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Effects of Training on Suicide Assessment and Intervention

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PROCESS DESCRIPTION

The rate of suicide is increasing in America. Suicide is now the 10th leading cause of death, claiming more lives than traffic accidents and occurring twice as frequently as homicides (The Joint Commission, 2016). In 2014, there were 41,149 deaths by suicide (CDC, 2015). This number is equal to 113 suicides each day, or one suicide every thirteen minutes. Healthcare professionals are instrumental in suicide prevention; In fact, approximately one third of people who commit suicide have had contact with mental health services within a year of their death, and 20% have had contact with mental health services within a month prior to their death (Luoma, Martin, & Pearson, 2002).

There have been continual national efforts to increase competencies in suicide prevention for behavioral healthcare workers. Suicide is believed to be mostly preventable if the person at risk is properly screened and assessed and mental health professionals intervene promptly and appropriately (Punttil, Limandri, Greene, Arauz, & Hobbs, 2013). In 2012, suicide was the fourth most frequent sentinel event. When analyzing the root cause, the Joint Commission found that assessment and communication were the top two factors contributing to suicides (The Joint Commission, 2013). In fact, the efforts to increase competencies in suicide prevention is goal seven of the 2012 National Action Alliance Care Critical Intervention Task Force. One aspect of this goal is to provide training to community and clinical service providers on the prevention of suicide and related behaviors (Schmitz et al., 2012). Within this goal are several objectives to increase the education and training for healthcare providers related to suicide assessment.

In 2013, the American Psychiatric Nurses Association published a position statement regarding competency-based training for psychiatric mental health nurse generalists and in-patient intervention for the prevention of suicide. The APNA acknowledged that there are serious gaps in nursing education, specifically in the area of suicide risk assessment, prevention, and intervention (APNA, 2013). The statement identifies nurses as the largest professional workforce in in-patient psychiatric units with 24-hour accountability for the care and safety of patients, yet this group has limited training in assessing patients at risk for suicide. Shortly before this statement was

published, the American Association of Suicidology published a policy paper directed towards reviewing literature regarding the prevalence of training in suicide risk assessment and management (AAS, 2013). The paper addressed the need for more training for psychiatrists, social workers, psychologists, and counselors, but failed to mention training for nurses. With this information, the APNA established a task force to develop suicide prevention competencies for registered nurses, as no standard competencies for nurse assessment and management of suicidal patients had ever been established. In 2015, the APNA published the Psychiatric-Mental Health Nurse Essential Competencies for Assessment and Management of Individuals at Risk for Suicide. Below are the 9 essential competencies stated by the APNA:

1. The psychiatric nurse understands the phenomenon of suicide.
2. The psychiatric nurse manages personal reactions, attitudes, and beliefs.
3. The psychiatric nurse develops and maintains a collaborative, therapeutic relationship with the patient.
4. The psychiatric nurse collects accurate assessment information and communicates the risk to the treatment team and appropriate persons (i.e. nursing supervisor, on duty M.D, etc.)
5. The psychiatric nurse formulates a risk assessment.
6. The psychiatric nurse develops an ongoing nursing plan of care based on continuous assessment.
7. The psychiatric nurse performs an ongoing assessment of the environment in determining the level of the safety and modifies the environment accordingly.
8. The psychiatric nurse understands legal and ethical issues related to suicide.
9. The psychiatric nurse accurately and thoroughly documents suicide risk. (APNA, 2015).

THEORETICAL FRAMEWORK

The theoretical framework used to address the topic of education on suicide assessment and intervention is Orlando's Nursing Process Discipline Theory. For three years, Ida Orlando observed and recorded the interactions between nurses and patients. These

interactions were placed into two categories: “good” and “bad” nursing. She found that when good nursing occurred, the nurse listened to the patient and identified the patient’s distress. The nurse also focused on the verbal and nonverbal communication and behavior throughout the entire interaction. In these interactions, the nurses identified the patient’s distresses and recognized that the patient needed the nurse’s help to relieve the distress. On the other hand, Orlando found that when bad nursing occurred, the nurse focused only on prescribed activities, not the patient’s behavior. From this information, Orlando produced a theory that the function of the professional nurse is to find out and meet the patient’s immediate need for help (May, 2013) Furthermore, Orlando’s theory states, “the presenting behavior of the patient, regardless of the form in which it appears, might be a plea for help“ (May, 2013, p. 288), although this need for help may not be what it appears. The theory explains that nurses have immediate reactions, both cognitive and emotional, to patients’ presenting behaviors, and act on these reactions. It is important for nurses to explore these initial reactions to understand the nature of the patient’s behavior. This is an ongoing process.

When interacting with possibly suicidal patients, nurses may deal with psychosocial factors that influence their own emotions, attitudes, and beliefs related to the patient. Evidence suggests that one factor that can negatively influence care towards a suicidal patient is poor attitudes of nurses (Valente, 2011). For some nurses, interacting with a suicidal patient may be uncomfortable because they simply do not know what to say and therefore remain silent. For other nurses, suicide may raise strong internal emotions that can lead to difficulty with the assessments of these patients (Valente, 2011). Beliefs and attitudes of nurses towards suicide, identified by Orlando as impacting a nurse’s relationship with a patient and the care provided, should therefore be addressed in educational programs. Training programs directed at suicide assessment and intervention can result in an increased comfort level and willingness to interact with suicidal patients. As Orlando addressed in her theory, the function of the nurse is to meet the patient’s immediate need for help. The urgency and importance in meeting this need for help is no greater than in a patient who is possibly suicidal. In these patients, death may be imminent without proper assessment and intervention.

EVIDENCE

Evidence suggests that suicide specific training programs have a positive impact on healthcare professionals. One study used participants from two large West Coast VA healthcare systems within multiple disciplines, 17% being nurses, to study the impact of a 6.5-hour training course (Huh et al., 2012). The goal of the course was to alter the awareness and attitudes of participants about suicide in older adults; its efficacy was assessed at three different points: pre-training, immediately post-training, and three months after the training. The results of the study indicate that confidence and knowledge related to suicide assessments increased significantly. At the three-month follow-up, 90% of respondents still agreed that the workshop increased their awareness of suicide risk and management in older adults and indicated continued interest in learning more about the topic (Huh et al., 2012). 84% of participants agreed that the workshop improved their ability to conduct a suicide risk assessment in older adults, and 43% of participants reported incorporating items, knowledge, and ideas learned from the workshop into their professional environments (Huh et al., 2012).

The term “gatekeeper” is used to refer to persons who regularly interact with potentially suicidal individuals and are available to recognize important behavioral cues (Tsai, Lin, Chang, Yu, & Chou, 2011). Nurses on a behavioral health unit serve as gatekeepers, as they directly interact with each patient on the unit multiple times within each shift. The Gatekeeper Suicide-Awareness Program (GSAP) for nursing personnel was the focus of Tsai et al.’s (2011) study. The study evaluated the effectiveness of GSAP, a 90-minute program, consisting of a 70-minute presentation and a 20-minute discussion. 195 nurses in Taiwan participated in this randomized controlled trial (Tsai, Lin, Chang, Yu, & Chou, 2011). The control group attended a regularly scheduled monthly continuing education class, while the experimental group participated in the 90-minute GSAP. The presentation links major depressive disorder to suicide and discusses the dangers of misguided and hostile attitudes of nurses towards suicidal patients, addressing this as a key barrier to providing adequate care. Both groups completed pre-

and post-training questionnaires, the “Awareness of Suicide Warning Signs Questionnaire”. While there were no statistically significant differences between the groups’ pre-test scores, the post-test scores showed statistically significant differences between groups. The experimental group also showed statistically significant differences between pre- and post-test scores. The study also showed an increased willingness to refer patients for counseling in the experimental group post-test in comparison to the control group. Overall, this study demonstrates that the GSAP has a positive effect on preparing nurses to be gatekeepers.

Another training program, the Recognizing and Responding to Suicide Risk (RRSR) program, is an intensive, two-day, skill-based training program offered by the American Association of Suicidology. The program uses guided case application to help participants learn how to translate knowledge into practice. The program also requires completion of an online learning module and successful completion of a test prior to participating in the program. The RRSR program was evaluated in a different study by Jacobsen, Osteen, Jones, & Berman (2012). Within this study, data was collected, using case vignettes and surveys, before training, after training, and four months later. The specific areas being investigated were attitudes towards suicide and suicide prevention, confidence in working with people at risk of suicide, suicide risk assessment skills, and immediate risk management skills (Jacobson, Osteen, Jones, & Berman, 2012). The results of the study indicate that the RRSR training program had a positive effect on each of the areas stated above. The use of vignettes, furthermore, provided evidence that participants showed changes in more realistic practice skills, rather than just knowledge.

CONCLUSION

Suicide continues to be a leading cause of death in America. Increasing competencies in suicide prevention should be a focused area of improvement. The obvious answer to the APNA’s acknowledgement of serious gaps in education regarding suicide risk assessment, prevention, and intervention is to increase education and training for nurses in these areas. Evidence validates that training not only increases nurses’ competency and confidence in suicide assessment skills but also alters the attitudes and beliefs of nurses’

regarding suicide in a positive way. Evidence also suggests that nurses on all units that interact with suicidal patients can benefit from suicide specific training programs. Like Orlando's theory states, the professional nurse's job is to find out and meet the patient's immediate need for help (May, 2002). With suicidal patients, this need is imminent. Increased suicide assessment training that improves nurses' abilities to assess, intervene, and acknowledge personal attitudes and beliefs towards suicide can save lives.

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