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Psychiatric Nurses' Knowledge of Suicide Prevention

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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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Walden University
2019

Abstract

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MSN, Eastern Kentucky University, 2007

BSN, Eastern Kentucky University, 2002

Project Submitted in Partial Fulfillment

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Doctor of Nursing Practice

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Abstract

Suicide is a major health concern worldwide. Nurse practitioners must possess suicide assessment skills and treatment knowledge to ensure appropriate identification of persons with suicidal ideation. The purpose of this project was to assess psychiatric nurse practitioners' knowledge of suicide prevention in rural Kentucky. The conceptual framework was Orlando's nursing process theory, which emphasizes the importance of nurse–patient interaction. A 13-item survey of suicide-related knowledge and skills was administered to 10 psychiatric nurse practitioners in rural Kentucky. Only 3 participants responded correctly to a question related to suicidality in persons with borderline personality disorder. Regarding competency and support for assessing suicide, 100% of participants reported that they were comfortable asking direct and open-ended questions regarding suicide. Nine of the 10 respondents assessed their knowledge and skills as sufficient to engage effectively with patients contemplating suicide, which indicates that psychiatric nurse practitioners may overestimate their ability to identify and treat persons with suicidal ideation. Healthcare providers in all specialties can benefit from this project by improving competencies and guiding continuing education to bridge any gaps in knowledge for adequately assessing suicide. Further education is needed for psychiatric nurse practitioners to promote positive social change for suicidal persons, their families, and their communities.

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Dedication

I dedicate this paper and project to my family. I have two wonderful sons and three French bulldogs. They have stood by me and supported me all the way. I also want to thank my wonderful coworkers who pushed me along the way. This has been an exceptional challenge and journey in my career.

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Section 1: Nature of the Project

Suicide is increasing every year in the United States (McFaul, Mohatt & Dehay, 2014). There were 11.3 completed suicides per 100,000 individuals in 2007 and 12.6 per 100,000 individuals in 2013 (Healthy People 2020, 2011). Every year, up to one million people complete suicide (Larkin, Blasi, & Arensman 2014). Suicide can be prevented if risk factors such as insomnia, suicide plan, previous attempts, and severe mental illness are identified and intervened effectively (Bryan, Corso, Neal-Walden, & Rudd, 2009). Barriers such as lack of therapeutic communication, stigma, and missed appointments must be overcome to improve risk assessment, promote compliance with treatment, and improve seeking appropriate care (Batterham, Calear, & Christensen, 2014). Suicide rating scales such as the Columbia-Suicide Severity Rating Scale (C-SSRS) have been identified as the standard for identifying suicidal ideation (Giddens, Sheehan, & Sheehan, 2014). Risk factor identification and therapeutic relationships have been found to be effective in decreasing suicide completion. McFaul et al. (2014) suggested strategies such as active treatment of mental illness and/or substance abuse to prevent suicide.

A therapeutic environment promotes trust and encourages communication of emotions during a critical moment to promote safety (Sun, Long, Boore, & Rsao, 2006). Clients who are contemplating suicide may reach out for help from nurse practitioners. More than half of those who had taken their life had made an appointment with a health care provider prior to completing suicide (Bryan et al., 2009). Over 80% of those who committed suicide had been in contact and kept appointments with their primary care provider within a year and over 70% within a month (Liu, Chen, & Huang, 2012). More

than 20% of those who committed suicide had seen a primary care provider within 1 day of suicide completion (Bryan et al., 2009). Less than half of those who committed suicide had been treated in a psychiatric setting in the previous year (Sun et al., 2006). The lack of effective suicide risk assessment could result in an increased chance of loss of hope and lethality.

In 2012, severe mental illness occurred in 1 of 17 persons diagnosed with mental health disorders (Thomas, MacDowell, & Glasser, 2012). A severe mental illness can lead to an altered state of thinking or processing of life events. These clients had impaired functioning and inability to make rational decisions (Thomas et al., 2012). Suicide is a nonrational decision when all hope is lost. More than 90% of clients who commit suicide have a mental health disorder that is diagnosable and treatable (Thomas et al., 2012). Persons at risk for suicide should be identified and treatment should be initiated as soon as possible for optimum effects.

Suicide is major health concern and a leading cause of preventable death all over the world (Cerel et al., 2016). If adequate treatment is provided, most suicidal ideations can be disengaged (Batterham et al., 2013). There are successful treatment options and resources available to promote sustainability of life. Successful treatment plans include psychotherapy sessions coupled with medication management to promote life sustaining interventions (Yip, 2011).

In the United States, 1 out of 64 people is a survivor to someone who has completed suicide (Cerel et al., 2016). Suicide can be detrimental to those left behind who are trying to continue to live in the community. Coping with a traumatic lethal event

of an acquaintance or family member can lead to pervasive psychosocial and psychiatric morbidities (Cerel et al., 2016). Suicide is hard to understand and cope with because many questions go unanswered. Survivors often wonder if something could have been done to prevent the suicidal event or blame themselves. Suicide bereavement is often associated with shame and guilt (Oulanova, Moodley, & Seguin, 2014). Also, death by suicide is perceived as more traumatic than other deaths and results in prolonged grief, depression, and potentially increased risk of others contemplating suicide (Cerel et al., 2016). Survivors can be at risk for suicidal ideations and should be assessed accordingly (Cerel et al., 2016). Exposure to any suicidal event can increase the risk of future suicide attempt (Cerel et al., 2016). High risk factors are significant warning signs in assessing active suicidal ideation.

Problem Statement

Actively suicidal patients are sometimes not appropriately identified in health care settings by psychiatric nurses (Stuber & Quinnett, 2013). Suicide assessment skills and trustworthiness are essential for clients to open up regarding feelings of suicidal ideation (McCarthy et al. 2015). There are mental health interventions as well as assessment skills that can be used to identify active suicidal ideations. The purpose of this project was to assess psychiatric nurses' knowledge of suicide assessment in practice to identify those at risk for lethal self-harm. The project question was: Do psychiatric nurses in this local setting have the knowledge necessary to effectively assess patients for the risk of suicide?

Purpose Statement

The purpose of this project was to assess psychiatric nurses' knowledge of suicide prevention in a rural community. Psychiatric nurses are on the front line treating those with chronic mental illness. Nurses must be responsibile for recognizing suicide risk and providing appropriate treatment referral (Ganzini et al., 2013). This project was conducted to identify psychiatric nurses' knowledge of suicide risk assessment in rural Kentucky. The project involved collection of data through administration of a knowledge questionnaire addressing effective suicide assessment skills. The objective was to identify knowledge gaps among psychiatric nurse practitioners regarding effective assessment of suicidal ideation.

Nature of the Doctoral Project

Suicide risk assessment is often overlooked (Bryan et al., 2009). Many medical and nursing schools limit suicide curriculum to a few lectures, and other training methods are inadequate (McFaul et al., 2014). Suicide screenings are essential for assessing suicidal risk. Suicide cannot be predicted with consistency or reliability; therefore, suicide screenings are recommended to identify those at risk (Bryan et al., 2009). Suicide rating scales can be used to identify those at risk for lethal self-harm (Giddens, Sheehan, & Sheehan, 2014). Talking about suicidal ideation is not easy for most people, and there can be a lack of trust between patients and providers (Ganzini et al., 2013). Psychiatric nurse practitioners should be able to identify those at risk for suicide and intervene with suicide prevention tactics and safety measures (McFaul et al., 2014). Suicide education

and training programs are lacking for all fields of study in health care (Stuber & Quinnett, 2013).

Significance

In 2012, mental health disorders accounted for 25% of premature mortality and disability in Canada and the United States (Thomas et al., 2012). Mental illness can have a range of effects on a person's life resulting in some form of disability(Raab, Mackintosh, Gros, & Morland, 2015). Symptoms such as social withdrawing, decreased energy/productivity, and loss of life enjoyment can impact a person's life negatively (Raab et al, , 2015). Negative effects include ending life violently by suicide or contemplating a suicide plan. Engagement in care for those with chronic mental illness can be challenging (Raab et al, 2015). Many clients with chronic mental illness disengage with psychiatric services and treatment due to lack of trust, lack of insight, and stigma (Smith, Easter, Pollock, Pope, & Wisdom, 2013).

Rural areas have limited mental health resources, and clients may wait for months to see a psychiatrist or psychiatric nurse practitioner for medication management. Due to the limited number of mental health providers in rural areas, outreach teams and primary care providers may be overutilized for treatment of psychiatric disorders (Thomas et al., 2012). Practitioners of all specialties need to be aware of effective suicide assessment skills to provide quality care (McFaul et al., 2014). Assessment of knowledge regarding suicide prevention among nurse practitioners can promote skill interventions in practice delivery (McKnight, 2013). Psychiatric nurses are versed in assessing mental health disorders and suicide risk precursors such as previous attempts and family history.

Evidence-based practice for assessing suicide can include identifiable factors. Identifying long-term and short-term warning signs is an effective strategy to calculate suicide risk (Fowler, 2012). Other critical factors can be measured by suicide rating scales such as the Columbia-Suicide Rating Scale (C-SSRS). The C-SSRS can be used to identify active suicidal ideation, intent, attempt, previous attempt, suicide plan, and means to complete those plans. Giddens et al. (2014) suggested that the C-SSRS is the standard for assessing suicidal ideations. Although there are identifiable risk and suicide rating scales, there is not a single exam or test that can be used to identify suicidal crisis every time without fail (Fowler, 2012).

Implications for Social Change in Practice

Some states such as Utah and Washington have mandated suicide prevention education programs for those providing health care services. In Washington, all mental health providers must include suicide education in the required continuing education credits; other medical professionals were excluded due to opposition (Stuber & Quinnett, 2013). McFaul et al. (2014) showed that effective suicide assessment can predict those at risk. Therapeutic interventions can be implemented to save a life. The development of suicidal risk assessment competencies can result in new innovations from psychiatric nurse practitioners to identify high-risk clients (McKnight, 2013).. Suicide risk assessments should be used to evaluate clients of ages to identify those with suicidal ideation (Bryan et al., 2009). McFaul et al. suggested suicide prevention programs and establishment of suicide risk procedures are effective in reducing completed suicides.

Social change in patient assessments and health care education competencies may make a positive difference and save lives.

Summary

Actively suicidal clients seek help at clinical settings including primary care centers and community mental health centers. Suicide assessment may not be performed by nonpsychiatric providers. Rural areas have limited access to providers and have transportation problems, social stigma, and/or privacy issues. Increased compliance with mental health treatment is necessary, as well as integrating current evidence-based practice for effective suicide risk assessments with a suicide severity rating scale, across a variety of health care settings. Suicide severity risk assessment tools are an effective way to identify those at risk of committing or attempting suicide.

Section 2: Background and Context

Articles and topics were searched through Walden University's library search platform. Nursing and health databases were the focus of the search. Most articles were found on CINAHL, MedLine, and psyARTICLES. Key words such as *suicide*, *suicide prevention*, *suicide interventions*, *suicide rating scales*, and *suicide assessment* were used in article retrieval. These searches aided in finding information that supported education gaps needed for the project.

Literature relevant to suicide and suicide prevention was explored over a 13-year span (2006-2019). Research into current educational standards for suicide assessment indicated a lack of educational programs for nurses. Recent research was limited concerning suicidal educational competencies in the United States. Information regarding suicide prevention from all relevant sources guided the project.

Concepts, Models, and Theories

The conceptual framework that guided the project was Orlando's (1961) nursing process theory. The theory was developed to address the psychodynamics between the nurse and patient, with the nurse responding to the patient's imminent need (Orlando, 1961). The theory is based on qualitative data retrieved from relationships between patients and nurses as well as teaching (Orlando, 1961). The nursing process theory emphasizes the importance of the nurse-patient interaction. This theory is instrumental to assessing patients for suicidal ideation.

The theory includes five major concepts: the professional nursing function, behaviors that present from the client, the nurse's response, the discipline of the nursing

process, and improving outcomes (Marriner-Tomey & Alligood, 2002). The nurse's main goal is to meet the needs of the client. Orlando (1961) reported that verbal and nonverbal behaviors from the client communicate immediate needs. The interactions between the nurse and the client (verbal and nonverbal) guide a response from the nurse to understand and plan for a particular situation (Orlando, 1961). Interactions between the nurse and client include perceptions, feelings, and thoughts (Marriner-Tomey & Alligood, 2002). Therapeutic communication is an essential piece of the theory. The nursing process discipline is described as the clear identification of the problem, which is communicated to the client by the nurse (Orlando, 1961). Improvement is making the situation better. The problem has been identified, a plan has been agreed upon, and the event is moved toward recovery.

Assumptions of the nursing process theory include specific ideas about nursing, patients, nurses, and the nurse-patient situation (Marriner-Tomey & Alligood, 2002). Nursing is distinct from other professions. The nursing role was described by Orlando (1961) as meeting the needs of a client by direct activity or collaborating with others. All clients exhibit verbal and nonverbal communication (Marriner-Tomey & Alligood, 2002). This may present a problem in physically challenged individuals. Many practitioners incorporate the nursing process theory to guide practice (Marriner-Tomey & Alligood, 2002). The theory has been shown to be effective and useful in mental health settings (Marriner-Tomey & Alligood, 2002). The nursing process theory positively correlates the empathy of the nurse and patient outcomes (Marriner-Tomey & Alligood, 2002). The theory validates the nursing discipline by empowering the client (Orlando,

1961). The theory of nursing process has been used to assess the knowledge of psychiatric nurse practitioners related to suicide prevention (Marriner-Tomey & Alligood, 2002). Effective suicide prevention requires therapeutic communication between the client and the nurse practitioner.

Definition of Terms

The following words or phrases have been defined for the purpose of this project:

Insomnia: Unwanted wakefulness and sleeplessness (Onj, 2017). Insomnia is differentiated from other sleep disorders due to problems of falling and staying asleep.

Practitioner: A person who works in the medical profession (Merriam-Webster, 2016). A practitioner is a health care provider in all fields of health. This designation can include therapists, registered nurses, advanced registered nurse practitioners, physicians, and physician assistants.

Rural area: A nonurban area with limited resources and opportunities (Ellehoj, Tepper, Barrett, & Iglesias, 2006). In the current study, rural area referred to the southeastern part of Kentucky that suffers from health care provider shortages.

Severe mental illness/*chronic mental illness*: A mental illness that affects a person's daily life, such as major depressive disorder, obsessive compulsive disorder, schizophrenia, schizoaffective disorder, and/or posttraumatic stress disorder. These who have severe mental illness are impaired in activities of daily living and are socially disabled (Parabiaghi, Bonetto, Ruggeri, Lasalvia, & Leese, 2006).

Suicide: Ending one's own life violently with an intent to do so (Oulanova et al., 2014).

Suicide assessment: The estimation of suicide risk using current ideas of a situation or intent to commit and complete suicide. Previous attempt, state of mind, drug and/or alcohol use, degree of depression, feelings of helplessness/hopelessness, and lack of support can increase the risk for suicide (McGlothlin, Page, & Jager, 2016).

Suicide ideation: Active thoughts of killing oneself with or without a specific plan or intent, directly or passively; predictor of suicidal behavior and self-injurious thoughts (Gillette et al., 2015).

Relevance to Nursing Practice

General Literature

Yip (2011) stated the most clients who completed suicide had no formal mental health treatment. Yip suggested that preventative care before the client contemplates suicide is the best option. Yip concluded that holistic risk assessment, educational programs, and community support will prevent suicide.

Huisman, Pirkis, and Robinson (2010) conducted a literature review of intervention studies in suicide prevention. Rigorous assessments are essential to identifying active suicidal ideation (Huisman et al., 2010). Practice and policy should reflect that suicide prevention risk assessments are necessary for best practices and improved health outcomes (Huisman, et al., 2010).

Mentally ill clients can have discrepancies with psychotropic regimens. Noncompliance with medications is a major concern. Tay (2004) examined 44 clients in a hospital over a 9-month period. The longevity of the study was a strength, but the sample

size was not. Tay concluded that poor compliance with the medication regimen was the leading cause of symptom relapse.

Chesin and Stanley (2013) reported that acute suicide assessments are essential in deciding an appropriate level of care. If the client is actively suicidal with a plan and intent, hospitalization for at least 72 hours is required by law in Kentucky. The 3-day hold does not include any weekend hours. An acute care setting with specific safety protocols may be necessary to keep a client safe and living (Chesin & Stanley, 2013). Follow-up appointments and therapy must be available upon discharge for continuity of care to improve mental health outcomes.

Caine (2013) examined the relationship between economic and social burdens and suicide. As suicides continue to rise each year, the financial costs of those lives lost also rise. The financial burden of suicide was estimated to be $34.6 billion in 2005 (Caine, 2013). The financial burden not only results from the loss of productivity, medical cost, and funeral cost, but also from the loss of productivity and other costs accrued by those who are left behind (Caine, 2013). These findings are significant when planning for state and federal health care budgets. Caine (2013) reported that these numbers would be much higher if suicide prevention programs did not exist.

There are differences between genders in planning for suicidal prevention programs. Males tend to be more successful in attempts, and females respond more positively to suicide prevention programs (Hamilton & Klimes-Dougan, 2015). Suicide rates continue to rise in the young adult population. Suicide prevention programs need to

be designed to increase awareness in high school education (Hamilton & Klimes-Dougan, 2015).

Stuber and Quinnett (2013) supported mandating suicide prevention education programs. These programs would be required for completion by primary care providers. There has been inadequate training in primary care for assessing suicide risk and treatment planning (Stuber & Quinnett, 2013). Stuber and Quinnett identified the gap and made suggestions for mandated training. Most individuals who are suicidal reach out for help. More people can use resources if interventions are more readily available through the Internet (Christensen, Batterham, & O'Dea, 2014). Young adults have an alarming rate of suicide, and programs need to be adapted toward the younger generations. The Internet could be used to offer suicidal screenings, psychological interventions, and therapy (Christensen et al., 2014). No studies have addressed the correlation between online resources and suicide prevention.

Specific Literature

Suicide is a global problem. Sun et al. (2006) looked at environmental factors that influenced the perception of nurses and suicidal patients. Sun et al. found a positive correlation in relation to decreasing suicide with an intervention regarding therapeutic relationship or alliances between a caregiver and the client. Sun et al. found that interventions and ward environment impacted the therapeutic relationship between nurses and suicidal clients.

Liu et al. (2012) examined outpatient utilization in the last year of life before suicide. Liu et al. found that most of those who committed suicide sought health care

within the last year of their life. Findings were significant in identifying a path to implement changes in health care delivery.

Ganzini et al. (2013) argued that trust is the most effective factor in assessing suicidal ideation. Ganzini et al. suggested that health care provider attitudes and behaviors led to a range of honesty from clients who were questioned about suicidality. Ganzini et al. concluded that dishonest answers about suicidal ideation were not seen as therapeutic.

Research has shown a group of successful interventions that reduce the risk of suicide completion. McFaul et al. (2014) described these interventions as a tool kit for primary care practice. The tool kit includes education, collaboration, patient management tools, and other resources (McFaul et al., 2014). These resources are designed to prepare office staff and manage the patients. McFaul et al. (2014) concluded that over 80% of the providers felt that the interventions of the tool kit were useful and increased competencies.

Chen et al. (2010) examined text messaging interventions with clients who attempted suicide. In a qualitative study, Chen et al. examined feedback from participants regarding mobile text messages after being hospitalized for a suicidal attempt. Chen et al. concluded that text messaging is a feasible follow-up method after hospitalization.

Saini, While, Chantler, Windfuhr, and Kapur (2014) examined suicide assessment and management in primary care settings. Saini et al. reported that in primary care settings suicide is only assessed in clients with diagnosed depression. Saini et al. concluded that suicide is hard to predict, there are gaps in consultation between primary

care and psychiatry, and primary care providers poorly assess suicide risk due to limited or no training.

Screening tests for suicide can be unreliable in primary care facilities across all ages (O'Connor, Gaynes, Burda, Soh, & Whitlock, 2013). O'Connor et al. (2013) conducted a systematic review of literature on effective suicide screening tools in primary care settings. O'Connor et al. (2013) included studies of English-speaking patients diagnosed with depression, posttraumatic stress disorder, substance abuse, or borderline personality disorders. Adolescents did not have a positive correlation with suicide rating scales and self-harm (O'Connor et al., 2013). Findings were the opposite in young and older adults. Nonpharmacological interventions such as psychotherapy were shown to reduce the risk of suicide in those populations (O'Connor et al., 2013).

National research has been published regarding suicide. Ten Canadian residents die daily from suicide (Crawford, 2015). Crawford (2015) promoted suicidal prevention policies in practice. Crawford examined the effectiveness of suicide prevention programs in schools and the prevention of multiple repetitive suicide attempts. Suicide occurs in most age groups and is a leading cause of death among young adults. Individualized risk assessments and identification of social factors are found to be significant (Crawford, 2015). Each person copes differently with stress and stressful events. External and hereditary factors can predict the development of coping skills. Suicide prevention programs can reduce completed suicide by half (Crawford, 2015). This reduction in suicide is significant in planning for suicide prevention standards in competencies.

A strong predictor of lethal suicide is insomnia (Pompili et al., 2013). Pompili et al. (2013) explainted that patients were admitted to the emergency room by a psychiatrist with comorbid mental illness. The research concluded that clients who used more violent methods to ensure suicide completion suffer from comorbid insomnia (Pompili et al., 2013). Sleep assessment is essential in suicidal risk assessments.

Larkin et al. (2014) suggested repetitive suicide attempts and self-harm are strong predictors of suicide completion. Larkin examined a large sample size and correlated statistically significant findings. Other factors that appeared to contribute to suicide attempts were drug use, severe mental illness, living alone, and personality disorders (Larkin et al., 2014).

Bryan et al. (2009) examined suicide assessing recommendations for managing suicide in primary care. Bryan et al. concluded that there are many assessable suicide predictors. Some factors were shown to be more lethal than others (Bryan et al., 2009). Past attempts and current thoughts of suicide with a plan are of the highest risk (Bryan et al., 2009).

Local Background and Context

Institutional Context

The purpose of the project was to identify psychiatric nurses' knowledge of suicide prevention and disseminate gaps in knowledge to psychiatric providers from which the data were collected. After the results of the survey were collected and analyzed, the data was examined to develop continuing educational competencies for the providers in order to promote and refresh evidence-based suicide assessment skills.

Educational efforts may continue after local promotion to encompass more broad social change in the state legislation. The information that was obtained may be used to lobby at the legislative level in an attempt to set standards for mandated suicide prevention programs for providers across the state of Kentucky. There are no current standards nor mandated trainings regarding suicide awareness/prevention locally or statewide as of this date, despite the recent legislative agenda. Stakeholders included persons who are at risk for suicide as well as the nurse practitioners and the facilities that employ them. The strategy for this project was to improve standards of care and increase safety precautions for persons contemplating suicide through increased competencies of the nurse practitioners assessing suicidal risk.

Student Context

This student has been practicing in mental health as a nurse practitioner since 2007. My mental health experience has included practice in community mental health centers and private practice. Standards of care should include suicide assessments due to the lack of mental health services, resources, and suicide prevention programs. My efforts have included developing mandated standards of care to implement suicide prevention programs for health care providers in Kentucky. Implementing the project to assess suicide prevention knowledge of psychiatric nurses revealed a need for further projects to bridge the gap in knowledge and improve suicide assessment skill competencies.

Role of the DNP Student

The role as a DNP student was to excel to the highest level of leadership and scientific analysis (American Association of Colleges of Nursing [AACN], 2006). This

project encouraged me to step forward, identify a clinical practice problem, and attempt a solution through implementing evidence- based practices. Doctorally-prepared nurses change practice to influence better patient outcomes. The purpose of this project was to identify knowledge deficits of psychiatric nurse practitioners in assessing suicide.

Summary

There are many interventions and treatments that can prevent suicide. The literature suggested that persons contemplating suicide make medical appointments and practitioners merely need ask the appropriate questions to identify suicidal ideation. Health care providers need to be empathetic in order to build a therapeutic relationship between the practitioner and the client. Simple actions such as sending a text message or calling someone who has missed an appointment has been shown to help people in crisis. Red flags such as previous suicide attempts, past self-injurious behaviors, family history of suicide, medication noncompliance, and insomnia can be precursors to a successful suicide attempt. Implementing suicide awareness programs for those attending school, as well as all health care providers, can increase competencies and save lives.

Section 3: Collection and Analysis of Evidence

The purpose of the project was to increase competence and compliance with evidence-based suicide prevention assessments across all health care settings. Objectives included assessing obstacles such as lack of assessment, poor communications, and nontherapeutic relationships. Objectives also included current knowledge regarding effective suicide assessment skills and implementation into practice. Activities such as mandated continuing education may increase competencies and compliance in assessing suicide effectively.

Practice-Focused Question

The project was conducted to assess psychiatric nurses' knowledge of suicide assessment in practice to identify those at risk for lethal self-harm. The project question was the following: Do psychiatric nurses in this local setting have the knowledge necessary to effectively assess patients for the risk of suicide?

Sources of Evidence

There is an increased awareness of gaps between theory and nursing practice (Rahnavard, Nodeh, & Hosseini, 2013). Professionals are not implementing evidence-based research into practice (Stuber & Quinnett, 2013). The clinical teaching associate model is an effective way to educate small groups with direction and supervision (Rahnavard et al., 2013). This project included research-driven suicide risk assessment protocols to drive educational competencies. A questionnaire was administered to psychiatric nurse practitioners in a rural area in Kentucky to identify gaps in assessing persons contemplating suicide. Specific risks and warning signs were examined among

the practitioners to facilitate identification of suicidality and effective and efficient mental health treatment. Project outcomes included increased awareness, increased collaboration between health care providers, and improved assurance that practitioners are providing evidence-based mental health care.

Descriptive studies are an effective way to determine an outcome based on education planning purposes (Friis & Sellers, 2014). A descriptive study is conducted to compare ideas that have been successfully implemented to assess suicide risk and to develop therapeutic relationships to open channels of communication. A cohort can be described as a population or group that is followed for a specific period of time (Friis & Sellers, 2014). Education can be used to improve assessment skills and practices in health care settings (Stuber and Quinnett, 2013). Clinical providers may be able to use the findings from this research to implement standardized interventions.

All health care clinics have been identified as essential settings to implement effective suicidality assessment interventions (Bryan et al., 2009). Clients who are contemplating suicide are coming to all types of health care providers for help. The social change leading to effective suicide prevention includes building relationships between psychiatric providers and other health care professionals for collaboration, education, implementation of patient education, and assessment of skills (McFaul et al., 2014). Integration of services should pave the way to a holistic approach to medicine and to improving access to mental health care.

Population and Sampling

The project population consisted of a convenience sample of 10 rural Kentucky mental health nurse practitioners. The questionnaire was delivered via e-mail to 22 local practitioners. The psychiatric nurse practitioners who agreed to participate completed the survey. Ten of those practitioners responded, and consent was implied with participation. The institutional review board of Walden University granted approval to complete the research (Approval #12-31-2018-05100).

Data Collection

Questionnaire data were analyzed to identify risk factors and interventions for those who are contemplating suicide. An assessment of suicide-related knowledge and skills survey developed by Smith, Silva, Covington, and Joiner (2013) was administered. The questionnaire was a 13-item survey assessing knowledge regarding suicidal behaviors and comfort of practitioners with the suicidal client (Smith et al., 2013). The survey took 10 to 15 minutes to complete. The survey has been shown to differentiate between those with suicide training and those without (Smith et al., 2013). The survey was administered by e-mail and data were analyzed to identify gaps in suicide assessment knowledge.

Data Analysis

Survey data were analyzed using descriptive statistics such as percentages and central tendencies. Questionnaires were administered and answers were analyzed to identify knowledge gaps in assessing suicide.

Outcome Evaluation

The evaluation plan included assessment of project objectives. The first step in developing an evaluation is to engage the stakeholders (Hodges & Videto, 2011). The purpose of this project was to assess knowledge of psychiatric nurses in assessing suicide. An effective project must meet the needs of the stakeholders. This project was conducted to identify knowledge gaps based on current evidence-based practice. Findings of this project will be shared with the psychiatric nurse practitioners and lawmakers to advocate for mandatory suicide assessment training for all health care providers. Publication, poster creation, and presentations were considered for dissemination of project results.

Summary

Many suicidal clients make appointments with health care providers hours to days before completing suicide. Continuing education programs are essential to improve competencies among nurse practitioners to assess suicide risk. Implementing evidence-based practice is the best way to change health outcomes. Monitoring suicide statistics in the area of concern is a place to start for evaluating improvement of care.

Section 4: Findings and Recommendations

The purpose of this project was to assess psychiatric nurse practitioners' knowledge regarding suicide prevention. A 13-item questionnaire of suicide-related knowledge and skills was sent to 22 local psychiatric nurse practitioners in a rural area in Kentucky.

Findings and Implications

The 10 participants showed mixed knowledge starting with the first question. The survey items were statements or questions, and participants answered on a 5-point scale (completely disagree, disagree, don't know, agree, or completely agree). The first item stated, "Few people want to kill themselves"; 40% of the practitioners answered incorrectly. The item should have been answered with completely disagree or disagree. Yearly, around one million people complete suicide (Larkin et al., 2014). Item 2 stated, "Youth ages 10-24 have a significantly greater risk of suicide than individuals aged 65 or older"; 50% of the practitioners answered incorrectly. Older adults are at higher risk for suicide attempts (Orden & Conwell, 2011). Elders are more at risk for suicide due to social disconnectedness, physical illness/pain, functional impairment, and cognitive/neurobiological processes (Orden & Conwell, 2011). Item 3 stated, "The rate of suicide among those with severe mental illness is six times the general population"; only 10% of the practitioners answered incorrectly. Zaheer et al. (2018) found that 11.3% of suicides are completed by those with schizophrenia. This finding does not include other mental illnesses that also increase risk, such as major depressive disorder or posttraumatic stress disorder. Item 4 stated, "If a person is serious about suicide, there is

little that can be done to prevent it"; 10% of the practitioners answered incorrectly. Suicide is preventable (Cerel et al., 2016). Item 5 stated, "If you talk to a client about suicide, you may inadvertently give them permission to seriously consider it"; 100% of the practitioners answered correctly. To effectively assess for suicidal ideation, the practitioner has to ask about thoughts of harming self. Previous attempts and current thoughts are predictors of the highest suicidal risk (Bryan et al., 2009). Item 6 stated, "Depression indicates a suicide risk"; 10% of the practitioners answered incorrectly. Around 90% of those who complete suicide have a chronic mental illness, such as depression (Thomas et al., 2012). Item 7 stated, "Suicide is always unpredictable"; 100% of the practitioners answered this question correctly. Stuber and Quinnett (2013) found that suicide assessments can adequately predict those at risk for suicide. Item 8 stated, "Suicidal people want to die"; 30% of the practitioners answered incorrectly. Suicidality is a symptom that is not wanted by the client, and these thoughts should be eradicated (Peterson & Collings, 2015). Item 9 stated, "Individuals with borderline personality disorder frequently discuss or gesture suicide but do not really intend to kill themselves: instead they intend to provoke or manipulate others"; 70% of practitioners answered incorrectly. Plans et al. (2019) found a direct correlation between increased completion of suicide and bipolar disorder.

Items 10-13 were questions regarding competency and support available in assessing suicide. Most (90%) participants reported their training was sufficient to engage with and assist persons contemplating suicide. Also, 90% reported their skills were sufficient to engage those with suicidal desire and/or intent. Only 10% reported that there

was sufficient support to engage with and assist those with suicidal ideation or intent. Lastly, 100% of participants reported that they were comfortable asking direct and open-ended questions regarding suicide. Table 1 includes the 13 items on the questionnaire with corresponding response data.

Table 1

Suicide Knowledge and Skills Questionnaire Reponses

Question	Completely disagree	Disagree	Don't know	Agree	Completely agree
Few people want to kill themselves	1	5	0	3	1
Youth ages 10-24 have a significantly greater risk of suicide individuals aged 65 and older	0	5	2	2	1
The rate of suicide among those with severe mental illness is 6 times the general population	0	0	1	5	4
If a person is serious about suicide, there is little that can be done to prevent it	4	5	0	1	0
If you talk to a client about suicide, you may inadvertently give them permission to seriously consider it	8	2	0	0	0
Depression indicates a suicide risk	0	1	0	7	2
Suicide is always unpredictable	3	7	0	0	0
Suicidal People want to die	1	6	1	2	0
Individuals with borderline personality disorder frequently discuss suicide but do not really intend to kill themselves; instead they intend to provoke or manipulate others	1	2	1	5	1
I have received the training I need to engage and assist those with suicidal desire and/or intent	0	1	0	6	3
I have the skills I need to engage those with a suicidal desire and/or intent	0	0	1	6	3
I have the support I need to engage and assist those with suicidal desire and/or intent	0	1	0	8	1
I am comfortable asking direct and open questions about suicide	0	0	0	4	6

Implications for practice show that there is a knowledge gap regarding suicide assessment. Evidence-based practice research has provided many ways to assess suicide adequately and effectively to prevent death. Practitioners should participate in competency programs to increase awareness to promote suicide assessment skills. Implications also include mandated suicide prevention education, as some states have done. Establishment of suicide risk procedures/competencies is effective in identifying those as risk and reducing completed suicides (McFaul et al., 2014).

Recommendations

The findings indicated a gap in suicide assessment knowledge among psychiatric nurse practitioners. Recommendations included dissemination of the literature review and results of the study. Suicide assessment competencies are essential to identify persons at risk for self-harm and suicide.

Strengths and Limitations of the Project

This project had limitations. First, data were from a small sample of participants in a rural area of Kentucky. Generalizing findings to all psychiatric nurses in this geographical area may not be possible. The projecct should be repeated across geographical locations in a variety of patient treatment settings such as hospitals and crisis stabilization units. Crisis stabilization units are in-patient facilities that are much smaller than hospitals, and admission criteria are broader. If the study were repeated in various geographical locations, generalizability would improve. The project was also limited to psychiatric nurse practitioners. The project would have benefited from data collection in more geographic areas and among other types of practitioners and settings.

Also, the sample size was low (10) due to the lack of nurse providers in the study site area. I assumed that the psychiatric nurse practitioners would answer the survey questions honestly. Strengths of the project included identification of a practice problem and exploration of competencies within a specialty field.

Section 5: Dissemination Plan

The results of this project will be disseminated at local and national conferences. Questionnaire results were shared with the practitioners who completed the survey.

Analysis of Self

This doctoral project has been a rigorous journey in my professional and educational career. The research has increased my awareness, fine-tuned my assessment skills, and improved my practice. Continuing education improves the quality of health care and improves overall health outcomes (Palacio & Carlos, 2014). This project increased my knowledge and ability to translate evidence to practice competencies. These competencies include disseminating research findings, conducting further research, mentoring others to identify clinical practice problems, and creating solutions. This project provided me with advanced education in research and evidence-based practice.

Summary

Suicide is increasing every year. Many suicidal patients are not being adequately assessed to prevent self-harm. Patients with suicidal ideation are coming to clinics and hospitals to get help. Many practitioners, including psychiatric nurse practitioners, are not adequately trained to identify those at risk for suicide. This project demonstrated that there is a knowledge deficit among psychiatric nurse practitioners related to suicide knowledge. Suicide prevention programs have been shown to be effective in increasing competencies and awareness training. Nurse practitioners need to be aware of warning signs to promote evidence-based practice that saves lives. Suicide assessment and

prevention programs should be required for all nurse practitioners in all settings to decrease suicide rates.

References

American Association of Colleges of Nursing. (2006). The essentials of doctoral education for advanced nursing practice. https://www.aacnnursing.org/DNP/DNP-Essentials

Batterham, P. J., Calear, A. L., & Christensen, H. (2013). Correlates of suicide stigma and suicide literacy in the community. *Suicide and Life-Threatening Behavior, 43*(4), 406-417. doi.org/10.1111/sltb.12026

Bolster, C., Holliday, C., Oneal, G., & Shaw, M. (2015). Suicide assessment and nurses: What does the evidence show? *Online Journal of Issues in Nursing, 20*(1), doi:10.3912/OJIN.Vol20No01Man02

Bryan, C. J., Corso, K. A., Neal-Walden, T. A., & Rudd, M. D. (2009). Managing suicide risk in primary care: Practice recommendations for behavioral health consultants. *American Psychological Association, 40*(2), 148-155. doi:10.1037/a0011141

Caine, E. D. (2013). Forging an agenda for suicide prevention in the United States. *American Journal of Public Health,* E1-E8. doi:10.2105/AJPH.2012.301078

Cerel, J., Maple, M., Venne, J., Moore, M., Flaherty, C., & Brown, M. (2016). Exposure to suicide in the community: Prevalence and correlates in one U.S. state. *Public Health Reports, 131,* 100-131. doi.org/10.1177/003335491613100116

Chen, H., Mishara, B., & Liu, X. (2010). A pilot study of mobile telephone message interventions with suicide attempters in China. *Crisis, 31*(2), 109-112.

Chesin, M., & Stanley, B. (2013). Ricks assessment and psychosocial interventions for suicidal patients. *Bipolar,* 15, 589-593. doi:10.1111/bdi.12092

Christensen, H., Batterham, P., & O'Dea, B. (2014). E-health interventions for suicide prevention. *International Journal of Environmental Research and Public Health, 11*, 8193-8212. doi:10.3390/ijerph110808193

Crawford, A. (2015). A national suicide prevention strategy for Canadians: From research to policy and practice. *Canadian Journal of Psychiatry, 60*(6), 239-241. doi:10.1177/070674371506000601

Ellehoj, E., Tepper, J., Barrett, B., & Iglesias, S. (2006). Research methodology for the investigation of rural surgical services. *Canadian Journal of Rural Medicine, 11*(3), 187-194. Retrieved from https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=edsovi&AN=edsovi.00024794.200611030.00007&site=eds-live&scope=site

Fowler, J. C. (2012). Suicide risk assessment in clinical practice: Pragmatic guidelines for imperfect assessments. *American Psychological Association, 49*(1), 81-90. doi:10.1037/a0026148.

Friis, R. H., & Sellers, T. A. (2014). *Epidemiology for public health practice* (5th ed.). Sudbury MA: Jones & Bartlett.

Ganzini, L., Denneson, L., Press, N., Bair, M., Helmer, D., Poat, J., & Dobscha, S. (2013). Trust is the basis for effective suicide risk screening and assessment in veterans. *Journal of General Internal Medicine, 28*(9), 1215-21. doi:10.1007/s11606-013-2412-6

Giddens, J. M., Sheenhan, K. H., & Sheenhan, D. V. (2014). The Columbia-suicide severity rating scale (C-SSRS): Has the "gold standard" become a liability?

Clinical Neuroscience, 11(9-10), 66-80. Retrieved from https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=rzh&AN=103863076&site=eds-live&scope=site

Gillette, M., Prinstein, M. J., Abela, J. Z., Gibb, B. E., Barrocas, A. L., & Hankin, B. L. 2015). Trajectories of suicide ideation and nonsuicidal self-injury among adolescents' in mainland China: Peer predictors, joint development, and risk for suicide attempts. *Journal of Consulting and Clinical Psychology, 83*(2), 265-279. doi:10.1037/ac0038652.

Griest, J. H., Mundt, J. C., Gwaltney, C. J., Jefferson, J. W., & Posner, K. (2014). Predictive value of baseline electronic Columbia- suicide severity rating scale (C-SSRS) assessments for identifying risk of prospective reports of suicidal behavior during research participation. *Innovations in Clinical Neuroscience, 11*(9), 23-31. PMCID: PMC4267797

Hamilton, E., & Klimes-Dougan, B. (2015). Gender differences in suicide prevention responses: Implications for adolescents based on an illustrative review of the literature. *Environmental Research and Public Health, 12*, 2359-2372. doi:10.3390/ijerph120302359

Healthy People 2020. (2011). Topics & objectives index. Retrieved from https://www.healthypeople.gov/2020/topics-objectives

Hodges, B. C., & Videto, D. M. (2011). *Assessment and planning in health programs* (2nd ed.). Sudbury, MA: Jones & Bartlett Learning.

Huisman, A., Pirkis, J., & Robinson, J. (2010). Intervention studies in suicide prevention

research. *Crisis, 31*(5), 281-284. doi: 10.1027/0227-5910/a000049

Langille, J. (2014). Suicide prevention and postvention initiatives. *Canadian Nurse, 112*(2), 32-34. Retrieved from https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=rzh&AN=104046071&site=eds-live&scope=site

Larkin, C., Blasi, Z. D., & Arensman, E. (2014). Risk factors for repetition of self-harm: A review of prospective hospital-based studies. *Plos one, 9*(1), 1-13. doi:10.1371/journal.pone.0084282

Leavey, G., Rosato, M., Galway, K., Hughes, L., Mallon, S., & Rondon, J. (2016). Patterns and predictors of help-seeking contacts with health services and general practitioner detection of suicidality prior to suicide: A cohort analysis of suicides occurring over a two-year period. *BMC Psychiatric, 16*. doi:10.1186/s12888-016-0824-7

Liu, H., Chen, L., & Huang, S. (2012). Outpatient health care utilization of suicide decedents in their last year of life. *Suicide and Life-Threatening Behavior, 42*(4), 445-452. doi.org/10.1111/j.1943-278X.2012.00103.x

Marriner-Tomey, A., & Alligood, M. R. (2002). *Nursing theorists and their work*. St.Louis, Mo: Mosby.

McCarthy, J., Bossarte, R., Katz, I., Thompson, C., Kemp, J., Hannemann, C., Nielson, C., & Schoenbaum, M. (2015). Predictive modeling and concentration of the risk of suicide: implications for preventative interventions in the US department of veteran affairs. *American Journal of Public Health, 105*(9), 1935-1942.

doi:10.2105/AJPH.2015.302737

McGlothlin, J., Page, B., & Jager, K. (2016). Validation of the SIMPLE STEPS model of suicide assessment. Journal of Mental Health Counseling, (4). 298. doi:10.17744/mehc.38.4.02.

McKnight, S. (2013). Mental health learning needs assessment: competency-based Instrument for best practice. *Issues in Mental Health Nursing,* 34, 459-471. doi:10.3109/01612840.2012.758205.

McFaul, M., Mohatt, N., & Dehay, T. (2014). Development, evaluation, and refinement of the suicide prevention toolkit for rural primary care practices. *Journal of Rural Mental Health, 38*(2), 116-127. doi: 10.1037/rmh0000020

O'Connor, E., Gaynes, B., Burda, B., Soh, C., & Whitlock, E. (2013). Screening for and treatment of suicide risk relevant to primary care: a systematic review for the U.S. preventative services task force. *Annals of Internal Medicine, 158*(10), 741-766. doi:10.7326/0003-4819-158-10-201305210-00642.

Onj, J.C. (2017). Insomnia: the problem of sleeplessness in, *Mindfulnes*s-*based therapy for insomnia* (pp.11-27). Washington, DC, US: American Psychological Association.

Orlando, I. (1961). *The dynamic nurse-patient relationship.* New York: G.P. Putnam's Sons.

Orden, V. O. & Conwell, Y. (2011). Suicides in late life. *Curr Psychiatry Rep,* June 13(3), doi:10.1007/s11920-011-0193-3.

Oulanova, O., Moodley, R., & Senguin, M. (2014). From suicide survivor to peer

counselor: breaking the silence of suicide bereavement. *Omega 69*(2), 151-168. doi.org/10.2190/OM.69.2.d

Palacio, A., & Carlos, A. (2014). The importance of continuing education. *Revista Colombiana de Psiquiatria, 43*(1), e1. https://doi.org/10.1016/S00347450(1470045-9

Parabiaghi, A., Bonetto, C., Ruggeri, M., Lasalvia, A., & Leese, M. (2006). Severe and persistent mental illness: a useful definition for prioritizing community-based mental health service interventions. *Social Psychiatry and Psychiatric Epidemiology, 41*(6), 457-463. doi:10.1007/s00127-006-0048-0

Peterson, D.H.M. & Dollings, S.C. (2015). "It's either do it or die". The role of self-management of suicidality in people with experience of mental illness. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 36*(3), 173-178. https://doi.org/10.1027/0227-5910/a000308.

Plans, L., Barrot, C., Nieto, E., Rios, J., Schulze, T. G., Papiol, S., Mitjans, M., Vieta. E., & Benabarre, A. (2019). Association between completed suicide and bipolar disorder: a systematic review of the literature. *Journal of Affective Disorders, 242,* 111-122. https://doi.org/10.1016/j.jad.2018.08.054.

Pompili, M., Innamorati, M., Forte, A., Longo, L., Mazzette, C., Erbuto, D., Ricci, F., Palermo, M., Stefani, H., Seretti, M., Lamis, D., Perna, G., Serafini, G., Amore, M., Girardi, P. (2013). Insomnia as a predictor of high-lethality suicide attempts. *International Journal of Clinical Practice, 67(12), 1311-1316.* doi:10.1111/ijcp.12211.

Practitioner. (n.d.) In *Merriam-Webster's collegiate dictionary*. Retrieved from http://www.merriam-webster.com/dictionary/practitioner.

Raab, P., Mackintosh, M., Gros, D., & Morland, L. (2015). Impact of comorbid depression on quality of life in male combat veterans with posttraumatic stress disorder. *Journal of Rehabilitation Research & Development, 52*(5), 563-576. doi:10.1682/JRRD.2014.05.0130

- Rahnavard, Z., Nodeh, Z.H., & Hosseine, L. (2013). Effectiveness of clinical teaching Associate model in nursing education: results from a developing country. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 45*(2), 174-181. https://doi.org/10.5172/conu.2013.45.2.174

Saini, P., While, D., Chantler, K., Windfuhr, K., & Kapur, N. (2014). Assessment and management of suicide risk in primary care. *Crisis, 35*(6), 415-425. doi:10.1027/0227-5910/a000277

Smith, A. R., Silva, C., Covington, D. W., & Joiner, T. E. (2014). An assessment of Suicide related knowledge and skills among health professionals. *Health Psychology: Official Journal Of The Division Of Health Psychology, American Psychological Association*, *33*(2), 110-119. doi:10.1037/a0031062

Smith, T., Easter, A., Pollock, M., Pope, L., Wisdom, J. (2013). Disengagement from care: perspectives of individuals with serious mental illness and of service providers. *Psychiatric Services, 64*(8), 770-775. https://doi.org/10.1176/appi.ps.201200394

Stuber, J., & Quinnett, P. (2013). Making the case for primary care and mandated suicide

prevention education. *Suicide and Life-Threatening Behavior, 43*(2), 117-124. doi:10.1111/sltb.12010

Sun, F., Long, A., Boore, J., & Tsao, L. (2006). Patients and nurses' perceptions of ward environmental factors and support systems in the care of suicidal patients. *Journal of Clinical Nursing, 15*(1), 83-92. https://doi.org/10.1111/j.1365-2702.2005.01232.x

Tay, C. (2007). Patients' gaining knowledge does not necessarily lead to a change in their attitudes or to improve clinical and adherence outcomes. *Journal of Psychological Nursing, 45*(6), 30-37. doi:10.1007/s11096-015-0086-3

Thomas, D., MacDowell, M., & Glasser, M. (2012). Rural mental health work force needs assessment-a national survey. *Rural and Remote Health,* 1-12.

Varia, S., Ebin, J., & Stout, E. (2014). Suicide prevention in rural communities: perspectives from a community of practice. *American Psychological Association, 38*(2), 109-115. http://dx.doi.org/10.1037/rmh0000019

Winter, D., Bradshaw, S., Bunn, F., & Wellsted, D. (2012). A systematic review of the literature on counselling and psychotherapy for the prevention of suicide: 2 qualitative studies. *British Association for Counselling and Psychotherapy, 14*(1), 64-79. https://doi.org/10.1080/14733145.2012.737004

Yip, P. (2011). Towards evidence-based suicide prevention programs. *Crisis, 32*(3), 117-120. DOI: 10.1027/0227-5910/a000100

Zaheer, J., Jacob, B., Oliveira, C., Rudoler, D., Juda, A., & Kurdyak, P. (2018). Service utilization and suicide among people with schizophrenia spectrum disorders,

Schizophrenia Research, December 2018, 347-353.

https://doi.org/10.1016/j.schres.2018.06.025

Appendix: Suicide Knowledge and Skills Questionnaire

(Smith, Silva, Covington, & Joiner, 2013)

Please rate your agreement with the following statements using this scale:

Completely Disagree = 1 Disagree = 2 Don't know = 3 Agree = 4
Completely Agree = 5

1. Few people want to kill themselves.
2. Youth ages 10-24 have a significantly greater risk of suicide than individuals aged 65 and older.
3. The rate of suicide among those with severe mental illness is 6 times the general population.
4. If a person is serious about suicide, there is little that can be done to prevent it.
5. If you talk to a client about suicide, you may inadvertently give them permission to seriously consider it.
6. Depression indicates a suicide risk.
7. Suicide is always unpredictable.
8. Suicidal people want to die.
9. Individuals with Borderline Personality Disorder frequently discuss or gesture suicide but do not really intend to kill themselves; instead they intend to provoke or manipulate others.

Suicide Skills

1. I have received the TRAINING I need to engage and assist those with suicidal desire and/or intent.
2. I have the SKILLS I need to engage those with suicidal desire and/or intent.
3. I have the SUPPORT/SUPERVISION I need to engage and assist those with suicidal desire and/or intent.
4. I am comfortable asking direct and open questions about suicide.