment, Management, and Treatment (2013) with its appendices were included.

Definition of Terms

SRA Toolkit: A resource to be used in the family practice or primary care setting that includes evidence based clinical practice guidelines and on-line resources for the assessment and treatment of suicidal persons and examples of questions as well as proper documentation of a SRA.

Suicide: Death from injury, poisoning, or suffocation where there is evidence (explicit or implicit) that the injury was self-inflicted and the decedent intended to kill themselves (O'Carroll et al. 1996).

Suicide Attempt with Injuries: An action resulting in nonfatal injury, poisoning, or suffocation where there is evidence that the injury was self-inflicted and the intent was to die (O'Carroll et al. 1996).

Suicide Attempt: A potentially self-injurious behavior with a nonfatal outcome for which there is evidence that the person intended at some level to kill themselves. A suicide attempt may or may not result in injuries (O'Carroll et al. 1996).

Suicidal Act: A potentially self-injurious behavior for which there is evidence (explicit or implicit) that the person intended at some level to kill themselves. A suicidal act may result in death, injuries, or no injuries (O'Carroll et al. 1996).

Instrumental Suicide-Related Behavior: Potentially self-injurious behavior for which there is evidence that the person did not intend to die **and** the person wished to use the appearance of intending to die in order to attain some other goal (seek help, punish others, attention seeking. (O'Carroll et al. 1996).

Suicide-Related Behavior: Potentially self-injurious behavior for which there is explicit or implicit evidence either that the person intended at some level to kill themselves or the person wanted to use the appearance of intending to kill themselves in order to attain some other end. Suicide-related behavior compromises suicidal acts and instrumental suicide-related behavior (O'Carroll et al. 1996).

Suicide Threat: Any interpersonal action, verbal or nonverbal, stopping short of a directly self-harmful act, that a reasonable person would interpret as communicating or suggesting that a suicidal act or other suicide related behavior might occur in the near future (O'Carroll et al, 1996).

Suicidal Preparatory Behavior: Acts or preparation towards engaging in Self-Directed

Violence, but before potential for injury has begun. This can include anything beyond a

verbalization or thought, such as assembling a method (buy a gun, collect pills) or preparing for

one's death by suicide (note, give things away) (O'Carroll et al. 1996).

Suicidal Ideation: Any self-reported thoughts of engaging in suicide-related behavior

(O'Carroll et al. 1996).

Suicidal Risk Factors: Factors that increase the likelihood of suicidal behavior and include

both modifiable and non-modifiable indicators. (VA/DoD Clinical Practice Guideline for

Assessment and Management of Patients at Risk for Suicide, 2013).

Suicidal Protective Factors: Capabilities, qualities, environmental and personal resources that

increase resilience and drive individuals toward growth, stability, health, and increase coping

with different events and decrease the likelihood of suicidal behavior (VA/DoD Clinical Practice

Guideline for Assessment and Management of Patients at Risk for Suicide, 2013).

Section 3

There are three examples of SRA's included in this toolkit. The first is a basic assessment that was available on-line from the Suicide Prevention Resource Center, Suicide Prevention Toolkit for Rural Primary Practice. It includes five components of a suicide risk assessment and examples of questions to ask during each component. The second example of a SRA is an excerpt from the appendices for the Air Force Guide for Suicide Risk Assessment, Management, and Treatment (2013). It includes examples of the information to include in the documentation of a SRA with additional information unique to members of the military. The final example of a SRA is from the VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide (2013). It also includes sample question in five topics during a SRA.

The three SRA included serve as examples of risk assessments based on current evidence; this toolkit is not meant to be an exhaustive or comprehensive collection, rather a helpful resource for those who work in the primary care or family practice setting.

Suicide Risk Assessment, Example 1

About 3% of adults (and a much higher percentage of youths) are entertaining thoughts of suicide at any given time; however, there is no certain way to predict who will go on to attempt suicide.

Key components of a suicide risk assessment

1. Assess risk factors
2. Suicide Inquiry: thoughts/plan /intent/access to means
3. Assess protective factors
4. Clinical judgment
5. Document

1. Risk Factors

Suicidal behavior is associated with many different types of events, illnesses, and life circumstances.[25]

The strongest predictor of suicide is one or more previous attempts; however, most people who die by suicide die on their first attempt.

There are many factors that increase risk for suicide. A greater number of identified risk factors is suggestive of greater risk.[26]

Individual Risk Factors

► Previous suicide attempt

► Major physical illnesses, especially with chronic pain

► Central nervous system disorders, including TBI

► Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders (e.g., PTSD), and certain alcohol and other substance use disorders; personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD). In youths: ADHD and conduct disorders (antisocial behavior, aggression, impulsivity)

► Psychiatric symptoms/states of mind: anhedonia, severe anxiety/panic, insomnia, command hallucinations, intoxication, self-hate

► Impulsive and/or aggressive tendencies

► History of trauma or abuse

► Family history of suicide

► Precipitants/triggering events leading to humiliation, shame, or despair (e.g., loss of relationship, health or financial status – real or anticipated

Social/Environmental Risk Factors

- ▶ Chaotic family history (e.g., separation or divorce, change in caretaker, change in living situation or residence, incarcerations)
- ▶ Lack of social support and increasing isolation
- ▶ Easy access to/familiarity with lethal means (e.g., guns, illicit drugs, medications)
- ▶ Local clusters of suicide that have a contagious influence
- ▶ Legal difficulties/contact with law enforcement/incarceration
- ▶ Barriers to accessing health care, especially mental health and substance abuse treatment

Societal Risk Factors

- ▶ Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)[27]
- ▶ Exposure to, including through the media, and influence of others who have died by suicide

2. Suicide Inquiry

- ▶ If any suicide warning signs are evident or if significant risk factors are present, an initial suicide inquiry is warranted. Patients will generally not spontaneously report suicidal ideation, but 70% communicate their intentions or wish to die to significant others. Ask patients directly about suicide and seek collateral information from other clinicians, family members, friends, EMS personnel, police, and others.[28] How you ask the question affects the likelihood of getting a truthful response. Use a non-judgmental, non-condescending, matter-of-fact approach.

- ▶ NEVER ask leading questions like:

   "You're not thinking of suicide, are you"?

- ▶ Practice questions several times prior to a clinical encounter; asking about suicide for the first time may be harder than you think.

Thoughts of Suicide

Ask patients you suspect may be feeling suicidal about thoughts or feelings related to suicide. The sample questions below will help you ease into the subject in a non-threatening way.

Sample questions to uncover suicidal thinking:[29]

- • Sometimes, people in your situation (describe the situation) lose hope; I'm wondering if you may have lost hope, too?
- • Have you ever thought things would be better if you were dead?
- • With this much stress (or hopelessness) in your life, have you thought of hurting yourself?
- • Have you ever thought about killing yourself?

▶ **Prior Attempt**

> A history of a prior attempt is the strongest predictor of future suicidal behavior. Always ask if the patient has attempted suicide in the past, even if there is no evidence of recent suicidal thinking.

Sample question to assess prior attempt:

- Have you ever tried to kill yourself or attempt suicide?

▶ If your questioning reveals no evidence of suicidal ideation, you may end the inquiry here and document the finding.

▶ If your patient initially denies suicidal thoughts but you have a high degree of suspicion or concern due to agitation, anger, impaired judgment, etc., ask as many times as necessary in several ways until you can reconcile the disagreement about what you see and what the patient says.

▶ If your patient is having suicidal thoughts, ask specifically about frequency, duration, and intensity.

> Sample questions to assess suicidal ideation:
> - When did you begin having suicidal thoughts?
> - Did any event (stressor) precipitate the suicidal thoughts?
> - How often do you have thoughts of suicide? How long do they last? How strong are they?
> - What is the worst they have ever been?
> - What do you do when you have suicidal thoughts?
> - What did you do when they were the strongest ever?

Plan

After discussing the character of suicidal thoughts, providers should inquire about planning.[30] Ask whether the patient has a plan and, if so, get the specifics.

> Sample questions to assess suicidal planning:
> - Do you have a plan or have you been planning to end your life? If so, how would you do it? Where would you do it?
> - Do you have the (drugs, gun, rope) that you would use? Where is it right now?
> - Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?

Intent

Determine the extent to which the patient expects to carry out the plan and believes the plan or act to be lethal vs. self-injurious. Also explore the patient's reasons to die vs. reasons to live. Inquire about aborted attempts, rehearsals (such as tying a noose or loading a gun), and non-suicidal self-injurious actions, as these are indicators of the patient's intent to act on the plan.[31] Consider the patient's judgment and level of impulse control. Administer mental status exam if in doubt about mental status.

> Sample questions to assess intent:
> - What would it accomplish if you were to end your life?
> - Do you feel as if you're a burden to others?
> - How confident are you that this plan would actually end your life?
> - What have you done to begin to carry out the plan?
>   For instance, have you rehearsed what you would do (e.g., held the pills or gun, tied the rope)?
> - Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?
> - What makes you feel better (e.g., contact with family, use of substances)?
> - What makes you feel worse (e.g., being alone, thinking about a situation)?
> - How likely do you think you are to carry out your plan?
> - What stops you from killing yourself?

Look for disagreement between what you see (objective findings) and what the patient tells you about their suicidal state (subjective findings). When possible, and always with adolescents, seek to confirm the patient's reports with information from a family member, spouse, or close friend. Patients are more likely to tell a family member than a PCP that they are suicidal.[32] It may also be helpful to explore the patient's cultural and/or religious beliefs about suicide and death.[33]

3. Protective Factors

While protective factors provide a poor counterbalance to individuals who are high-risk for attempting suicide (i.e., someone with strong ideation, intent, a plan, preparatory behaviors, and impaired judgment), protective factors can mitigate risk in a person with moderate to low suicide risk. Strengthening protective factors can be a part of safety planning, which will be discussed in Module 5.

Some important protective factors are:[34]
- Sense of responsibility to family
- Life satisfaction
- Social support; belongingness

- ▶ Coping skills
- ▶ Problem-solving skills
- ▶ Strong therapeutic relationship
- ▶ Reality testing ability
- ▶ Religious faith

4. Clinical Judgment of Suicide Risk

Assessing suicide risk in primary care is complex when patients have medical illnesses, mental health and substance abuse problems, and myriad family, contextual and environmental risk and protective factors. At the low end of the risk spectrum are patients with thoughts of death or wanting to die, but without suicidal thoughts, intent or a plan. Those with highly specific suicide plans, preparatory acts or suicide rehearsals, and clearly articulated intent are at the high end. Impaired judgment (intoxication, psychosis, TBI, impulsiveness) further exacerbates that heightened risk. There is no screening tool or questionnaire that can accurately predict which patients from among the many with suicidal risk will go on to make a suicide attempt, either fatal or non-fatal. The decision tree below is a snapshot of the pocket guide developed by the WICHE Mental Health Program and Suicide Prevention Resource Center for use by primary care professionals in assessing suicide risk and determining appropriate interventions (covered in Module 5). The copy of the pocket guide is also available as a separate document/tool for reference.

Suicide Prevention Resource Center. Suicide Prevention Toolkit. Retrieved from thttp://www.sprc.org/sites/sprc.org/files/pctoolkit.pdf

Suicide Risk Assessment, Example 2

<u>RISK ASSESSMENT</u>: (Adjust risk assessment for patients at risk for harm to others as clinically appropriate) the patient <u>endorsed</u> suicide-related *ideation and/or behaviors and intent/plan, thoughts about death and dying in session and during the period since last appointment*.

       Suicidal Ideation: *(Address frequency, intensity, duration, and onset; quote thoughts)*
       Suicidal Intent: *(Address extent of wish to die, likelihood of acting on thoughts, reasons for dying, time frame)*
       Suicidal Plan: *(Address when where how availability and lethality of means, motivation, planning, rehearsal*
       Suicidal Behaviors: *(Address specifics of behavior, e.g. how many pills taken, did pt load the gun)*
       Access to Means: *(Assess if the patient owns a weapon including a privately owned firearms, have plans to acquire a*
       weapon/firearm, ammunition or other weapons/means of hurting themselves or others).

(The below warning signs, risk and protective factors must be in each note and updated as needed)

Warning Signs: (possible warning signs, document only those that apply):
Threats of harming or killing self, seeking means, such as access to weapons, talking or writing about death, dying, or suicide, giving belongings away, hopelessness, rage, anger, seeking revenge; acting reckless or engaging in risky activities; feeling trapped; increased alcohol or drug use; withdrawing from family, friends, society; anxiety, agitation, insomnia, hypersomnia; dramatic changes in mood; no perceived reason for living or sense of purpose

Current risk factors are: (*possible risk factors, document only those that apply):*
History of suicide attempt; history of psychiatric inpatient care; history of non-suicidal self-injurious behaviors; depression or other mood disorders; personality disorders or traits; PTSD or anxiety disorders; sleep disorders; substance-use disorders; family history of suicide and /or psychiatric illness; psychotic disorders, hopelessness; thwarted belongingness; perceived burdensomeness; acquired capability for suicide; impulsivity; problem-solving deficits; shame; guilt, relationship problems; legal or financial problems; work related problems; lack of social support, TBI or other physical injury, chronic pain, other medical problems, access to lethal means; combat exposure; history of physical, emotional, mental and or sexual abuse; sexual orientation; mental health stigma and perceived barriers to care; recent local cluster of suicides (consider possible contagion)

Current Protective factors are: (*possible protective factors, document only those that apply):*
Compliance with psychiatric medication; engagement in evidenced-based treatment; motivation and readiness to change; insight about problems, problem solving and effective coping strategies; resilience; reasons for living; future orientation; perceived internal locus of control, healthy intimate relationships; social support and community involvement, medical compliance; able to access care as needed; support for help seeking, restricted access to lethal means; religion/spirituality, crisis response or other related training.

Risk Level: *(choose one)* Not Currently at Clinically significant risk: Currently at Clinically Significant Risk, but not imminent; Currently at Clinically Significant Risk, Imminent.

High Interest log:
No indication at this time
<u>OR</u>
Indicated at this time (document Command, PCM, ED and MH provider notifications)

Hospitalization **is/is not** deemed necessary at this time as the patients **does/does not** present a clear or imminent danger to self or others. No indication for pursuing higher level of care-Out pt management is currently most appropriate and least restrictive level of care. Pt is deemed to be a reliable reporter. Pt is competent to make healthcare decisions.

(United States Air Force (2013). Air Force guide for suicide risk assessment, management, and treatment. https://kx2.afms.mil/ki/kx8/MentalHealth)

Suicide Risk Assessment, Example 3

Suicide risk assessment is a process in which the healthcare provider gathers clinical information in order to determine the patient's risk for suicide. The risk for suicide is estimated based on the patient's suicidal thoughts and intent, suicide related behavior, warning signs, risk and protective factors.

Suicidal Ideation/Thoughts

Ask the patient if he/she has thoughts about wishing to die by suicide, or thoughts of engaging in suicide-related behavior. The distinction between non-suicidal self-directed violence and suicidal behavior is important.

Example Questions on Ideation:

- *With everything that has been going on, have you been experiencing any thoughts of killing yourself?"*
- *When did you begin having suicidal thoughts?*
- *Did any event (stressor) precipitate the thoughts?*
- *How often do you have thoughts of suicide?*
- *How long do they last?*
- *How strong are the thoughts of suicide?*
- *What is the worst they have ever been?*
- *What do you do when you have these (suicidal) thoughts?*
- *What did you do when they were the strongest ever?*
- *Do thoughts occur or intensify when you drink or use drugs?*

Suicidal Intent

Assess for past or present evidence (implicit or explicit) that the individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions.

Example of Questions on Intent:

- *Do you wish you were dead?*
- *Do you intend to try to kill yourself?*
- *Do you have a plan regarding how you might kill yourself?*
- *Have you taken any actions towards putting that plan in place?*
- *How likely do you think it is that you will carry out your plans?*

Preparatory Behavior

Assess if the patient has begun to show actual behavior of preparation for engaging in Self-Directed Violence (e.g., assembling a method, preparing for one's death).

Examples of Questions on Preparation:
- *Do you have a plan or have you been planning to kill yourself? If so, how would you do it? Where would you do it?*
- *Do you have the (drugs, gun, rope) that you would use? Where is it right now?*
- *Do you have a timeline in mind for killing yourself?*

- *Is there something (an event) that would trigger acting on the plan?*
- *How confident are you that your plan will end your life?*
- *What have you done to begin to carry out the plan?*
- *Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?*

Previous Suicide Attempt

Obtain information from the patient and other sources about previous suicide attempts. Historical suicide attempts may or may not have resulted in injury, and may have been interrupted by the patient or by another person prior to fatal injury.

Example Questions on previous attempts:
- Inquire if the attempt was interrupted by self or other, and other evidence of effort to isolate or prevent discovery
- Inquire about other previous and possible multiple attempts
- For patients who have evidence of previous interrupted (by self or other) attempts, obtain additional details to determine factors that enabled the patient to resist the impulse to act (if self-interrupted) and prevent future attempts.

Warning Signs – Indications for Urgent/Immediate Action

Recognize precipitating emotions, thoughts, or behaviors that are most proximally associated with a suicidal act and reflect high risk.

Examples: Assess for other warning signs that may indicate likelihood of suicidal behaviors occurring in the near future, and require immediate attention:
- **Substance abuse** – increasing or excessive substance use (alcohol, drugs, smoking)
- **Hopelessness** – expresses feeling that nothing can be done to improve the situation
- **Purposelessness** – express no sense of purpose, no reason for living, decreased self-esteem
- **Anger** – rage, seeking revenge
- **Recklessness** –engaging impulsively in risky behavior
- **Feeling Trapped** – expressing feelings of being trapped with no way out
- **Social Withdrawal** – withdrawing from family, friends, society
- **Anxiety** – agitation, irritability, angry outbursts, feeling like wants to "jump out of my skin"
- **Mood changes** – dramatic changes in mood, lack of interest in usual activities/friends
- **Sleep Disturbances** – insomnia, unable to sleep or sleeping all the time

(VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide)

Section 4

Risk Factors

PSYCHOLOGICAL FACTORS
- Suicide of relative, someone famous, or a peer
- Suicide bereavement
- Loss of loved one (grief)
- Loss of relationship (divorce, separation)
- Loss of status/respect/rank (public humiliation, being bullied or abused, failure work/task)

SOCIAL FACTORS
Stressful Life Events (acute experiences)
- Breakups and other threats to prized relationships
- Other events (e.g., fired, arrested, evicted, assaulted)

Chronic Stressors (ongoing difficulties)
- Financial Problems
- Unemployment, underemployment
- Unstable housing, homeless
- Excessive debt, poor finances (foreclosure, alimony, child support)
- Legal Problems (difficulties)
- DUI/DWI
- Lawsuit
- Criminal offence and incarceration
- Social Support
- Poor interpersonal relationship (partner, parents, children)
- Geographic isolation from support
- Barriers to accessing mental health care
- Recent change in level of care (discharge from inpatient psychiatry)

MENTAL DISORDERS
- Mood or affective disorder (major depression, bipolar, post-partum)
- Personality disorder (especially borderline and antisocial)
- Schizophrenia
- Anxiety (PTSD, Panic)
- Substance Use Disorder (alcohol, illicit drugs, nicotine)
- Eating disorder
- Sleep disturbance or disorder (See Appendix B-4)
- Trauma (psychological)

MEDICAL CONDITIONS
- History of Traumatic Brain Injury (TBI)
- Terminal disease
- HIV/AIDS
- New diagnosis of major illness

- Having a medical condition
- Worsening of chronic illness
- Intoxication
- Substance withdrawal (alcohol, opiates, cocaine, amphetamines)
- Use of prescribed medication w/ warning for increased risk of suicide (See Appendix B-3)

Physical Symptoms
- Chronic pain
- Insomnia
- Function limitation

MILITARY-SPECIFIC
- Disciplinary actions (UCMJ, NJP)
- Reduction in rank
- Career threatening change in fitness for duty
- Perceived sense of injustice or betrayal (unit/command)
- Command/leadership stress, isolation from unit
- Transferring duty station (PCS)
- Administrative separation from service/unit
- Adverse deployment experience
- Deployment to a combat theater

PRE-EXISTING & NON-MODIFIABLE
- Age (young & elderly)
- Gender (male)
- Race (white)
- Marital status (divorce, separate, widowed)
- Family history of:
- Suicide/ attempt
- Mental illness (including SUD)
- Child maltreatment trauma-physical/psychological/sexual
- Sexual trauma
- Lower education level
- Same sex orientation (LGBT)
- Cultural or religious beliefs

(VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, p 38)

Protective Factors

Social Context Support System
- Strong interpersonal bonds to family/unit members and community support
- Employed
- Intact marriage
- Child rearing responsibilities
- Responsibilities/duties to others
- A reasonably safe and stable environment

Positive Personal Traits
- Help seeking
- Good impulse control
- Good skills in problem solving, coping and conflict resolution
- Sense of belonging, sense of identity, and good self-esteem
- Cultural, spiritual, and religious beliefs about the meaning and value of life
- Optimistic outlook -Identification of future goals
- Constructive use of leisure time (enjoyable activities)
- Resilience

Access to Health Care
- Support through ongoing medical and mental health care relationships
- Effective clinical care for mental, physical and substance use disorders
- Good treatment engagement and a sense of the importance of health and wellness

(VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, p 40)

Section 5

Links to Clinical Practice Guidelines

American Psychiatric Association. (2003). Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors. Retrieved from
http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf
Published by the American Psychiatric Association and contains valuable information regarding suicide assessment and treatment of suicidal persons. Although the information was published in 2003, there is still valuable information on the assessment, management, treatment, and documentation when treating suicidal persons.

Registered Nurses' Association of Ontario. (2009). Assessment and Care of Adults at Risk for Suicidal Ideation and Behavior. Retrieved from
http://rnao.ca/bpg/guidelines/assessment-and-care-adults-risk-suicidal-ideation-and-behaviour
This is a thorough review of the literature with recommendations based on the evidence available when they published in 2009. It is primarily focused on the inpatient setting but there is valuable information for those who practice in an out-patient setting.

United States Air Force. (2013). Air Force Guide for Suicide Risk Assessment, Management, and Treatment. Retrieved from
https://kx2.afms.mil/kj/kx2/AFSuicidePrevention/Documents/AF%20Guide%20to%20Suicide%20Risk%20Assessment,%20Management,%20and%20Treatment/Tab%206%20AF%20Guide%20for%20Suicide%20Risk_JUNE%202014%20Revised_FINAL%20FOR%20DISSEMINATION.pdf
This was published by the US Air Force in 2013 as a guide for the assessment and treatment of suicidal persons. It contains practical guidance and is separated into suicide risk assessment and management, High Interest Log and communicating with command, Documentation, Evidence based interventions, and special considerations. The guidance is focused primarily at mental health providers and military members.

United States Air Force. (2013). Appendices, Air Force Guide for Suicide Risk Assessment, Management, and Treatment. Retrieved from
https://kx2.afms.mil/kj/kx2/AFSuicidePrevention/Documents/Forms/ShowFolders.aspx?RootFolder=%2Fkj%2Fkx2%2FAFSuicidePrevention%2FDocuments%2FAF%20Guide%20to%20Suicide%20Risk%20Assessment%2C%20Management%2C%20and%20Treatment&FolderCTID=&View={CBB16315-66E0-4C54-AF96-A007377AE2AB}
This is an appendix to the Air Force Guide for Suicide Risk Assessment, Management, and Treatment. It includes example forms for screening, assessment, safety planning, and documentation.

VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide. Retrieved from http://www.healthquality.va.gov/guidelines/MH/srb/
Contains very good guidance on the assessment and treatment of suicidal veterans. Discusses specific treatments and their efficacy. It is divided into five modules that walk you through assessment to follow-up and monitoring.

On-Line Resources

The following are a list of websites that have been gathered by the Suicide Prevention Resource Center (http://www.sprc.org/webform/primary-care-toolkit www.wiche.edu/mentalhealth) and include training sites for suicide assessment and prevention as well as resources to initiate a suicide prevention program.

Nationally Disseminated Trainings on Suicide Assessment and Management for Mental Health Professionals

Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals. A one-day workshop for mental health professionals and employee assistance professionals that focuses on competencies that are core to assessing and managing suicide risk. The curriculum is a collaboration of theAmerican Association of Suicidology and the Suicide Prevention Resource Center. For information contact amsr@edc.org. (Offered by the National Suicide Prevention Resource Center.) http://www.sprc.org/training-institute/amsr

Recognizing and Responding To Suicide Risk: Essential Skills for Clinicians. A two-day advanced interactive training augmented by pre-workshop, web-based assessment and post workshop mentoring. For information go to http://www.suicidology.org

QPRT: Suicide Risk Assessment and Management Training. (QPRT stands for Question/Persuade/ Refer/Treat.) A 10 - hour course available either on-line or face-to-face for professionals who may evaluate, assist, counsel or treat potentially suicidal persons - a tool that is uniquely designed to gather critical information about a person's status at intake and to establish a safety and intervention plan. For more information to go http://www.qprinstitute.com. (Offered by QPR Institute)

Listings on the SPRC Best Practices Registry (BPR). Listings on the SPRC Best Practices Registry (BPR). The BPR lists best practices reviewed according to the following criteria: evidence-based programs,expert and consensus statements, and adherence to standards. To search listed trainings for mentalhealth professionals visit: http://www.sprc.org/search/bpr/?filters=sm_resource_type%3Abpr_listing%20 tid%3A33. Scroll to the bottom for list results.

On-Line Resources for Providers

Depression
Patient Health Questionnaire Depression Scale (PHQ-9)
(http://www.phqscreeners.com/pdfs/02_PHQ-9/English.pdf)
The PHQ-9 is the 9-item depression scale of the Patient Health Questionnaire. The final item
screens for the presence of suicidal ideation. May be downloaded free of charge.

Improving Access to Health Care
Mental Health Services Locator
(http://findtreatment.samhsa.gov/MHTreatmentLocator/faces/quickSearch.jspx)
1-800-662-HELP (4357)
The Substance Abuse and Mental Health Services Administration (SAMHSA) of the federal
government provides an online service to locate mental health services.

Substance Abuse Treatment Facility Locator
(http://findtreatment.samhsa.gov/) 1-800-662-HELP (4357).
The Substance Abuse and Mental Health Services Administration (SAMHSA) of the federal
government provides an online service to locate treatment facilities for substance abuse
problems.

Means Restriction
Look It up Campaign
(http://www.kingcounty.gov/healthservices/health/injury/lokitup.aspx   )
LOK-IT-UP raises awareness about the importance of safe firearm storage, informs the public
about safe storage options, and promotes the availability of safe storage devices. The Public
Health Seattle King County website contains information for healthcare providers including
brochures and answers to important questions regarding gun storage.

Means Matter
(http://www.hsph.harvard.edu/means-matter/)
The Means Matter website, created by the Harvard Injury Control Research Center at the
Harvard School of Public Health, contains information on means reduction and why it is
important. Means reduction statistics and programs are provided by state.
Suicide Fact Sheets
Risk and Protective Factors for Suicide
(http://www.sprc.org/library_resources/items/understanding-risk-and-protective-factors-suicide-
primer- preventing-suicide)
This primer provides a brief overview of the importance of risk and protective factors as they
relate to suicide and offers guidance about how communities can best use them to decrease
suicide risk.

U.S. Suicide Fact Sheet
(http://www.cdc.gov/ViolencePrevention/pub/Suicide_factsheet.html)
This 2-page fact sheet provides a basic overview of suicide, developed by the Centers for
DiseaseControl and Prevention.

Trainings andGuides

After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors
(http://store.samhsa.gov/product/A-Guide-for-Medical-Providers-in-the-Emergency-Department-Taking- Care-of-Suicide-Attempt-Survivors/SMA08-4359)
Brochure intended to provide medical professionals with tips on how to enhance care in the emergency department for people who have attempted suicide. The guide also contains information on HIPAA, patient discharge, and resources about suicide for medical professionals, patients and their families.

Is Your Patient Suicidal?
(http://www.sprc.org/sites/sprc.org/files/library/ER_SuicideRiskPosterVert2.pdf)
A four-color poster that provides Emergency Department practitioners with information on recognizing and responding to acute suicide risk. It is designed to be hung in staff-only areas. The poster features the most common and noticeable warning signs of acute risk for suicide as well as simple questions clinical staff can ask to uncover suicide risk when warning signs are noticed or suspected. The poster, resource guide
(http://www.sprc.org/sites/sprc.org/files/library/ER_SuicideRiskGuide8.pdf)and accompanying information insert (http://www.sprc.org/sites/sprc.org/files/library/UsingIsYourPtSuicidal.pdf) can be ordered from the Emergency Nurses Association through the ENA Marketplace (https://admin.ena.org/store/).

Recognizing and Responding to Suicide Risk in Primary Care
(http://www.suicidology.org)
A training Developed by the American Association of Suicidology in collaboration with primary care practitioners specifically for primary care physicians and staff.

SAFE-T Pocket Card
(http://store.samhsa.gov/shin/content//SMA09-4432/SMA09-4432.pdf)
The SAFE-T Card guides mental health clinicians through five steps which address the patient's level ofsuicide risk and suggest appropriate interventions. It is intended to provide an accessible and portableresource to the professional whose clinical practice includes suicide assessment. The card lists key risk and protective factors that should be considered in the course of completing the five-steps. The PDF image of the card prints out on in the center of 8.5 X 11 paper because the original is a 6x7 2-sided, folded pocket card. Quantities of the SAFE-T cards are available for order through Screening for MentalHealth, Inc. at http://www.sprc.org/sites/sprc.org/files/SAFE-TOrderForm.pdf. Toobtain a freeprint- quality file for reproducing the cards, please email info@sprc.org, include your name, organization/company, and your plans for using the SAFE-T Cards.

Safety Planning Guide
(http://www.sprc.org/sites/sprc.org/files/SafetyPlanningGuide.pdf)
The pocket-sized safety planning guide reminds clinicians of the most important points to cover in collaboratively developing a safety plan with a patient. The guide was adapted from content developed by the Department of Veterans Affairs.

State Suicide Prevention Coordinators
(http://www.sprc.org/states/all/contacts)
Contact your state suicide prevention coordinator to determine whether there are additional suicide prevention posters and other materials available in your state.

Talking With Your Adult Patients about Alcohol, Drug, and/or Mental Health Problems: A Discussion Guide for Primary Health Care Providers
(http://store.samhsa.gov/product/Talking-with-Your-Adult-Patients-about-Alcohol-Drug-and-or-Mental- Health-Problems/SMA12-4584)
An online guide to equip primary health care providers with questions to begin discussions with their patients about alcohol, illicit drug, and mental health problems, as well as co-occurring disorders. This brief guide also includes resources for patients who need an evaluation based on positive screening results.

(http://www.sprc.org/webform/primary-care-toolkit www.wiche.edu/mentalhealth)

Appendix C

Structured Interview Questions

1. How likely do you feel that the information provided in the SRA Toolkit will be utilized in a

family practice or a primary care practice?

1	2	3	4	5
Very Unlikely	Unlikely	Neutral	Likely	Very Likely

2. What suggestions would you like to offer for improving the SRA Toolkit?

3. What information was the least helpful in the SRA Toolkit?

4. What information did you find the most helpful in the SRA Toolkit?

5. In what clinical setting do you think this instrument would be the most useful?

6. Are there any additional comments you would like to make?

Appendix D

Structured Question Responses

Structured Questions; MD, FP

1. How likely do you feel that the information provided in the SRA Toolkit would be utilized in a family practice or a primary care practice?

1	2	3	**4**	5
Very Unlikely	Unlikely	Neutral	**<u>Likely</u>**	Very Likely

2. What suggestions would you like to offer for improving the SRA Toolkit?

You may consider just including one of the SRA's (#2 seems the most user friendly) and including just the references for the others. Often times if we're giving multiple options, we'll ignore them altogether b/c we don't want to have to decide which one to use.

3. What information was the least helpful in the SRA Toolkit?

        NO RESPONSE TO QUESTION #3

4. What information did you find the most helpful in the SRA Toolkit?

The examples of SRAs (specifically #2 b/c it was the easiest to use).

5. In what clinical setting do you think this instrument would be the most useful?

This would be useful at Family Health clinic appointments. Typically, we have patients complete a PHQ-9 if they have any mental health diagnoses, insomnia or are on any psychotropic meds (even if for tobacco cessation, migraines, etc.). If the patient answers question 9 ("thoughts that you would be better off dead or of hurting yourself in some way") with anything other than "not at all", then the SRA could be used to further clarify/assess the patient's risk of suicide.

6. Are there any additional comments you would like to make?

I agree that suicide risk assessment is a very important overlooked area of needed training. We are trained to ask if patient's are having thoughts of harming themselves or others but not want to do if someone says "yes". I think this training can go a long way in helping mitigate this risk

Structured Questions: (BSN)

1. How likely do you feel that the information provided in the SRA Toolkit would be utilized in a family practice or a primary care practice? Unlikely

1	2	3	4	5
Very Unlikely	Unlikely	Neutral	Likely	Very Likely

2. What suggestions would you like to offer for improving the SRA Toolkit?

In the primary care setting, it seems the practitioners are so overwhelmed with patients, there really isn't time to actually know the patient, let alone screen them for suicidal ideation. Even if the patient has expressed suicidal thoughts, the practitioner has been too preoccupied to hear it. I find this especially true in the military health care system.

3. What information was the least helpful in the SRA Toolkit?

Suicide Risk Assessment, Example 1 is lengthy. Knowing if your patient had a previous suicide attempt would require having the same health care professional. In the military, you can see five different providers for the same issue and I have found often times symptoms are overlooked.

4. What information did you find the most helpful in the SRA Toolkit?

Example 2 was briefer and I think appropriate for a primary care physician screening. I think section 4 is helpful, again provides a quick assessment.

5. In what clinical setting do you think this instrument would be the most useful?

I do think this would be appropriate in a primary care setting, but I also think it would be appropriate and work if the providers weren't so pressed for time.

6. Are there any additional comments you would like to make?

NO RESPONSE TO QUESTION #6.

Structured Questions: FNP, DNP

1. How likely do you feel that the information provided in the SRA Toolkit would be

    utilized in a family practice or a primary care practice?

    I believe the SRA toolkit would be very useful in family practice/primary care setting= 5

1	2	3	4	5
Very Unlikely	Unlikely	Neutral	Likely	Very Likely

2. What suggestions would you like to offer for improving the SRA Toolkit?

    An additional page for the practice /provider to add for the linkage resources for that
community in times of crisis (who to call)

3. What information was the least helpful in the SRA Toolkit?   The examples are a little
confusing—are they used as comparisons or are just plain examples? I believe this should be
clarified or to address the comparisons. Are we the reader to find the links or the
commonalities?

4. What information did you find the most helpful in the SRA Toolkit?
Specific questions to address to the patients I thought was very helpful

5. In what clinical setting do you think this instrument would be the most useful?
In all settings with adults.

6. Are there any additional comments you would like to make?
I would like more information on concussions/or repetitive mild brain injuries and risk —should
be addressing these as well? Overall very useful and practical

Structured Questions: (PMHNP, DNP)

1. How likely do you feel that the information provided in the SRA Toolkit would be utilized in a family practice or a primary care practice?

1	2	3	4	5
Very Unlikely	Unlikely	Neutral	Likely	Very Likely

2. What suggestions would you like to offer for improving the SRA Toolkit? Select one example to follow. I like the VA/DOD CPG example. It provides questions to ask to get more information about previous suicide attempt, whereas the second example doesn't. The first example is also good by providing example of questions to ask to gather information which I feel would be good and more helpful for primary care providers

3. What information was the least helpful in the SRA Toolkit? Risk level and High Interest log (pg21) for the primary care setting, doesn't seem to apply and other providers outside of the AF MHC won't really know what that means.

4. What information did you find the most helpful in the SRA Toolkit? Sample questions- for examples 1 and 3, feel this is most helpful for primary care. They may know what questions to ask but don't really know how to go about asking these specific questions or may not know how detailed they need to be. I think these questions are very helpful to the primary care provider to obtain the information they need in order to determine how at risk their patient may be.

5. In what clinical setting do you think this instrument would be the most useful? I think it would be useful in all clinical settings. Since the JC 2015 Hospital National Patient Safety Goal

NPSG.15.01.01 requires all areas to: *Find out which patients are most likely to try to commit suicide,* there needs to be adequate and thorough suicide risk assessments in all areas of clinical practice.

6. Are there any additional comments you would like to make? On page 19, in the clinical judgment of suicide risk, it mentions a decision tree and a pocket guide. These would probably be very helpful to the primary care provider.

Structured Questions: (Psychologist)

1. How likely do you feel that the information provided in the SRA Toolkit would be utilized in a family practice or a primary care practice?

1	2	3	**4**	5
Very Unlikely	Unlikely	Neutral	**Likely**	Very Likely

2. What suggestions would you like to offer for improving the SRA Toolkit?

-would add "substance abuse" to social/environmental risk factors section

-Would change "chaotic" to "unstable" family history in same section to avoid pejorative word choice

-On page 17 you have a question about strong urge. This works. However, may gather more info from question such as "how hard is it to resist the urge to follow through on your thought of suicide or self-harm?"

-Also, page 17 on question "have you ever tried to kill yourself or attempt suicide", would change wording to "injure yourself or attempt suicide" to gather data on non-lethal self-injurious behavior which sometimes result in death of escalates to it.

-Would consider adding "or eliminate it" to final question on page 17 about "is there something (an event) that would trigger the plan?" to assess for a mitigating factor (e.g., wife would return to me, headaches would go away-that kind of thing).

-Examples 1-3 are helpful but don't tell the PCM/PCP how to implement in the decision-making framework. For example in "example 2" how do the providers leverage risk and protective factors to help them decide "risk levels" or even how concerned about a patient they should be.

A brief sentence or two about how to leverage risk and protective factors and to consult with

BHOP or MHC may assist.

-To really sell the questions you offer, I would consider a one-page summary/notecard that

PCM/PCP, nurse, techs could keep in exam rooms. This might make all the difference in putting

the concepts/questions into action in a busy work center.

3. What information was the least helpful in the SRA Toolkit?

-the purpose of the examples was a little unclear (e.g., documentation vs decision-making

algorithm vs general info).

4. What information did you find the most helpful in the SRA Toolkit?

-Really like your sample questions. Staff becoming more direct in their lines of inquiry is critical

and you offer some VERY good lines of inquiry on page 16-17. By far, the best part from my

point of view.

5. In what clinical setting do you think this instrument would be the most useful?

-Primary care, flight meds, peds.

6. Are there any additional comments you would like to make?

-Grammar and usage in the background paper needs considerable work. Some work choice type

issue in the SRA. Truly, not trying to knit pick but make it digestible to all. The back ground

paper has many lines that are not sentences or don't flow. If you'd like input, I can provide

some. If not, suggest you have your resident grammarian take a look.

I think your tool has potential to be highly beneficial in a primary care context.

Structured Questions: (Psychiatrist)

1. How likely do you feel that the information provided in the SRA Toolkit would be

   utilized in a family practice or a primary care practice?

   LIKELY (4)

1	2	3	4	5
Very Unlikely	Unlikely	Neutral	Likely	Very Likely

2. What suggestions would you like to offer for improving the SRA Toolkit?

**Condense common features of all SRA's (Risk factors, Current Risks, Protective Factors,

Overall Assessment) into single manageable one page form. Give clear instructions for when to

utilize the SRA (such as positive PHQ2 elicits PHQ9; positive PHQ9 elicits SRA, etc.)

3. What information was the least helpful in the SRA Toolkit?

**Generally helpful, though possibly repetitive in attempts to be all-inclusive

4. What information did you find the most helpful in the SRA Toolkit?

**Comparison of multiple SRA's – makes it easier to tailor to appropriate populations.

5. In what clinical setting do you think this instrument would be the most useful?

**All primary care and mental health clinic settings should have a standard of practice which

includes when/how to use SRA.

6. Are there any additional comments you would like to make?

**Emphasis on the impulsive nature of suicidal patients could be added. Especially in the USAF, there is a misconception that all suicides can be prevented – and requiring SRA use can add to that myth. Clearly, doing SRA when appropriate and having a mechanism in place to initiate an SRA is essential to providers making appropriate interventions. However, saddling providers with the burden of responsibility simply because they were the last to interact with a patient is misleading and harmful to providers who are already expected to be omniscient during a typically very brief patient interaction.

Appendix E

UNIVERSITY *of* VIRGINIA
OFFICE OF THE VICE PRESIDENT FOR RESEARCH
INSTITUTIONAL REVIEW BOARD FOR THE SOCIAL AND BEHAVIORAL SCIENCES

January 5, 2015

Douglas E. Dillon
School of Nursing
University of Virginia
6040 Kelsey Ct.
Falls Church, VA 22044

Dear Mr. Dillon,

The Institutional Review Board for the Social and Behavioral Sciences (IRB-SBS) at the University of Virginia (UVA) has reviewed the research study titled "Suicide Risk Assessment Toolkit for the Primary Care Setting" which was submitted to our IRB on January 5, 2015. After reading the protocol and speaking with you over the phone, we have determined that you are not engaged in research that needs to be covered by the IRB-SBS at UVA. It is our understanding that you are currently developing an information tool kit about suicide risk assessment and that your current activities are limited to seeking feedback about the tool kit from professionals who might be likely to use such a kit in the future. This activity does not meet the federal definition of human subject research and does not require an IRB submission. You may proceed with your project.

If your project changes such that IRB-SBS review may be required, please contact my office immediately to discuss.

Sincerely,

Bronwyn Blackwood
Director, Institutional Review Board for the Social and Behavioral Sciences
University of Virginia
434-243-2915
blackwood@virginia.edu

Appendix F

Instruction for Authors: *Military Behavioral Health*

SCHOLARONE MANUSCRIPTS™

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the guide for ScholarOne authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

Please note that *Military Behavioral Health* uses CrossCheck™ software to screen papers for unoriginal material. By submitting your paper to *Military Behavioral Health* you are agreeing to any necessary originality checks your paper may have to undergo during the peer review and production processes.

Military Behavioral Health receives all manuscript submissions electronically via its ScholarOne Manuscripts site located at: http://mc.manuscriptcentral.com/mbh. ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts, and facilitates the review process and internal communication between authors, editors, and reviewers via a web-based platform. ScholarOne technical support can be accessed at http://scholarone.com/services/support/. If you have any other requests, please contact Anschion Maiden, the journal's Managing Editor, at amaiden@usc.edu.

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Manuscript Submissions

Two complete original manuscripts should be attached to the electronic mail. The first one should be complete and include all the necessary information. The second document should be clear of the author(s) name(s); any information that can identify the origin/author of the manuscript (will be used for blind peer review).

Submission of a manuscript to this journal represents a certification on the part of the author(s) that it is the original work of the author(s) and that is has not been published, submitted simultaneously for publication elsewhere. A note to state the above should accompany the manuscript.

Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. All accepted manuscripts, artwork, and photographs become the property of the publisher.

Manuscript format

All manuscripts must be typed, double-spaced, using the 12-point font, with margins of at least one inch on all sides. The page size should be set to 8.5 x 11 inches and manuscripts should be approximately 20 pages (5,000 words) in length. Page numbers should appear at the top of each page. Every submission should include an abstract of not more than 100 words, followed by a minimum of 10 key words. Please note that the current American Psychological Association Style (www.apa.org) should be followed. Author contact information should be listed after the key words and should include academic degrees, professional titles, affiliation, mailing address as well as phone numbers, fax numbers and e?mail addresses. The corresponding author should be clearly identified. Acknowledgements (if any) follow after author(s) contact information. Please consult our guidance on keywords here.

Reference list

A reference list should appear at the end of the manuscript followed by any referenced tables and figures.

Illustrations

Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clear originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher

- Sized to fit on journal page

- EPS, TIFF, or PSD format only

- Submitted as separate files, not embedded in text files

Tables and Figures

Tables and figures (illustrations) should follow after the reference list. All units must be included. Figures should be completely labeled, taking into account necessary size reduction.

Peer Review

Submitted manuscripts will undergo a blind peer review of at least two reviewers. Following the review process the Editor will make the final decision based on the reviews received. Reviewer comments will be shared with authors.

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Appendix G

Draft Manuscript

Suicide Risk Assessment Toolkit for the Primary Care Setting

Suggested Running head: Suicide Risk Assessment

Douglas Dillon

DNP, RN, PMHNP-BC

Lt Col, USAF

University of Virginia

Author declares no conflict of interest.

Abstract

Suicide is the 10th leading cause of death for all ages with over 38,000 successful suicides and an additional 487,000 cases of self-inflicted wounds (CDC, 2012, 2013). There is a shortage of mental health providers (Thomas, Ellis, Konrad, Holzer & Morrissey, 2009) and many patients are seen by their primary care provider (PCP) for mental health management. Would a Suicide Risk Assessment Toolkit based on current clinical practice guidelines be beneficial for utilization in a primary care setting? All except one panel member rated the SRA Toolkit as "Likely" or "Very Likely" to be utilized in a primary care setting.

Key Words: suicide, risk assessment, attempt, risk factors, ideation, clinical practice guideline, evidence based, primary care, depression, mental illness.

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Suicide Risk Assessment in the Primary Care Setting

Suicide is not only a leading cause of death in the United States, it is a significant cost to the economy as well. According to a Center for Disease Control and Prevention report, in 2010 suicide had become the tenth leading cause of death for all ages (CDC, 2013), costing $34.6 million dollars in lost work and medical expenses (CDC, 2012). In addition, there were 38,364 suicides in the United States with an additional 487,700 cases of self -inflicted injuries requiring emergency treatment (CDC, 2012). The suicide rate for 2010 was more than twice the 14,748 murders in the United States (Federal Bureau of Investigation, 2010). The CDC (2013) reported suicide rates had increased by 28.4% from 1999 through 2010. The three most common methods of suicide were firearms, suffocation, and poisoning. Firearms were the most common method for men while poisoning was the most popular method for women (CDC, 2013). To counter the alarming rate of suicide in 2007 of 11.3 per 100, 000, the U.S. government established a goal to reduce suicide by 10% (U.S. Department of Health and Human Resources, 2014). During 2008-2009, approximately 8.3 million adults or 3.7% of the adult population in the United States reported having a suicidal thought, 2.2 million reported having developed a suicide plan and approximately one million adults reported making a suicide attempt (Crosby, Han, Ortega, Parks, & Gjroerer, 2011).

Suicide is not a specific mental illness but rather a symptom that is associated with several different mental health diagnoses. Some specific mental disorders associated with elevated suicide rates are Major Depressive Disorder (MDD), Bipolar Disorder, and Schizophrenia (Sadock & Sadock, 2010).

MDD is a mental illness that at times can be debilitating such that up to 50% of people who commit suicide had previously reported having depressive symptoms (Sadock & Sadock,

2010, pg 334). The Diagnostic and Statistical Manual of Mental Disorders 4th edition Text Revision reports 15% of individuals with a diagnosis of MDD will eventually commit suicide. Individuals with MDD who are admitted to a nursing home have an increased likelihood of dying in the first year. Those with MDD report more pain and physical illness when being seen by their primary care provider (American Psychiatric Association, 2005). Almost two-thirds of individuals who reported having a mental illness considered suicide while 77.5% of individuals with a mental illness develop a suicide plan, 79.6% make a suicide attempt, and 83.4% with a mental illness made a planned suicide attempt (Nock, Hwang, Sampson, & Kessler, 2010).

The American Psychiatric Association is changing its attitudes toward suicide and suicidal behaviors. The newly released Diagnostic and Statistical Manual of Mental Disorders 5th Edition includes a proposal for the diagnosis of Suicidal Behavior Disorder with recommended diagnostic criteria and specific risk factors to address the issue of suicide (American Psychiatric Association, 2013).

Due to the shortage of mental health providers in the United States, individuals with mental illness who may be having suicidal thoughts have no access to a mental health specialist and are being seen by their primary care provider (PCP) or in an emergency department (ED). In 2009, 77% of U.S. counties had a "severe" shortage of both mental health providers and mental health prescribers while 96% of U.S. counties had some level of shortage in mental health prescribers (Thomas et al. 2009) which can lead to PCP's treating patients with self-harm thoughts and mental health issues. Despite the high correlation between depression and suicide (Cooke, Gotto, Mayorga, Grant, & Lynn, 2013), many patients with depressive symptoms are evaluated, treated, and medically managed by their PCP instead of a mental health specialist. McDowell, Lineberry, & Bostwick (2011) reported that PCP's write antidepressant prescriptions

more often than mental health providers and lack additional psychopharmacological training that would allow them to expertly prescribe psychotropic medications. Pratt, Brody, & Quipping (2011) reported antidepressants were the third most commonly prescribed medication in the United States between the years of 2005 and 2008. While this statistic is imposing, Pratt et al., (2011) also reported less than 50% of patients on multiple antidepressants visited a mental health provider in the past 12 months. Finally, McDowell et al. (2011) also reported persons who were successful in their suicide were more likely to have seen their PCP during the final 30 days of their life. Additionally, studies indicate that 75% of patients who completed suicide had contact with their PCP within 12 months of committing suicide and 45% had contact with their PCP within one month of successful suicide (Bostwick & Rackley, 2012). In the elderly population there is an even higher rate of patients completing suicide who have seen their PCP within one month of their suicide (Luoma, Martin & Pearson, 2002).

Legal liability associated with treating a person who successfully commits suicide is another issue for a health care provider in today's litigious society. A commonly accepted medical legal concept is malpractice has occurred if an accepted standard of care is not followed and results in a negative outcome to the patient (Knapp & Vandecreek, 1983). A thorough assessment is required in any clinical situation and as mentioned earlier in this paper, treating suicidal patients was a common experience in many healthcare professions (Palmieri et al., 2008). A study on the legal aspects of SRA, (Smith et al., 2008) reported that psychiatrists, psychologists, and other mental health providers were not routinely conducting an adequate SRA due to lack of time, belief that documentation will make them more liable, anxiety about suicide, and not being properly trained in conducting a SRA. Not conducting a SRA does not relieve a

health care provider of legal liability if a patient successfully commits suicide (Smith et al., 2008).

Performing a SRA does not imply that the PCP assumes responsibility if a patient commits suicide. The therapeutic relationship between a health care provider and a patient is complicated and should be based on honesty and trust. In actuality, lying in the clinical setting is fairly common by both parties for multiple reasons (Palmieri & Stern, 2009). Patients may deny suicidal intentions to their PCP in order to avoid embarrassment or hospitalization (Simon, 2008). The results of an on-line survey by WebMD in 2004 found that 13% who responded stated they had lied to their doctor while an additional 32% reported they had "stretched the truth" with their doctor (DeNoon, 2004). In a study of persons who had committed suicide, Fawcett (2001) noted only 18% had communicated suicidal thoughts to a health care provider, despite inquiries being made by the provider and that 77% of in-patients who had committed suicide denied any suicidal intent within a week of suicide (Fawcett, 2001).

In certain cases suicide is an impulsive act with only a brief period between the suicidal ideation and the suicidal act. This impulsiveness makes it difficult to accurately predict who will commit suicide despite conducting a thorough SRA. Deisenhammer et al. (2008) reported 47.6% of suicide attempters had less than 10 minutes from their first thoughts of committing suicide to the actual attempt. In a study of 158 persons who attempted suicide, 24% had less than five minutes from the decision to attempt suicide to their initial attempt (Simon et al., 2001).

This evidence suggests a significant number of patients with depressed mood are either not receiving any mental health treatment from a specialist or are receiving mental health treatment from their PCP who may lack adequate clinical knowledge to manage them. One source (Mann et al., 2005) reported that mental illness, specifically depression, is not correctly

diagnosed and therefore undertreated in the primary care setting, and that suicide reduction programs should include educating PCP's. Feldman et al. (2007) reported that a PCP would only ask about suicidal ideation approximately 27% of the time unless prompted by a request for antidepressants by the patient and assessment of suicidal thoughts was inconsistently conducted. Cattell & Jolley (1995) studied suicides in the elderly and found only 14% of those who committed suicide had been seen by specialty care, 43% were seen by their general practitioner and referrals to mental health in the elderly prior to committing suicide were inconsistent. In a study of Italian health professionals including psychiatrists, general practitioners, psychiatric nurses, emergency room physicians, emergency room nurses, and medical students, Palmieri et al. (2008) found that treating suicidal patients was a common experience across the spectrum of health care specialties while training for suicide risk assessment (SRA) training was inconsistent. Graham, et al. (2011) concluded a PCP's willingness to treat suicidal patients was dependent on the training the provider had received and female PCPs had less self-perceived competency for treating suicidal patients.

The purpose of this study was to develop and evaluate an evidence based SRA Tool kit to provide appropriate evidence based and timely information to all staff employed in a primary care setting.

Review of Literature

The electronic data bases CINHAL, PubMed, Ovid MEDLINE, ERIC, and PsychArticle were searched to identify studies that were relevant to the issue of SRA. The search terms used were suicide, suicide risk assessment, training, education, primary care, and family practice. Pertinent articles were limited to studies that were published in peer reviewed English language journals. The subjects were limited to patients who were aged 19 or older. Journal articles were

excluded if they were opinion pieces, editorial articles, or non-peer reviewed articles. The initial search identified 104 articles. A review of titles and abstracts was completed and 15 articles were selected for full review. One additional article was included after conducting a review of references for a total of 16 articles for this part of the literature review.

Accomplishing a SRA in the ED is a challenging procedure, the patient may deny any suicidal intention to avoid hospitalization and collateral information from the therapist or family members may not be available (Simon, 2008) so the ED practitioner must rely on their own observations and clinical judgement. In a literature review of 51 articles about suicide and ED's it was reported that emergency physicians, not mental health, conduct up to 90% of suicide evaluations that took place in the ED (Hickey et al., 2000). In another study, up to 58.9% of patients who were brought to the emergency department (ED) for deliberately committing self-harm were discharged from the hospital without being seen by mental health for an assessment (Hickey et al., 2000).

The completion of a SRA based on current clinical evidence is a critical issue in the treatment of patients with suicidal thoughts. There have been efforts to improve the quality of training in professional graduate health care programs on suicide risk assessment. Schmitz et al. (2012) reviewed SRA practices in a graduate mental health training program and found that only one half of psychology trainees had any didactic training on suicide. Schmitz, et al. (2012) recommended the inclusion of suicide assessment education in mental-health training programs, SRA continuing education requirements for state licensure, credentialing bodies verify SRA training, and non-SRA trained providers have a supervised clinical practice while treating suicidal persons. Cramer et al. (2013) conducted a literature review to evaluate the effectiveness of SRA and to propose an evidence-based training program for SRA. The authors found that it

was difficult to measure SRA training in graduate health care programs and identified 10

competencies when completing an SRA. The competencies that Cramer et al. (2013) suggested

were: 1) to know and manage your own attitudes toward suicide, 2) develop and maintain a

collaborative relationship with the patient, 3) know and elicit evidence-based risk and protective

factors, 4) focus on the current plan and intent, 5) determine level of risk, 6) develop a

collaborative evidence-based treatment plan, 7) notify and involve other persons, 8) document

risk plan and reasoning, 9) know the law regarding SRA, 10) and engage in a debriefing and self-

care. Granello (2010) identified and suggested 12 similar core principles to guide a health care

provider in performing a SRA that should be included in educational programs. These principles

are: 1) the SRA of each person is unique, 2) understand that SRA is a complex process, 3) be

aware that SRA is an ongoing process, 4) be cautious when doing a SRA, 5) be collaborative, 6)

use your clinical judgment, 7) take all risks, threats, and warning signs serious, 8) ask difficult

questions, 9) realize that SRA is treatment, 10) uncover underlying messages, 11) use cultural

context when conducting a SRA, 12) thoroughly document the SRA (Granello, 2010). Wyman et

al. (2008) reported that the staff perceptions on management of suicidal persons was higher after

receiving SRA training.

     In a retrospective study of 198 successful suicides in England, Saini, While, Chantler,

Windfuhr, & Kapur (2014) reported a relative lack of a SRA being conducted prior to a

successful suicide in the primary care setting and current SRA and suicidal assessment scales

have a poor predictive value. Consequently, Saini et al. (2014) recommended PCP's take into

account additional factors such as various demographic and clinical factors when conducting a

SRA.

A PCP's previous training in suicide prevention (SP) and SRA was predictive of an increased willingness to treat suicidal persons and lower training levels correlated with lower perceived competency among PCPs in treating suicidal persons (Graham, Rudd, & Bryan, 2011). In a study of a one hour educational program on suicidal risk conducted at a Veterans Administration hospital for 71 employees, Matthieu, Chen, Schohm, Lantiga, & Knox (2009) reported that referrals to mental health increased after suicide prevention gatekeeper training and there was additional interest in ongoing training for SRA. At a hospital in Japan, Takahiro et al. (2010) evaluated a two-hour SRA brief educational program for 44 first-year medical students and showed an immediate improvement in provider's confidence and attitudes of SRA but those improvements were limited at the six month follow up.

There are several articles that assessed the efficacy of educational programs in SRA and the treatment of suicidal persons with mixed results. Milton et al. (1999) conducted a retrospective study of SRA and PCP attitudes after a patient's successful suicide and found that a SRA was recorded for only 38% of successful suicides. In addition, psychiatric training for a general practitioner did not predispose them to conducting a SRA and length of practice time reduced the likelihood of an SRA being conducted. Berlin, Perizzlo, Lejderman, Fleck, & Joiner (2006) conducted a brief evaluation of a suicide prevention program for frontline hospital staff in Brazil and found that after training, short-term knowledge on suicide prevention improved and the staff felt more capable of helping suicidal individuals. In contrast, Morriss, Gask, Webb, Dixon, &Appleby (2005) evaluated 103 frontline healthcare workers after a brief educational skills training on SRA and found the training did not reduce the rate of successful suicides.

In a study evaluating an 18 hour suicide prevention program, Chan, et al. (2009) found nurses felt more competent to conduct a SRA after an 18 hour educational program but positive

results may not be significant at the six-month point. After a 60 minute seminar on suicide

prevention PCPs reported improved confidence and knowledge regarding suicidal persons and

the training resulted in an increase number of SRA's being conducted (Falluco, Conlon, Gale,

Constantino, & Glowinski (2011). Oordt, et al. (2009) conducted a 12 hour educational program

for newly trained mental health providers and found 43% had little or no prior SRA training and

97% agreed the training would change their practice. A 6 month follow up showed 83%

reported making a change in their practice and improved overall confidence in treating suicidal

persons. Pasco, Wallack, Sartin, & Dayton, (2012) evaluated the efficacy of a three-hour training

program for university residential advisors and found crisis skills in self-efficacy had increased

after the training.

Summary of research articles

Suicide rates have been increasing so that it is now is the 10th leading cause of death in

the U. S. (CDC, 2012) and there is a shortage of mental health providers (Thomas et al., 2009).

This can lead to a significant amount of individuals with significant risk factors for suicide being

treated by their PCP (Bostwick & Rackley, 2012, Cattell & Jolley, 1995, Luoma, et al., 2002).

There have been several brief educational programs that have demonstrated effectiveness at

improving a healthcare provider's knowledge and perceived efficacy in treating suicidal persons

(Graham, et al., 2011, Matthieu, et al., 2009, Takihiro, et al., 2010).

Based on the research parameters used for the literature review, there were no evidence-

based SRA Toolkits for frontline healthcare providers to utilize when treating suicidal persons.

The research also indicates there are inconsistencies in the training of healthcare professionals in

conducting a SRA and treating suicidal persons. The quality of SRA's conducted in the primary

care, family practice, and ED setting are inconsistent (Aflague & Ferszt, 2010) and formal

training in SP and SRA is not standardized in graduate training programs with didactic training

social worker, psychology, and child psychiatry programs in SP ranging from 29% to 94%

(Matthieu, et al. 2009).

The lack of formal training in SRA and suicide risk management is not only an issue in

the primary care field. Mental health specialties also lack consistency between training programs

regarding SRA and suicide risk management training. Oordt, Jobes, Fonseca, & Schmidt (2009)

conducted a study of SRA training with 82 active duty USAF mental health providers in San

Antonio, Texas and in the preliminary needs assessment found most had "little or no" training in

their post graduate training programs on SRA. Additionally, most of the mental health

professionals had some experience treating patients with suicidal patients while 74 % reported

being only "somewhat or moderately" experienced with suicidal patients (Oordt, et al. 2009).

In an effort to increase SRA training for medical personnel the State of Washington

mandated six hours of continuing education in the assessment, treatment, and management of

suicidal patients every six years for psychologists, occupational therapists, mental health

counselors, marriage and family therapists, advanced social workers, chemical dependency

professionals, certified counselors, and certified advisors (Stuber & Quinnett, 2013). Ironically,

primary care physicians and nurses objected to this new law and were excused from the mandate,

thus not benefiting from additional training in suicide risk assessment (Stuber & Quinnett, 2013).

In a pre-post study of additional training in suicide assessment and management, Oordt et al.

(2009) reported psychiatrists and psychiatric nurse's confidence in conducting a SRA improved

after a 12 hour training program.

Although conducting a SRA with some type of a risk estimate is the current standard of

care if the provider has any concerns, the predictive value of a SRA is questionable (Homaifar,

Matarazzo, & Wortzel, 2013). In addition, the value of the risk assessment to the patient in

mitigating suicidal thoughts is unclear and may only be done to mitigate organizational liability

in case of a successful suicide thus wasting the providers time (Mulder, 2011). Even when a SRA

is conducted there is very little standardization of what is required and how it should be

conducted. Cramer, Johnson, McLaughlin, & Rauch (2013) reported there were no clear

standards in psychological doctoral programs for education about SRA and they recommended

the development of specific SRA training to be included in doctoral education programs.

Aflague & Ferszt (2010) studied psychiatric nurses and found there was no standardization of

conducting a SRA and in fact there was significant variability in the performance of a SRA

among the nurses who were in the study.

Ronquillo, Minassian, Vilke, & Wilson (2012) conducted a literature review on suicide

assessment in the emergency department and recommended training in SRA due to the number

of patients who were seen at the emergency department with suicidal ideation. Despite the

research indicating the need for training in SRA for those working the primary care settings and

the existence of clinical practice guidelines there are multiple reason that implementation of

evidence based practices are delayed being implemented into clinical practice.

Cabana et al. (1999) identified both patient related and environmental barriers to the

implementation of best practices. A study of oncology nurses and their knowledge of suicidal

risk factors found that most rated themselves as having "little to some skill" with suicidal

evaluation and had difficulty identifying demographic factors associated with suicidal thoughts

(Valente, 2010).

A barrier to changing a physician's behavior identified by Bain (2007) was not having the

necessary information at the point of care. Mann et al. (2005) conducted a literature review with

experts from 15 countries of suicide prevention strategies. This study identified physician education and restricting access to lethal means to suicide as promising strategies for reducing suicide rates.

Rationale Based on Literature Review

There are a significant number of health care consumers who are experiencing suicidal ideations and are being seen by either family health or primary care providers. PCP's do not get consistent training in conducting a SRA. Several brief educational programs have demonstrated effectiveness at improving a healthcare provider's knowledge and perceived efficacy in treating suicidal persons (Graham, et al., 2011, Matthieu, et al., 2009, Takihiro, et al., 2010). The development of an evidence based SRA tool kit that could be reviewed by primary care providers could be beneficial and enhance provider confidence and skills at conducting a SRA.

Theoretical Framework

The Theory of Planned Behavior (TPB) was developed out of the Theory of Reasoned Action, is based on social behavior theory, and used to explain the rationale behind planned behaviors (Armitage & Conner, 2001). The TPB has been thoroughly studied and a meta-analysis conducted by Armitage & Conner (2001) found support that the TPB is efficacious as a predictor of an individual's behavior and their intentions to engage in that behavior. In a recent review of the TPB, Ajzen (2001) reported that it can be used to accurately predict behavior.

According to the TPB the intention to perform a behavior is preceded by attitudes, subjective norms, perceived behavioral control, and intention toward that behavior (Ajzen, 2002). The definitions for the primary concepts of the TPB are;

1. Attitudes; the behavioral belief regarding possible consequences of a specific action (Ajzen, 2002).

2. Subjective norms; the individual's perception about a specific behavior and the likelihood that important groups in the individual's life either approve or disapprove of a given behavior (Ajzen, 2002).

3. Perceived behavioral control; the individual's perception on how easy or difficult the specific behavior will be. This is composed of perceived self-efficacy and perceived controllability regarding the behavior (Ajzen, 2002).

4. Intention; the intention to perform the behavior itself.

5. Behavior; The individual's observable reaction in a specific situation (Ajzen, 2002).

Research Question

Would a panel of clinical healthcare experts find a resource kit designed for the primary care environment about suicide risk assessment and treatments based on current clinical practice guidelines to be an effective tool to improve the frequency and quality of a SRA?

Method

The literature suggests health professionals who work in the primary care setting are seeing a significant percentage of those who successfully commit suicide in the period before they take their lives. The literature also shows that a health care provider may not have received training or inconsistent training in SRA while in their educational programs. A SRA Toolkit in the primary care setting would be a valuable resource for a PCP to assist them in treating suicidal persons.

Study Design

This was a descriptive study to determine whether the SRA Toolkit is a useful resource for health care professionals working in primary care.

Purpose

The purpose of this project was the development and assessment of an information tool kit about SRA to be used by healthcare professionals who practice in the family practice or primary care arena.

Definition of Terms

SRA Toolkit: A resource developed by the author that included an introduction to the subject, on-line resources on the assessment and treatment of suicidal persons, the most recent versions of clinical practice guidelines on SRA available, examples of assessment questions, as well as proper documentation of a SRA based on current standards of care.

Suicide: Death from injury, poisoning, or suffocation where there is evidence (explicit or implicit) that the injury was self-inflicted and the decedent intended to kill themselves (O'Carroll et al.1996).

Suicide Attempt with Injuries: An action resulting in nonfatal injury, poisoning, or suffocation where there is evidence that the injury was self-inflicted and the intent was to die (O'Carroll et al. 1996).

Suicide Attempt: A potentially self-injurious behavior with a nonfatal outcome for which there is evidence that the person intended at some level to kill themselves. A suicide attempt may or may not result in injuries (O'Carroll et al. 1996).

Suicidal Act: A potentially self-injurious behavior for which there is evidence (explicit or implicit) that the person intended at some level to kill themselves. A suicidal act may result in death, injuries, or no injuries (O'Carroll et al. 1996).

Instrumental Suicide-Related Behavior: Potentially self-injurious behavior for which there is evidence that the person did not intend to die **<u>and</u>** the person wished to use the appearance of

intending to die in order to attain some other goal (seek help, punish others, attention seeking. (O'Carroll et al. 1996).

Suicide-Related Behavior: Potentially self-injurious behavior for which there is explicit or implicit evidence either that the person intended at some level to kill themselves or the person wanted to use the appearance of intending to kill themselves in order to attain some other end. Suicide-related behavior compromises suicidal acts and instrumental suicide-related behavior (O'Carroll et al. 1996).

Suicide Threat: Any interpersonal action, verbal or nonverbal, stopping short of a directly self-harmful act, that a reasonable person would interpret as communicating or suggesting that a suicidal act or other suicide related behavior might occur in the near future (O'Carroll et al. 1996).

Suicidal Preparatory Behavior: Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (buy a gun, collect pills) or preparing for one's death by suicide (note, give things away) (O'Carroll et al. 1996).

Suicidal Ideation: Any self-reported thoughts of engaging in suicide-related behavior (O'Carroll et al. 1996).

Suicidal Risk Factors: Factors that increase the likelihood of suicidal behavior and include both modifiable and non-modifiable indicators. (VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, 2013).

Suicidal Protective Factors: Capabilities, qualities, environmental and personal resources that increase resilience and drive individuals toward growth, stability, health, and increase coping

with different events and decrease the likelihood of suicidal behavior (VA/DoD Clinical Practice

Guideline for Assessment and Management of Patients at Risk for Suicide, 2013).

Setting

The SRA Toolkit and structured review questions were sent electronically to the panel

members. They were provided four weeks for reviewing the SRA Toolkit and completing the

review questions. The setting for the review as well as the completion of the structured questions

was determined by the personal preferences of each panel member.

Description of Sample

Inclusion criteria were the health care providers were known to the DNP student and

were currently practicing in their specialty.

Criteria for exclusion was providers who were not known to the DNP student.

The resulting review panel consisted of six health care providers; All providers were

known to this DNP student. The specific training of the panel members was DNP Psychiatric

Mental Health Nurse Practitioner, DNP Family Practice Nurse Practitioner, Psychologist, Family

Practice Physician, Psychiatrist, and a BSN prepared Registered Nurse who had worked in a

primary care setting.

Measures

The evaluation measures constructed for this study is provided in appendix C. Question

#1 evaluated their likelihood of using the SRA Toolkit in a family practice or primary care

setting clinical practice in a Likert scale with answer ranging from "very unlikely" to "very

likely". The Likert format has given similar results to other measures and in some situations is

desirable since it requires only one response (Maurer & Pierce, 1998). Simple descriptive

statistics were used to describe the most common answer to question one.

Questions #2 through #6 were qualitatively analyzed by the DNP student determining patterns or themes among the panel members on specific questions. These themes were reviewed for bias by a non-interested party.

Procedure

The SRA Toolkit was developed after a literature review for current guidelines for the assessment and treatment of suicidal persons. The following electronic data bases were searched to identify relevant SRA clinical practice guidelines; CINHAL, PubMed, Ovid MEDLINE, ERIC, PsychArticle, and the U.S. Department of Health & Human Resources National Guideline Clearinghouse. The search terms used were suicide, suicide risk assessment, and clinical practice guidelines. Pertinent articles were limited to clinical guidelines that were published in peer reviewed English language journals. Links to three Clinical Practice Guidelines were chosen for inclusion in this SRA Toolkit. The author included the Air Force Guide for Suicide Risk Assessment, Management, and Treatment (2013) with its appendices.

The SRA Toolkit was explained to each panel member and after they agreed to participate, the SRA Toolkit was electronically submitted to each member of the panel for review and critique. The panel members were able to review the SRA Toolkit at any setting of their choosing and were able to contact the DNP student for clarification about the material and expectations. They were provided up to four weeks for review of the material and to formulate comments. At the end of this period all six panel members had returned the completed questionnaire. Only one individual had questions that required telephonic communication.

Human Subject Protection

The study was approved by the University of Virginia, Institutional Review Board. No personal identifying information was gathered from panel members. No financial compensation was offered to panel members.

Data Analysis

The numerical answers to the first Likert scale question were tabulated and a mean was computed. The answers to the comments gathered from the structured interview questions were collected and qualitatively analyzed for common themes and suggestions. These themes were reviewed for bias by a two non-interested party. No investigator bias was identified.

The identified themes and suggestions will be incorporated in the completed SRA Toolkit for future testing in clinical settings.

<div align="center">

Results

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This descriptive study examined the appropriateness of the SRA Toolkit for utilization in a primary care setting.

Question # 1: How likely do you feel that the information provided in the SRA Toolkit would be utilized in a family practice or a primary care practice?

The six raters' scores on the first Likert scale question were averaged. Both the average and mode was four or likely to be utilized.

Five of the six panel members reported that this SRA Toolkit would be either "Likely" or "Very Likely" to be utilized in a primary care setting. Both the FNP and the PMHNP identified the SRA Toolkit as "Very Likely" to be utilized in a primary care setting while the psychiatrist, family practice doctor, and the psychologist identified the toolkit as "Likely" to be utilized in a primary care setting. Only the BSN rated the toolkit as "Unlikely" to be utilized in a primary care setting citing time restrictions as the primary reason for not being utilized.

Question # 2: What suggestions would you like to offer for improving the SRA Toolkit?

A common theme for question #2 was to shorten or condense the toolkit. One respondent specifically discussed the time limitations when a PCP is seeing a patient. The recommendations from all respondents were to either limit the toolkit to a single example of a risk assessment or to provide a single page that combines the best from all the example risk assessments.

Question #3: What information was the least helpful in the SRA Toolkit?

The length of the SRA Toolkit and the repetitive nature of the risk assessment examples were identified as being least helpful. The purpose of being a broadly usable tool and including three example risk assessments was not identified in the introduction to the toolkit and the one respondent identified this as an attempt to be all inclusive in the toolkit. Including information that was exclusively for mental health use was another piece of information that was identified as being not helpful. The use of the high interest log utilized in the USAF assessment example was identified as not being useful in a primary care setting.

Question #4: What information did you find most helpful in the SRA Toolkit.

The example of sample questions to ask during a SRA was identified as helpful by all the respondents. Respondents preferred different SRA examples based on their area of expertise. Three respondents specifically identified the second example SRA as the most helpful, which is also the briefest.

Question #5: In what clinical setting do you think this instrument would be most useful?

All respondents reported that they believed the toolkit would be of use in a primary care setting. One respondent, who was a provider in the USAF system, identified flight medicine and pediatrics as additional areas that would find the SRA Toolkit useful. Flight medicine is a clinic that provides primary care to persons who are in career fields that involve flying and their

families. One respondent stated that the SRA should be conducted in all clinical areas. Another respondent added that a SRA would work in a primary care setting if staff were provided adequate time to conduct assessments.

Question #6: Are there any additional comments you would like to make?

One respondent suggested adding the pocket guide and decision tree while another suggested adding information about head injuries. One respondent stated that this type of training would be helpful since training received thus far, only extended to asking about thoughts of harming themselves, which did not include what to do or ask afterwards. Another respondent felt the SRA Toolkit had potential to be helpful after further corrections. One respondent suggested adding information about the impulsive nature of suicide, correcting the mistaken belief that all suicides are preventable and avoiding adding an additional responsibility to the PCP.

Discussion

There have been reports of suicide since mankind began keeping records and cultural attitudes about suicide have changed over the years. The term suicide was first used in the year 1642, prior to that suicide was considered self-murder and a crime punished by burial in the highway (Shneidman, 1998). In historical Greek culture, suicide was seen as an act against the gods and persons who committed suicide were denied a funeral. In Roman culture suicide was criminalized and all personal property belonging to the individual who committed suicide was forfeited to the state after a person committed suicide to eliminate any legacy for the family (Crone, 1996). During the middle-ages, suicide was seen as an unnatural act that violated Gods power over mankind, since God gave life, only God should have the right to take life (Crone, 1996).

In recent years attitudes toward suicide have changed such that suicide is no longer seen as a crime where the individual is punished or incarcerated but rather a symptom of a mental illness that deserves treatment and care. Both the United States (U.S. Department of Health and Human Services, 2014) and the World Health Organization (2014) have identified suicide as a mental health problem that needs to be reduced.

Several CPG's have been developed regarding the assessment and treatment of suicidal persons. The American Psychiatric Association (2003), The Registered Nurses' Association of Ontario (2009), The USAF (2013), and the Department of Veterans Affairs (Assessment and Management of Risk for Suicide Working Group, 2013) have all published evidence based guidelines for assessing and treating suicidal persons.

Despite the existence of multiple guidelines for the assessment of suicidal persons, suicide risk assessments in primary care setting are being inconsistently implemented (Oordt et al., 2009). Additionally, there are evidence based CPG's on the assessment and treatment of suicidal persons, educational programs have been inconsistent with standardizing training in suicide risk assessment (Cramer et al., 2013).

Perceived behavioral control (PBC) is one of the concepts of the TPD and has an effect on a person's intention to engage in a behavior as well as an independent predictor of a persons' intention and engage in certain behaviors (Armitage & Conner, 2001). Increasing an individual's PBC through increasing knowledge and necessary skills will increase the likelihood of the behavior. In this study descriptive study the majority of the panel members identified the SRA Toolkit as likely or very likely to be utilized in practice.

Strengths and Weaknesses

Strengths: The recommendations from the expert panel provides the basis for further review and implementation of a SRA Toolkit in primary healthcare. An additional strength is the diverse clinical experience among the panel members who provided a wide range of feedback.

Limitations: A major limitation of this study is the small size of expert subject panel and the limitation of evaluation questions. The panel members were not equally experienced in patient care and suicide assessment standards so their individual feedback may vary in relevance based on their education and experience.

Nursing Practice Implications

In 2002, Luoma et al., reported that a significant percentage of suicidal persons were being treated and managed by their family practice or primary care provider within a year of a successful suicide. As nursing responsibilities expand at both nurse practitioner and RN levels, nurses are frequently the frontline contact when dealing with potentially suicidal persons. An evidence-based SRA Toolkit with specific information on the facts regarding suicide and how to conduct an effective SRA made available in the primary care setting could improve the confidence and consistency in assessing risk of suicidal persons.

Implications for future Research

There were several valuable suggestions for improvements to the SRA Toolkit that are worthy of consideration in conducting future research. All panel members recommended modifying the toolkit to make it shorter and including a one page assessment example that the PCP could refer to during a patient appointment. A pocket guide that synthesizes and summarizes the major points of a SRA could be developed to help the practitioner remember important aspects of a SRA while meeting with a patient.

      This SRA Toolkit was reviewed by clinical practitioners who practice in different specialties and patient populations. The future development of a SRA Toolkit that focuses on specific patient populations such as predominantly military or civilian populations that the PCP treat could be beneficial. Further study with larger samples of providers is needed to better understand the SRA Toolkit rating as "very unlikely" to be utilized when the other members of the panel rated it more likely to be utilized.

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