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Universal Suicide Screening in Outpatient Primary Care and Specialty Care

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Executive Summary: Staff Education Project

Universal Suicide Screening in Outpatient Primary Care and Specialty Care

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Summary

Native Americans are disproportionately affected by suicide, with mortality rates that are 2.5 higher than White and non-Hispanic Americans. Nursing staff in an Indian Health Service (IHS) outpatient and specialty care clinic inconsistently assess for suicide risk prior to outpatient and specialty clinic appointments due to sporadic use of screening tools and lack confidence to ask patients suicide risk screening questions. The purpose of this staff education project was to determine if interactive education of outpatient nursing providers regarding universal screening for suicide risk using the Ask Suicide Screening Questions (ASQ) for patients who are 8 to 11 and Patient Safety Screener (PSS-3) for patients who 12 older increases nursing providers' knowledge and self-perceived confidence regarding suicide risk screening during triage are. The practice-focused question was: Does an educational intervention focused on use of the PSS-3 and ASQ increase knowledge and confidence among nursing providers working in an outpatient clinic? Pre- and post-knowledge testing was done to assess significance to practice and screening techniques as well as nursing care providers' confidence in terms of using the ASQ and PSS-3. Among the nine participants, knowledge testing involving tool comprehension, rationale, and technique increased. This reflected an increase in confidence in terms of using the ASQ and PSS-3, and additional education was needed among nursing care providers who desired additional training. Interactive training proved to increase nursing providers' knowledge and confidence in terms of universal suicide screening. This contributes to social change, equity, and inclusion for those Native Americans whose risk for suicide is higher than any other cultural group in the United States.

Background

Suicide is among the top 10 leading causes of death in the United States among people between 10 and 64 (Centers for Disease Control and Prevention [CDC], n.d.). American Indians (AIs) are disproportionately affected by suicide, with mortality rates that are over 2.5 higher than White and non-Hispanic Americans (CDC, n.d.). Individuals who visit healthcare providers prior to suicide death frequently report somatic complaints (Horowitz, et al., 2020). Approximately 50% of AIs who die by suicide did not have mental health diagnoses (Stone et al., 2022). Further, 70% of individuals who attempt suicide die on the first attempt, and up to 35% of people who survive the first attempt will make a second attempt within 4 years (Fetter et al., 2023). Thus, universal suicide screening is an essential first step in terms of identification and mitigation of suicide attempts (Spottswood et al., 2022; Stone et al., 2022). Universal suicide screening is recommended by the U.S. Preventative Service Taskforce (USPTF) as the standard of care for high-risk groups (Spottswood, et al., 2022).

Early identification of suicidality is essential to mitigate suicide death; however, lack of suicide risk screening tends to be a primary barrier (Aguinaldo et al., 2021). LeCloux et al. (2022) determined only 33.33% of primary care providers (PCP) reported routine screening. However, 15.5% of outpatient primary care clinic patients and 13.4% of outpatient specialty clinic patients screened positive for suicidality (Aguinaldo et al., 2021). If only one third of these patients were screened for suicidality approximately 20% of primary and specialty care patients' suicide risk was missed during triage. Primary and specialty care outpatient appointments are the most frequent type of healthcare interactions prior to suicide death (Spottswood, et al., 2022). Studies indicate

between 45% to 60% of patients are seen by outpatient primary care or outpatient specialty care healthcare providers within a month of a suicide death, and 77% to 83% of patients were seen within 1 year of death (Horowitz et al., 2020; Spottswood et al., 2022).

Education of healthcare providers to increase knowledge and confidence in terms of screening and follow-up recommendations is necessary to identify individuals who are at risk for suicide. 79% of PCPs reported they needed additional training regarding screening methods and interviewing techniques (LeCloux et al., 2022). Training to increase understanding and confidence of PCPs in terms of completing suicide screening can decrease stigma, overreactions, and loss of patient autonomy as well as increase identification of suicidal individuals prior to attempts (Richards et al., 2019). Increasing self-perceived confidence and competence of PCPs may be accomplished through initial and continuing education (Solin et al., 2021). South Dakota has the sixth highest crude mortality rate for suicide in the United States, and the fifth highest age-adjusted suicide mortality rate in the United States. The county under study in South Dakota has the highest mortality rate in the state at 61.4 per 100,00 persons (South Dakota Department of Health, 2023). The primary care outpatient and specialty care clinic serves AIs and Native Alaskans, which are high-risk groups. Observations and interviews with nursing care providers in the clinic responsible for universal suicide risk screening of patients showed inconsistent use of screening tools and discomfort with asking patients suicide risk screening questions.

Staff Education Project Development

Participants were nursing care providers in an outpatient and specialty care department of an AI and Alaska Native hospital. Nine nursing providers who were

responsible for triage and universal suicide risk screening participated in this staff development project. Knowledge was assessed using 14 true/false and multiple-choice questions. To measure confidence, participants were asked to rate their level of confidence regarding use of the ASQ and PSS-3 on a Likert scale from one (none of the time) to five (all of the time). Two questions were asked to determine past training and need for additional training. In collaboration with the Chief Nurse Executive, all nine participants participated in the pretest, interactive education, and posttest for universal suicide screening.

Results

Interactive education on universal suicide screening in the outpatient and specialty care clinic increased knowledge and confidence involving completion of suicide risk screening. Four participants indicated they had some type of training prior to the educational intervention. The mean pretest score for knowledge was 8.78 (*SD* = 1.09) with a range of 3, and the mean posttest score was 12.0 (*SD* = 1.22) with a range of 4, demonstrating a numerical increase between pretest and posttest scores. Confidence was measured using six questions that participants rated using a Likert scale. There were numerical increases in confidence for all six questions (see Table 1). Last, all participants indicated additional training regarding universal suicide screening was desired to increase knowledge and confidence.

Table 1

Self-Reported Confidence Results

Self-Reported Confidence Survey		Mean (SD)	Range
I use the ASQ or PSS-3 (as applicable) for every outpatient patient every time they have an appointment in primary care or specialty care.			
	Pretest	2.89 (1.37)	4
	Posttest	4 (1.41)	3
I ask the questionnaire verbatim, do not combine questions or change the wording of the questions.			
	Pretest	3 (1.33)	4
	Posttest	4.78 (0.68)	2
I am confident asking the questions of the ASQ for children 8 – 11 years old?			
	Pretest	2.67 (1.25)	3
	Posttest	4.56 (0.68)	2
I am confident in asking the parent or family member to exit the room for the screening to occur in private.			
	Pretest	1.89 (1.45)	4
	Posttest	4.45 (0.83)	2
I am confident asking the questions of the PSS-3 to patients 12 years and older?			
	Pretest	3.77 (1.23)	4
	Posttest	4.56 (0.68)	2
I notify the provider of a positive screening or a non-acute positive screening prior to the patient being seen.			
	Pretest	4 (1.41)	4
	Posttest	4.89 (0.31)	1

Results of this DNP project include several implications. First, there was a numerical increase between pretest and posttest scores. This demonstrates increased knowledge and confidence of participants regarding early identification of persons who are at risk of suicide. Increased knowledge as numerically indicated via the ASQ and PSS-3 will increase confidence according to posttest scores and hopefully translate into practice in terms of early identification of suicide risk. . Early identification of suicidal ideation is necessary for patients to receive services within the facility and provide significant cost savings that could be used for additional mental health services. Every one person who commits suicide impacts an average of 60 people, leaving lasting effects resulting in subsequent depression and increased risks of suicide (Solin et al., 2021).

Training may be translated throughout the United States for increased interactive training at other healthcare facilities. This training may be modified and replicated at this and other IHS sites throughout the United States. Increasing education of nursing care providers during orientation and biannually will ensure training has occurred and knowledge becomes routine practice. Increasing knowledge of nursing staff through interactive training leads to confidence in terms of suicide in order to ask questions that are necessary as part of risk assessments. Increased knowledge and confidence of nursing care providers would positively affect communities that are served by every IHS hospital throughout the United States by confidently administering the ASQ and PSS-3 and identifying patients who are at risk.

Limitations to the staff education program on universal suicide precautions include the inability to connect the screening tool to subsequent assessments. The ASQ has a secondary screener the Brief Suicide Safety Assessment (BSSA) and the PSS-3 has

a secondary assessment the ED-SAFE Patient Secondary Screener (ESS-6), but the information in the ASQ may not be used in the ESS-6 and the information gathered in the PSS-3 does is not used in the BSSA. Medical and specialty providers should be part of subsequent education and reeducation with nursing care providers to coordinate process flow. Screening for universal suicide precautions is mandated throughout the hospital. However, it is not completed because of lack of education for both nursing and medical care providers.

Conclusions

Primary and specialty care outpatient provider appointments are optimal points of contact to determine suicidality among AI and Alaska Native peoples. These high-risk groups are disproportionately impacted by suicide, and training of nursing providers regarding suicide risk is necessary to increase knowledge and confidence during identification. Interactive training of nursing care providers leads to increased knowledge and confidence in terms of use of the ASQ and PSS-3 for early identification of suicide risk. I showed additional interactive training can increase knowledge of practice and increase self-reported confidence in terms of triaging of suicide risks in outpatient primary and specialty care among nursing care providers.

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Appendix A: Universal Suicide Screening Knowledge Test

Suicide Screening Pre- & Post- Knowledge Test Date: _____

Position Title: _____
Do Not Include Name

Circle the correct letter:

1. Suicide rates for American Indians are 2.5 times that of white Americans.
   A. True
   B. False

2. Todd County South Dakota has the highest suicide rate in South Dakota.
   A. True
   B. False

3. Asking a patient about suicide causes a patient to start thinking about suicide?
   A. True
   B. False

4. For each patient that comes to an acute care setting for a suicide related complaint:
   A. There is an equal number of patients with suicidal ideations that go undetected.
   B. There are twice as many patients with suicidal ideations that go undetected.
   C. There are half as many patients that have suicidal ideations that go undetected

5. The Patient Safety Screener (PSS-3) is an evidence-based suicide screening tool used for all patients:
   A. Eight years old and older
   B. Twelve years old and older
   C. Adults only (>18 years old)

6. The Ask Suicide Screening Questions (ASQ) is an evidence-based suicide screening tool used for all patients:
   A. Eight years old and older
   B. Twelve years old and older
   C. Children only (<19 years old)

7. The PSS-3 or the ASQ is completed:
   A. During triage of ALL Outpatient Primary Care patients, initial assessment of ALL Inpatient Patients and during triage of ALL Emergency Department patients over the age of eight years old.
   B. During triage of ALL Outpatient Primary Care patients, initial assessment of all Inpatient Patients and during triage of all Emergency Department patients over the age of twelve years old.

C. During triage of all Behavioral Health patients in the Outpatient Primary Care, initial assessment of all Behavioral Health Inpatient Patients and during triage of all Behavioral Health Emergency Department patients.

Use screening tools to answer the next five questions.

PSS-3 Questions:

1. **Over the past two weeks, have you felt down, depressed or hopeless?**
2. **Over the past two weeks, have you had thoughts of killing yourself?**
3. **Have you ever attempted to kill yourself?**
   - **Within the past 24 hours (including today)**
   - **Within the last month (but not today)**
   - **Between 1-6 months ago**
   - **More than 6 months ago**
   - **Refused**
   - **Patient unable to complete**

ASQ:

1. **In the past few weeks, have you wished you were dead?**
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?**
3. **In the past week, have you been having thoughts about killing yourself?**
4. **Have you ever tried to kill yourself?**
5. **Are you having thoughts of killing yourself right now?**

8. The questions must be asked as written?
   A. True
   B. False

9. Questions may be skipped or combined if the words have the same meaning? (hurting, cutting, killing)
   A. True
   B. False

10. If using the PSS-3, answering yes to questions 1, 2 and 3 always indicates a positive suicide risk?
    A. True
    B. False

11. If using the ASQ, answering yes to 1, 2, 3, or 4, but no to question 5 indicates a non-acute positive screen?
    A. True
    B. False

12. If a patient answers no to all the questions, the suicide screen is negative and there is no risk of suicide?
    A. True
    B. False

13. If either the PSS-3 or ASQ is positive the provider is notified by completing a triage note and adding them as the additional signer.
    A. True
    B. False

14. Universal Suicide Screening means:
    A. Detects patients at risk for suicide
    B. Is the first step in suicide prevention
    C. Is a best care practice
    D. All the above

Appendix B: Self Evaluation of Confidence in Universal Screening for Suicide Risk

Self-Evaluation Date: _____

Position Title: _____ Pre / Post
Do Not Include Name Circle One

Please circle response below question:

1. I have been trained in the use of the ASQ and PSS-3 and I feel confident in using the suicide screening tools.

   Yes No

2. I use the ASQ or PSS-3 (as applicable) for every outpatient patient every time they have an appointment in primary care or specialty care?

   None of the Time (NEVER) | Rarely (<50%) | Some of the Time (>50%) | Often (>75%) | All of the time (Always)

3. I ask the questionnaire verbatim, do not combine questions or change the wording of the questions.

   None of the Time (NEVER) | Rarely (<50%) | Some of the Time (>50%) | Often (>75%) | All of the time (Always)

4. I am confident asking the questions of the ASQ for children 8-11 years old?

   None of the Time (NEVER) | Rarely (<50%) | Some of the Time (>50%) | Often (>75%) | All of the time (Always)

5. I am confident in asking the parent or family member to exit the room for the screening to occur in private.

   None of the Time (NEVER) | Rarely (<50%) | Some of the Time (>50%) | Often (>75%) | All of the time (Always)

6. I am confident asking the questions of the PSS-3 to patients 12 years and older?

None of the Time (NEVER) | Rarely (<50%) | Some of the Time (>50%) | Often (>75%) | All of the time (Always)

7. I notify the provider of a positive screening or a non-acute positive screening prior to the patient being seen.

None of the Time (NEVER) | Rarely (<50%) | Some of the Time (>50%) | Often (>75%) | All of the time (Always)

8. Additional Training is needed to increase the knowledge and confidence of the staff using the ASQ and PSS-3.

Yes No