

12-30-2025

For Evidence-Based Suicide Risk Assessment

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Walden University

College of Nursing

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Walden University
2025

Executive Summary: Clinical Practice Guideline

For Evidence-Based Suicide Risk Assessment

by

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MS, Walden University 2023

BS, Walden University, 2019

Executive Summary Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

February 2026

Summary

This clinical practice guideline (CPG) project was developed to address a practice gap regarding the lack of systemic approach to suicide assessment in adult patients. This Doctor of Nursing Practice (DNP) project identified a significant gap in care at a private mental health clinic, which lacked a consistent, evident-based approach to suicide risk assessment. The inconsistency increased the likelihood of under-identifying at risk patients, posing substantial medical-legal and patient safety concerns. The practice-focused question guiding this project was: Does the evidence support the development of a CPG for suicide risk screening that receives an AGREE II quality score by an expert panel and receives approval for use in the practice settings for end-users? The purpose of this project was to develop a CPG for practitioners in a clinic. A literature search and synthesis were performed using the Johns Hopkins Nursing evidence-based practice (JHNEB) model. Databases such as CINAHL and PubMed yielded 120 articles, and after screening for relevance and quality, 22 articles were selected. The evidence consisted of high-quality Level I and II evidence. An expert panel of five evaluated the CPG using the Appraisal of Guidelines for Research and Evaluation II (AGREE II) tool. The results indicated high quality, with scores for the six domains ranging from 83% to 94%. The panel rated the overall quality of the guideline 6 out of 7 and recommended its use in practice. An important recommendation is to adopt and implement the CPG within the clinic, accompanied by comprehensive staff training. The project has implications for nursing to drive positive social change by enabling proactive health initiatives, increasing awareness, and engaging routine suicide screening among all patients when indicated to improve access to services enhancing patient safety and prevent suicide.

Background

This DNP project was initiated to address a gap between the clinic's current procedures and evidence-based standards for suicide risk assessment. Approximately 48,000 deaths by suicide occur in the United States each year (Martinez et al., 2022). The clinical setting is a crucial point of intervention for patients receiving mental health care especially those at risk for suicide. As a private outpatient mental health clinic, the project site did not have a unified protocol for assessing suicide risk. Elzinga et al. (2020) stated that the mental health care population is among the most vulnerable, making clinical settings—in outpatient clinics—key frontlines for identifying and intervening with individuals at-risk for suicide. The authors added that suicide risk assessment is a mandatory part of standard care in these settings. The challenge, however, is transforming this standard into consistent, reliable practice.

A lack of a standard suicide risk assessment and individual clinical judgment on the part of providers contributed to inconsistencies in care quality and patient safety in the mental health clinic. To fill this gap, this project was developed as a CPG for suicide risk assessment, using an evidence-based approach to ensure that patients receive an effective and uniform assessment of their suicide risk. Evidence supports the need for this change. The Joint Commission and the American Psychiatric Association have released guidelines and safety standards that explicitly recommend that structured tools and clinical pathways be used to detect and manage suicide risks (Powsner et al., 2023; Ryan & Oquendo, 2020). Studies have also demonstrated that standardized assessment instruments such as the Columbia-Suicide Severity Rating Scale (C-SSRS) are more effective at identifying suicidal ideation and behavior than unstructured clinical

interviews alone (Bjureberg et al., 2022). This body of evidence exceeds expert opinion in its strength, including high-quality clinical trials and synthesizes that demonstrate a compelling need for practice change. This project addresses the well-documented gap between published research and everyday clinical practices by synthesizing this evidence into a practical, clinic-specific CPG.

A rigorously developed CPG was evaluated for quality and usefulness by an expert panel as part of the project. Developing an implementable guideline to improve patient safety and clinical outcomes was the goal. Bjureberg et al. (2022) and Austria-Corrales et al. (2023) recommended using structured tools and clinical guidelines to detect and manage suicide risk.

Evidence supporting the effectiveness of standardized assessment over unstructured clinical inquiry is strong, consisting of Level I meta-analyses and Level II randomized controlled trials (Boggs et al., 2024; Walsh et al., 2025). Using the Johns Hopkins Model for evidence-based practice, a literature review was conducted to support the development of a CPG for suicide risk assessment. The search resulted in 120 articles, from which 35 were selected for in-depth analysis based on their relevance and quality.

The article varied in their level of evidence. Ten of the articles were Level I, which includes systematic reviews and meta-analyses (Vatkar et al., 2025). Level I sources provide the strongest evidence due to their comprehensive nature (Vatkar et al., 2025). Fifteen articles were Level II, which consisted of randomized controlled trials (RCTs) which, according to Vatkar et al. (2025), offer robust findings. The remaining articles fell under Level III, which included cohort studies and case control studies. Level I evidence highlighted the effectiveness of standardized tools like the C-SSRS, which

were shown to identify suicidal ideation and behaviors than unstructured interviews. Level II evidence for RCTs further supported these findings showing better outcomes with the use of structured assessments. Finally, Level III also added good context clarifying patient experiences and risk factors.

Clinical Practice Guideline Development

Five qualified members were selected to review the CPG. This panel consisted of two psychiatric-mental health nurse practitioners (PMHNPs) with over 15 years of clinical experience. Their extensive background equips them with the necessary skills to assess and manage suicide risk effectively. Additionally, a clinical social worker specializing in suicide was included bringing valuable insights into the social factors affecting suicidal behavior. The panel also included a nurse director from a clinic system affiliated with a hospital system whose experience adds a realistic experience on implementing guidelines. In selecting panelists, consideration was given to their recognized expertise in mental health, suicide prevention, and clinical operations.

To evaluate the quality of the CPG, the panel used the AGREE II tool, an international standard for assessing the quality of guidelines. The process began with panelists reviewing the draft of the CPG which came with detailed instructions on how to use the AGREE II tool. AGREE II assesses 23 key items across six key domains, including Scope and Purpose, Stakeholder Involvement, Rigor of Development, Clarity of Presentation, Applicability, and Editorial Independence.

Each panelist rated the items on the scale on a 7-point Likert scale, where 1 represents strong disagreement and 7 indicates strong agreement with each statement related to the quality of the guideline (Wang et al., 2025). After completing their

assessments individually, the panel met to discuss their scores and rationale behind them, which facilitated an exchange of perspectives and insights. They also provided comments to highlight the strengths and areas for improvement, Specific feedback was categorized into themes, focusing on usability, clarity and implementation strategies. On a 7-point Likert scale, each item is rated from 1 (*strongly disagree*) to 7 (*strongly agree*). Independently, panelists completed the appraisal and provided narrative comments (Wang et al., 2025).

Results

In evaluating the CPG, for evidence-based suicide risk assessment, the expert panel provided two critical global scores that reflect the guidelines overall quality and its recommendation for practical application. The overall quality of the guideline was rated at 6 out of 7, indicating a high level of confidence in its soundness and its relevance. This score suggests that the CPG meets the necessary criteria for effective implementation in clinical settings. Furthermore, the panel explicitly recommended the guideline for use in practice underscoring its potential to enhance patient safety and improve consistencies in suicide risk assessment. This recommendation aligns with the high score achieved across the six AGREE II domains, which assessed various aspects of the guideline's development and presentation.

A strong endorsement of the CPG across all six domains was shown in the AGREE II appraisal. The scores for each domain were as follows: Scope and Practice received 92% indicating that the goals and patient population were clearly defined. Stakeholder involvement scored 87% suggesting relevance to various professional groups but highlighting the need for better inclusion of patient perspectives. The Rigor of

Development domain earned a score of 89% showing strong research methods and a clear link between the recommendations and supporting evidence. Clarity of Presentation achieved the highest score at 94% demonstrating that guidelines are specific and easy to understand. The Applicability domain received a score of 83% with recommendations for more detailed implementation strategies. Finally, Editorial Independence scored 90% confirming that the guideline was developed without external influence. The two global scores, which represent the overall quality of the CPG also indicated strong endorsement. The first global score assessed the overall quality of the CPG, whereas the second measured the likelihood of the guideline being recommended for use. Both scores reflected the panel's confidence in the CPG's potential to enhance patient safety and standardized care.

The expert panel's evaluation supports the adoption and implementation of the CPG within the clinical setting. The strong scores across the domains suggest that the guideline is a high quality, evidence-based resource. However, feedback indicated areas for improvement particularly in terms of usability. It was recommended that the CPG be implemented with comprehensive staff training and that regular updates be conducted to ensure its relevance and effectiveness in practice.

A summary of the mean domain scores calculated from the ratings of the panelists is presented in Table 1. Among the domains, Clarity of Presentation received the highest score (94%), which indicates that the recommendations contained within the guideline are specific, unambiguous, and readily recognizable. Although still high, the Applicability domain scored slightly lower (83%), with panelists suggesting that more detailed implementation strategies be included.

The qualitative comments from the panel were categorized into themes. Usability and flow were two of the main themes. Among the panelists, there was one who commented, “The inclusion of a clinical flowchart would make an already clear guideline even more useful at the point of care.” The formulation of comprehensive risks was a secondary theme. There was an appreciation for both risk and protective factors being included and an emphasis placed on integrating the score of the assessment tool with clinical judgement, rather than using it alone. According to the expert panel, the CPG “fills a critical gap in our current workflow” as well as “provides a clear, defensible standard for our assessment.” The participants appreciated the specific scripting for obtaining information about suicidal ideation and the algorithm for identifying risk levels and actions.

There are several potential impacts of adopting this CPG on the organization. In addition to directly improving patient safety, it is expected to improve the quality and consistency of documentation and reduce medical-legal liability by demonstrating adherence to an evidence-based standard of care in suicide risk assessment. Despite their prominent level of expertise, one of the primary limitations of this project phase was the small size of the panel. Additionally, the appraisal focuses on the quality of the guideline itself, rather than its implementation effectiveness, which should be evaluated in a future pilot study. Even though the CPG was developed for a local site, it addresses a common gap in private practice settings, making it a highly transferrable model. The results of the AGREE II evaluation including scores across various domains are summarized.

Table 1*AGREE II Expert Panel Domain Scores*

Domain	Mean score (%)	Key strengths by panelists
Scope and Practice	92%	The overall goals, patient population and clinical questions were described with clarity
Stakeholder Involvement	87%	Patient perspective should be included in future updates. The guideline is relevant to professional groups (nurses, social workers)
Rigor of Development	89%	The systematic methods for research and selection are strong there is a clear link between the recommendations and supporting evidence
Clarity of Presentation	94%	All the panelists agreed that the recommendations are specific and easy to identify
Applicability	83%	The guideline identifies key facilitators and barriers. To increase this score, reviewers suggested adding a more detailed implementation checklist and a document sample
Editorial Independence	90%	The CPG was viewed as independent from competing interests with the funding body (the clinic) not influencing the content.

Conclusions

The findings suggest that the CPG is a high-quality evidence-based resource. However, the panel also highlighted areas for improvement, particularly concerning usability and implementation strategies. It is recommended that the CPG be adopted in the clinical setting with comprehensive training for healthcare providers. This will ensure

that staff can use the guidelines effectively and address the diverse needs of patients (Pereira et al., 2022). Regular evaluations and updates to the CPG should also be conducted to maintain relevance and effectiveness in practice (Pereira et al., 2022). The AGREE tool served as a rigorous framework for this evaluation ensuring that the guideline meets high standard of quality and applicability in the clinical setting.

A suicide risk assessment based on evidence-based CPGs may create a safer clinical environment and have a significant impact on the organization. This evidence-based CPG for suicide risk assessment may have a substantial and multifaceted impact on the organization, supported by evidence from the literature on implementation science and patient safety (Boggs et al., 2024). The primary organizational impact is an increase in patient safety and the standardization of care.

The use of standardized tools, such as those incorporated into this CPG, significantly improves the accuracy and reliability of identifying suicide risk patients when compared with unstructured clinical judgment alone (Powsner et al., 2023). By replacing variable practices with a standard protocol, the organization mitigates its risk of missing critical warning signs, thereby directly preventing sentinel events (Horowitz et al., 2023). In addition, the CPG provides a clear, step-by-step methodology for determining the optimal clinical response based on the severity of suicide risk, which has been shown to reduce staff decisional uncertainty and ensure that patients receive timely and appropriate interventions, including safety planning and acute referrals (Ryan & Oquendo, 2020).

A detailed implementation plan should be developed after the clinic's board adopts and approves the CPG. Education must be provided for clinical staff, key

assessment questions must be integrated into the clinic's electronic health record, and a post-implementation audit plan must be developed to assess effectiveness and adherence (Kim, 2022). Other recommendations include conducting a post-implementation audit to measure the CPG's effectiveness in real-time and developing patient education materials to complement the clinical protocol (Pereira et al., 2022).

This guideline has profound implications for nursing practice, as it provides a clear standard of care, facilitates clinical decision-making, and reinforces the nurses' role in identifying suicide risk for patient safety (Powsner et al., 2023). In a broader sense, the project has the potential to foster positive social change and advance diversity, equity, and inclusion (Versavel et al., 2023). In developing the guideline, emphasis was placed on evaluating unique sociodemographic and cultural risk factors to go beyond a generic risk assessment.

The project (see Appendix) encourages clinicians to pay particular attention to the elevated risk associated with LGBTQ+ youth, rural populations who lack access to mental health services, veterans, and individuals from different racial and ethnic backgrounds who may face systemic barriers to mental health treatment. As these factors are explicitly incorporated into clinical assessment, the CPG promotes culturally competent and equitable care, helping reduce the disparities in suicide rates and outcomes that have been well-documented (Versavel et al. 2023).

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Appendix

Clinical Practice Guideline for Suicide Risk Identification

Introduction

The document provides best practice evidence for improving the suicide risk assessment in an outpatient psychiatric mental healthcare private clinic. The project aims to empower the healthcare staff by offering evidence-based guidelines that can be used to assess and administer suicide risk assessments. Suicide is a global health issue that is growing rapidly. One main reason for the increased suicide rate is the lack of best practices for identifying suicide risk in patients. Poor identification of the suicide risks leads to delayed intervention, affecting patient safety. This clinical practice guideline (CPG) is addressing the problem of suicide by providing evidence-based protocol to identify the risk in a timely. The CPGs are employed systematically to assess the suicide potential in patients. Firstly, the presence of depression and the possibility of suicidal ideation will be evaluated by Patient Health Questionnaire-9 (PHQ-9). The positive response to the PHQ-9 question concerning suicidal ideation leads to the use of the Columbia-Suicide Risk Severity Scale (C-SSRS) tool by healthcare providers to identify the suicidal risk in patients, lowering suicidal attempts.

The assessment of the benefits and harms of alternative care options refers to the systematic evaluation of the different clinical interventions or treatment strategies to determine their potential positive and negative outcomes for patients. This process is essential in clinical practice to ensure that care decisions are evidence-based, patient-centered, and optimized for the best possible outcomes. In terms of mental, emotional, and physical health, effective treatments prevent suicide risk and improve overall quality

of life. Psychotherapy and medication improve quality of life with lower risks of unwanted side effects. Accessibility is also a factor, as interventions need to be possible and convenient for patients to comply with. Benefits of care alternatives also bear associated risks, such as drug side effects or mental trauma from aggressive therapy. An inaccurate or overdiagnosed illness can lead to unnecessary treatment, and financial or organizational issues can deny patients access to the care they require. Some interventions may also lack robust evidence, thus failing to be effective. Alternative treatments, including therapy, medication, and lifestyle modifications, must be considered case-by-case. Cognitive behavior therapy (CBT) can reduce suicidal thoughts but is too lengthy and inappropriate for application during periods of acute crisis. Selective serotonin reuptake inhibitors (SSRIs) rapidly act to stabilize mood but risk making initial symptoms worse. Whenever a patient's needs, goals, and values converge with what the patient desires, interventions are afterward tailored to individuals. By means of solving conflicts between different interventions' effectiveness, risks, and availability, healthcare providers can realistically do the best and minimize harm. This balanced approach aids in informed decisions so that the best possible care can be provided.

Methods

To facilitate the development of a robust CPG, a systematic method was used to obtain and evaluate the supporting evidence. The Johns Hopkins evidence-based practice (JHEBP) model was utilized to collect and evaluate the evidence supporting this CPG. The JHEBP model provides a systematic method for identifying, appraising, and synthesizing scholarly evidence to ensure high-quality recommendations. A thorough

search using the JHEBP model initially yielded fifty articles. However, forty articles were excluded due to their lack of adherence to the topic of suicide risk identification, leaving ten articles for use in developing the CPGs.

Evaluating the articles through the JHEBP model ensured that high quality and best evidence were used to create the CPGs. The model was used to critically appraise each article. The method used for finding the articles was using keywords and academic databases to find articles for developing evidence-based CPGs for suicide risk identification. The Walden University Library provided access to the online databases to find the articles. For instance, databases such as PubMed, Medline, Embase, ProQuest Nursing, and CINAHL were used to search for articles related to suicide risk identification. Additionally, the keywords such as suicide risk, suicide prevention, and suicidal thought were used. According to the JHEBP model, the level of evidence for the selected articles ranges from I to V, which helped develop the CPGs for improving suicide identification at the behavioral clinic. For the synthesis, the findings of each study were provided in the literature review matrix, demonstrating the value and relevance of the evidence to the CPG and for improving suicide risk identification at this outpatient psychiatric mental health private clinic.

The CPG will also undergo a robust validation process. The Appraisal of Guidelines for Research and Evaluation II (AGREE II) instrument will be used to validate the formation of the CPGs. The AGREE II is a well-recognized tool used to evaluate the methodological quality of CPGs. The AGREE II tool comprises six categories with a total of 23 items. The six categories are scope and purpose, stakeholder

involvement, rigor of development, clarity of presentation, applicability, and editorial independence:

- **Scope and Purpose:** Evaluation based on the overall aim and the definite problems which the guidelines were meant to address and their targeted audience.
- **Stakeholder Involvement:** Healthcare professionals and patients were assessed as key stakeholders because they were taking part in the guidelines' developing process.
- **Rigor of Development:** Validation ensured that there was systematic methodology that was used to gather and synthesize evidence, with clear criteria for recommendations.
- **Clarity of Presentation:** The guidelines were assessed on the clarity of guidelines, structure, and ease of understanding.
- **Applicability:** As part of the AGREE II tool, the researchers examined how those guidelines can be implemented into clinical practice, including facilitators, barriers, and resource implications.
- **Editorial Independence:** In the assessment of the guidelines, we focused on biases associated with guidelines originating from funding sources or other conflicting interests.
- **Scoring and Validation:** In AGREE II, 23 items were scored on a 7-point Likert scale (1 = *strongly disagree*; 7 = *strongly agree*) over 6 domains. The sums of each of the six domains yield a total score. In general, a high-quality clinical practice guideline has a score of 70 or higher across all categories.

The CPGs are validated by an expert panel to ensure their practical applicability in clinical settings.

The AGREE II instrument **will ensure** that the developed CPGs **meet** the highest quality standards to enhance clinical practice at the behavioral clinic. Developing CPGs based on supported evidence **will be essential** to providing evidence-based recommendations for improving suicide identification and management. A systematic approach **will be used** in CPG development. First, a literature search **will be conducted** to identify high-quality articles supporting suicide risk assessment and prevention strategies. Next, a multidisciplinary expert panel **will evaluate** the proposed recommendations to enhance suicide identification and management practices. For validation, each recommendation **will be assessed** against AGREE II criteria to ensure methodological quality. Iterative and transparent processes **will guarantee** that the final guidelines meet the highest standards. AGREE II validation process offers a suicide identification and management framework in the behavioral clinic, supported by evidence-based recommendations and clinically informed practices.

Evidence

Finding evidence-based suicide risk assessment tools is necessary to address the suicide risk in the patients. Effectiveness of Evidence-based Suicide Risk Assessment Tools: literature reviews Baek et al. (2021), Baldaçara et al. (2021), Beaudry et al. (2022), and Legazpi et al. (2022) points out the necessity of an investigative protocol that calls for evidence-based suicide risk assessment tools in the ability to individualize suicide risks among patients. These studies underscore that these suicide risk assessment tools have been effective at identifying patients who might be at an elevated risk for

committing suicide, thereby lowering their risk of committing suicide. This collectively advocates for a systematic and structured assessment of suicide risk in behavioral health settings and supports recommendations to use validated risk assessment tools.

The C-SSRS is an effective tool for suicide risk assessment, it emerged as a valuable tool in suicide risk assessment. Bjureberg et al. (2021), Kanter et al. (2023), and Syndergaard et al. (2022) presented even more support for using the C-SSRS to identify suicidal thoughts and behaviors earlier among individuals at high risk. While many tools exist to capture or assess a history of suicidal thoughts and behaviors, the C-SSRS is particularly useful in establishing different levels of suicidal ideation and behaviors and becomes an important component of a comprehensive suicide risk assessment.

Another important tool in depression identification and risk assessment is the PHQ-9, which assesses levels of depression. Research by Costantini et al. (2020), Ford et al. (2020), and Korsen & Gerrish (2022) further support the role of PHQ-9 in identifying the severity of depression closely associated with suicide risk. Depression remains a significant risk factor for suicide, and thus, using PHQ-9 can help identify such patients who might need monitoring and intervention more closely.

It is importance for staff to be educated on using screening tools. Across the literature, a common thread continuously posited the necessity of staff education on using evidence-based suicide risk assessment tools correctly. Staff trained to do so are capable of recognizing signs of suicide risk and intervening appropriately. Training staff on the purpose of such tools and when to use them could significantly bolster outcomes in identifying suicide risk in the earliest stages.

Recommendations

- **Utilize Evidence-Based Suicide Risk Assessment Tools**

Employ tools like the Columbia-Suicide Severity Rating Scale (C-SSRS) to assess various degrees of suicidality. Integrate the Patient Health Questionnaire-9 (PHQ-9) for depression screening, particularly leveraging its item on suicidal thoughts.

- **Implement Comprehensive Clinical Practice Guidelines (CPGs)**

Develop and adopt CPGs that standardize suicide risk assessment protocols to improve patient safety and outcomes. Incorporate evidence-based tools such as C-SSRS and PHQ-9 into the CPG framework to enhance the identification of suicidal thinking.

- **Train Healthcare Staff**

Provide education and training for healthcare staff on the proper use of suicide screening tools and interpretation of results. Ensure that personnel are equipped to apply CPGs effectively in care delivery settings.

- **Enhance Risk Identification Through Integrated Approaches**

Combine tools like PHQ-9 with more comprehensive assessment strategies to improve the detection of patients at elevated suicide risk. Use evidence-based protocols to systematically evaluate and address suicidality within healthcare practices.

- **Prioritize Patient-Centered Care**

Implement protocols that recognize the individual health status of patients to deliver tailored interventions. Ensure that risk assessments are followed by appropriate clinical responses to address identified needs.

- **Monitor and Evaluate CPG Implementation**

Establish mechanisms for assessing the effectiveness of suicide risk assessment protocols over time. Continuously update the guidelines based on emerging evidence to maintain relevance and effectiveness.

These recommendations aim to enhance the systematic identification and management of suicide risk within healthcare settings, ensuring improved outcomes and patient safety.

- Use of validated tools (C-SSRS, PHQ-9) for suicide risk assessment.
- Type of screening protocols that identify individuals at risk, including recommended intervals for screening.
- Training for staff in the use of suicide risk assessment and the interpretation of results.
- Standardized guidelines that provide for integrating suicide risk assessments into routine care.
- Criteria for unique circumstances where more frequent than normal suicide screenings are indicated.

Clinical Practice Guideline for Suicide Risk Assessment

This guideline outlines the systematic process for implementing a suicide risk assessment protocol in compliance with current best practices. It includes detailed

instructions on staff education, the use of evidence-based tools (C-SSRS and PHQ-9), and procedures for managing and documenting the data collected.

Staff Education

All nursing staff and practitioners involved in patient care participate in training, facilitated by a mental health professional and a clinical educator.

- Training covers the proper administration, scoring, and interpretation of PHQ-9 and C-SSRS, as well as guidance on clinical decision-making, risk stratification, and documentation.
- Conducted biannually (twice a year) and is mandatory for all nursing staff.
- Held in the clinic's conference room or via virtual learning platforms.
- Training involves interactive presentations, role-playing, and hands-on practice, with materials including user guides, case studies, and sample documentation.
- Attendance and participation are tracked and reviewed by the clinical educator, with competency assessments conducted post-training to ensure understanding.

Implementation of Suicide Screening Tools

Step 1: Administer PHQ-9

- Administered by trained nursing staff during patient intake or follow-up visits.
- The PHQ-9 (Patient Health Questionnaire-9) is a nine-question tool that screens for depressive symptoms over the past two weeks.

- Focuses on Question 9: “Thoughts that you would be better off dead or of hurting yourself in some way?” This helps determine if further suicide risk assessment is needed.
- Conducted during initial visits and at follow-up visits as clinically indicated.
- Administered in a private consultation room to ensure confidentiality.
- To complete the PHQ-9, provide the patient with a paper or digital form, or read the questions aloud. The patient selects one of four response options (0–3) for each question:
 - 0 = Not at all
 - 1 = Several days
 - 2 = More than half the days
 - 3 = Nearly every day

Once completed, the practitioner reviews the total score (0-27), specifically reviews Question 9 for suicidal ideation, and documents responses in the Electronic Medical Record (EMR).

- Actions based on PHQ-9 results:
 - If the patient answers “Yes” to Question 9 (any score 1-3), proceed immediately to Step 2 (C-SSRS Assessment).
 - If the total PHQ-9 score is 10 or above (Moderate to Severe Depression), consider mental health referral even if Question 9 is negative.
 - If the total PHQ-9 score is 5-9 (Mild Depression), educate on coping strategies and schedule follow-up screening.

Step 2: Administer C-SSRS

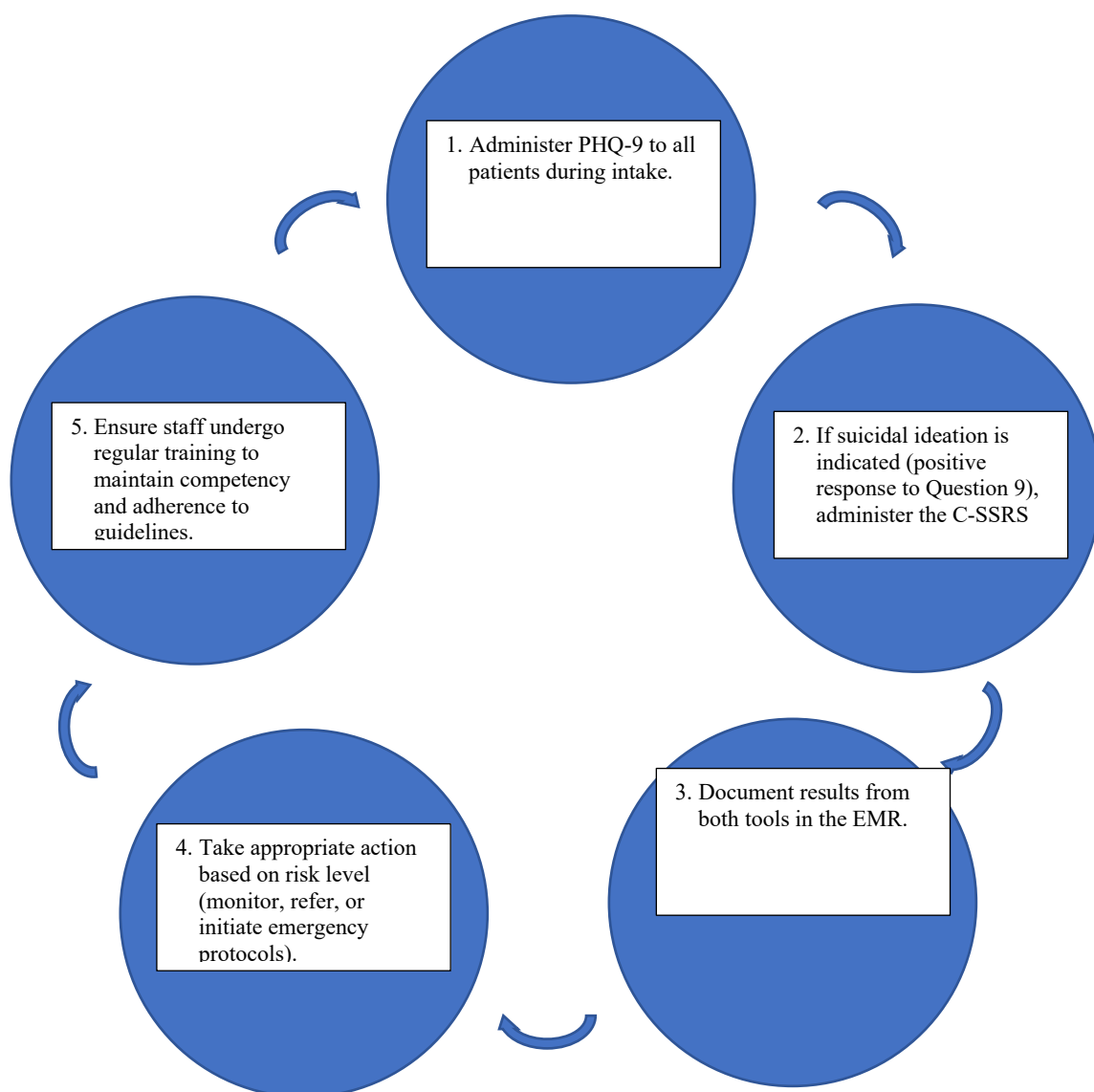
- Conducted by trained nursing staff or a mental health professional.
- The C-SSRS (Columbia-Suicide Severity Rating Scale) assesses:
 - Suicidal Ideation (thoughts about suicide)
 - Suicidal Behavior (past attempts or preparatory actions)
- Administered immediately after a positive response to PHQ-9 Question 9.
- Conducted in a quiet, private setting to ensure patient comfort and confidentiality.
- To complete the C-SSRS:
 - Ask the patient the first five questions regarding suicidal ideation:
 - Have you wished you were dead?
 - Have you had thoughts about killing yourself?
 - Have you had thoughts about how you might do it?
 - Have you had intent to act on these thoughts?
 - Have you had a specific plan?
 - If the patient answers “Yes” to any ideation question, proceed to suicidal behavior questions:
 - Have you ever attempted suicide?
 - Have you started to take action but stopped yourself?
 - Have you done anything to prepare for suicide?
 - Score the severity using the C-SSRS risk stratification guide and document responses in the EMR, including patient statements and clinical observations.
- Actions based on C-SSRS results:

- Mild Risk (Passive Ideation, No Plan or Intent): Provide safety planning, educational materials, and schedule follow-up.
- Moderate Risk (Active Ideation with Plan, No Recent Behavior): Refer to a mental health provider for urgent evaluation.
- Severe Risk (Active Ideation with Intent, Recent Behavior, or Plan):
 - Initiate emergency protocols:
 - Keep the patient under direct supervision.
 - Contact crisis intervention services or emergency responders.
 - Arrange for immediate psychiatric evaluation or hospitalization.

Data Management and Documentation

- Nursing staff and practitioners are responsible for accurate documentation.
- Document PHQ-9 and C-SSRS results, including:
 - Scores and patient responses
 - Observations and clinical impressions
 - Actions taken (e.g., safety planning, referrals, crisis intervention)
- Document immediately after completing the assessments.
- Enter data into the clinic's EMR system for secure storage and easy access.
- Use standardized EMR templates for PHQ-9 and C-SSRS, and clearly document next steps, including:
 - Referrals to mental health services
 - Emergency interventions taken
 - Scheduled follow-ups

Summary of Workflow



By following these detailed guidelines, practitioners can effectively identify, assess, and manage suicide risk, ensuring patient safety and improving clinical outcomes.

Conclusion

The higher ratio of suicide among patients underscores the need for CPGs to improve patient safety. Nursing leadership underscores the need for CPGs to improve

suicide risk identification practices. Additionally, the literature search helped in finding the ten articles. These articles were used to develop the CPGs. Academic databases such as PubMed, Medline, Embase, ProQuest Nursing, and CINAHL were used to find the articles. The AGREE II instrument was used to validate the CPGs. The searched articles supported the CPGs to use evidence-based suicide risk assessment tools such as C-SSRS and PHQ-9 for assessing the risk of suicide in the patients. The key recommendation was the utilization of evidence-based suicide risk assessment tools such as C-SSRS and PHQ-9 during the assessment.