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Expanding Suicidality Triage to Primary Care Nurses: Improving Confidence and Knowledge

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Abstract

Suicide is a growing public health crisis and there is an increasing need for skilled medical professionals educated to triage patients experiencing suicidality. Most of the training available for triage and resource utilization is offered to professionals already working in a behavioral health discipline. Given the increasing prevalence of suicide and depression, individuals experiencing mental health crises face reduced access to specialized care, complicated referral processes, and exceedingly long waitlists. In response, they are seen with increasing frequency in primary care settings where nurses are not as prepared to manage their needs appropriately. The aim of this project was to determine if a training improved nurse knowledge and confidence related to suicide triage. Results showed the intervention did improve knowledge and confidence of primary care nurses in triaging patients experiencing suicidal ideation, thus increasing the likelihood patients will receive triage and resources.

Keywords: Suicide triage, primary care, nurse training, PHQ-9, C-SSRS, depression, nurse confidence, non-psychiatric suicide intervention.

Expanding Suicidality Triage to Primary Care Nurses

Suicide is a preventable public health crisis that has reached epidemic scale in the United States and exceeds homicide by a three to two ratio (Bolster et al., 2015). For each person who completes suicide, it is estimated that 25 more individuals attempt suicide (Frost et al., 2020). Due to increased rates of suicide in recent years, behavioral health units are often at maximum capacity and thus, patients are being seen more frequently on medical units, in primary care clinics, and community settings (Frost et al., 2020). According to 2017 mortality records from Centers for Disease Control and Prevention (CDC), more than 50% of completed suicides were individuals not previously diagnosed with a psychiatric disorder, supporting the idea that suicide assessment and intervention should not be limited to behavioral health settings (Harmer et al., 2020). Additionally, complex and lengthy processes requiring referrals and transfer of care from primary care providers to psychiatrists or therapists often delay necessary treatment (Harmer et al., 2020). While there are 24-hour crisis lines and other outreach options available to those experiencing thoughts of self-harm, most people who die by suicide were seen by a healthcare provider within one month of the completed suicide, which suggests there is opportunity to increase intervention related to suicide and depression in primary care settings (Bolster et al., 2015).

A review of literature suggests primary care nurses are increasingly required to triage patients experiencing mental health crises including depression and suicidality, often receiving no specialty training. This project assessed the impact a behavioral health training had on knowledge and confidence of primary care nurses in managing suicidal patients, with the overall goal of reducing the rate of death by suicide through quicker response times and more effective triage and resource utilization.

Literature Review

Significance

For people between the age of 15-44, death by suicide is one of the three most prevalent causes of death globally and risk factors include, “gender (men), age, family history of/mental illness, severe depression, having a co-morbid mental illness, deprivation, previous suicide attempts, hopelessness, substance misuse and chronic physical illness” (Kerr et al., 2018, p. 58). When these factors are identified in patient screening, further assessment is warranted, ideally in a timely manner and with close follow up. A preexisting diagnosis of depression is strongly linked to suicidality, as well as expressed feelings of hopelessness and social isolation (Lewis et al., 2014). New research suggests moderate to severe depression with suicidal ideation, termed “suicidal depression,” may be a subtype of depression with poorer outcomes than depression without suicidal ideation (Nobile et al., 2022).

The Interpersonal Theory of Suicide posits the following pathways to the development of suicidal desire and suicidal behaviors: thwarted belongingness, perceived burdensomeness, and capability for suicide (Chu et al., 2017). Though there is also a strong genetic component to suicidal behavior, a twin study utilizing three causal factors hypothesized by the Interpersonal Theory of Suicide revealed belongingness and burdensomeness are heavily influenced by environmental factors (Smith et al., 2012). One study aimed at exploring attitudes and opinions regarding suicidality of healthcare professionals working with oncology patients revealed a large majority (87.8%) were able to understand why an oncology patient would commit suicide; ranking pain and physical impairments, social isolation, and loss of control and autonomy as the top three reasons (Senf et al., 2022).

Special Populations

While it is not unreasonable to assume every patient carries some risk of depression or thoughts of self-harm, there are specific factors and groups at heightened risk requiring special attention. The National Institute of Mental Health (NIMH) found the following medical conditions to correlate with higher rates of suicide than other diseases: congestive heart failure, moderate to severe pain, HIV, anxiety disorders, urinary incontinence, chronic obstructive lung disease, and any diagnosis of a terminal illness (Roberson, 2019). Additionally, chronic or disabling medical concerns, such as epilepsy, Parkinson disease, and multiple sclerosis, are considered an increased risk factor for suicide, and nurses without psychiatric training should be aware of this consideration (Lewis et al., 2014).

Data shows women attempt suicide three times more often than men, while men complete suicide four times as often as women. This is commonly attributed to the fact that men tend to attempt suicide through more lethal or violent means; specifically, use of a firearm which is responsible for more than half of all completed suicides (Frost et al., 2020). Men also tend to plan in advance and complete tasks that are later seen as warnings signs, such as expressing they no longer have a reason to live, giving their things away, and updating their will (Roberson, 2019).

There is a disproportionate prevalence of suicide in vulnerable populations such as American Indians/Alaska Natives, adolescents, indigenous adults and youth, survivors of suicide, members of the LGBT community, and combat veterans (Antai-Otong, 2016). Veterans remain a group of interest at high risk of dying by suicide with a 1.5 times greater suicide rate compared to the general public in 2017 (DeBeer et al., 2020). More than fifty percent of veterans are not enrolled in the Veterans Health Administration (VHA) care, and many are not eligible for VHA

services (DeBeer et al., 2020). Suicide rates have shown to be increasing more in this population specifically, and for the majority who do not receive VHA care, their needs must be addressed in the variety of community clinics where they choose to be seen (DeBeer et al., 2020).

COVID-19

The impact of the COVID-19 pandemic on mental health is significant. In the past, increasing rates of suicide have been linked with unemployment and economic hardship, shown in multiple studies during the recession of 2008 (Nelson & Adams, 2020). Given the predictable ongoing global economic crises expected due to the economic burden of COVID-19, there is increased concern for rising suicide rates and attempts (Nelson & Adams, 2020). Risk is heightened for healthcare workers providing direct care to COVID-19 patients, older adults, people isolated and living alone, and essential workers - which includes grocery store workers, media professionals, and government employees (Nelson & Adams, 2020). Social isolation can have devastating effects on people experiencing depression or schizophrenia, increasing despair and hopelessness, and increasing risk for suicidal behaviors (Nelson & Adams, 2020).

Gaps in Practice

Suicide prevention training is often available only to nurses working specifically within a mental health discipline, and global efforts recommend expanding training to healthcare workers in other disciplines to reduce rates of completed suicide (Kerr et al., 2018). Care delivery is influenced by nurse/provider beliefs and attitudes toward suicide which can be informed by religious beliefs, education level, personal experience with suicidal patients, and cultural norms such as the belief suicide is a crime (Roberson, 2019). A study evaluating the effect of education related to suicidality on non-psychiatric nurses showed a statistically significant increase in

nurses reported self-efficacy in the delivery of support and prevention for patients experiencing suicidal ideation (Blair et al., 2018).

Attitude may also be a key factor related to efficacy and impact of training. A study done in Lithuania showed after a suicide prevention/intervention training, the skills of nurses working in emergency medical services did not change; however, the physician scores decreased on the SIRI-LT (Suicide Intervention Response Inventory) which measures counseling skills (Lygnugaryte-Griksiene & Leskauskas, 2018). This may be attributable to motivation and attention, as doctors who attended the training were noted to be distracted, taking phone calls, expressing already possessing the knowledge, and showing less engagement in the material (Lygnugaryte-Griksiene & Leskauskas, 2018).

Screening

There is no standard best-practice guideline for assessing and managing people who have expressed suicidal thoughts (Harmer et al., 2020). Due to the significant variability in patient presentation of suicidality, healthcare professionals implementing prevention or intervention during a crisis may find it difficult to form an effective assessment of severity from a binary, “yes” or “no,” questionnaire (Harmer et al., 2020). For this reason, it is important to be aware of the most common risk factors, including which groups of people experience a higher prevalence of suicidal ideation. Research shows past history of suicidal ideation remains the strongest predictor of future risk. Thus, assessment should focus on severity and effect of previous suicidal ideation and attempts (Harmer et al., 2020).

An important area for education, and a common struggle identified in assessment, is determining whether an individual’s injuries were due to a self-harm attempt or a suicide attempt (Frost et al., 2020). This is an important distinction which remains in disagreement between

researchers, indicating further research is necessary (Nielsen et al., 2017). Self-harm may, at times, be a coping mechanism without lethal intent, though this distinction is often difficult to define. One qualitative study concluded there remains a belief amongst healthcare providers that self-harm or statements of suicidal intent are a ploy for the patient to gain attention or manipulate situations (Elzinga et al., 2020). A different study posits self-harm may serve a role in lessening distressful symptoms and aid in de-escalation of ruminative thoughts, though encourages individuals to develop other coping responses (Nielsen et al., 2017).

Purpose

The purpose of this quality improvement project was to improve primary care nurses' skills related to triaging patients experiencing suicidal ideation. This could lead to increased resource utilization and quicker response times for patients in crisis. The aims of this project were to: a) increase primary care nurses' knowledge of current, county-specific, resources for suicidal patients; and b) increase the confidence level of primary care nurses related to triaging patients experiencing suicidal ideation or thoughts of self-harm.

Conceptual Framework

The Donabedian Quality Framework was utilized to organize and analyze this project. This framework functions around three concepts integral and inter-related to the execution of quality care: structures (physical buildings, spaces, equipment), processes (patient care activities), and outcomes of care provided (Berwick & Fox, 2016). Structures as defined by this framework included the physical clinic spaces as well as telephonic and electronic health record messaging functions as modes of triage and suicide intervention for clinical staff. The processes this project aimed to improve were assessment and intervention of severe depression and acute suicidality in patients not yet seen by the behavioral health department. Anticipated outcomes

included reduced stress on non-psychiatric nursing staff, as well reduced death by suicide in the community served by the healthcare entity. The Donabedian Quality Framework was utilized in evaluating whether processes were carried out consistently according to current best practice, and the impact on the outcome of interest.

Methodology

Design

The purpose of this quality improvement project was to provide a training for primary care nurses, improving their skills related to triaging patients experiencing suicidal ideation. This could lead to increased resource utilization and quicker response times for patients in crisis. The aims of this project were to: a) increase primary care nurses' knowledge of current, county-specific, resources for suicidal patients; and b) increase the confidence level of primary care nurses related to triaging patients experiencing suicidal ideation or thoughts of self-harm. The training was implemented during the bi-monthly, nurse meeting. The meeting was held online, allowing participants to attend whether working that day or not. Data was collected through participant feedback on pre- and post- surveys. The intervention included topics commonly faced by nurses working in primary care and participation was voluntary.

Setting

The setting for this project was nine primary care clinics located throughout greater King County, Washington, operated by a large multi-state managed care health system. Nurses working in these clinics serve patients of varying resources and needs.

Participants and Recruitment

Participants for this project included all nurses working at the nine primary care clinics operated by the managed care health system. Nurses who did not perform duties related to phone or in-person triage of urgent care needs were excluded. Recruitment occurred through department-wide email from the nurse educator, confirming routine nurse education. Seattle University's Institutional Review Board determined this project was not human subjects research. Subject matter, as related to self-harm and suicide, was consistent with topics commonly faced by nurses working in primary care. Participation was voluntary and informed consent was obtained as part of the survey.

Intervention

The intervention consisted of a 20-minute training regarding suicidality and depression in patients who present to primary care. The training included: assessment tools for depression and suicidality such as the Patient Health Questionnaire-9 (Appendix A) and Columbia Suicide Severity Rating Scale (Appendix B); laws surrounding involuntary detainment in King, Pierce, and Snohomish Counties; and common de-escalation techniques. Participants were shown examples of appropriate questions to ask, pertinent information to gather, scenarios of novel situations, and types of statements or actions that should trigger immediate emergency intervention. The training took place virtually during the bi-monthly nurse training for the primary care department.

Instrument/Data Collection Procedures

Data were collected through a pre- and post-training survey designed to assess nurse knowledge and confidence levels before and after the training. The same survey was delivered via a link embedded in the training email invitation. The survey was a 10-item questionnaire

utilizing Likert scale and multiple-choice options, assessing knowledge and confidence levels, and requesting two indirect identifiers (Appendix C). The indirect identifiers determined location of clinical site and number of years working as a registered nurse.

The survey was developed from information specific to local laws and project site protocol, including the healthcare organization's preferred telephone triage protocol developed by Julie Briggs (Briggs, 2021). Confidence-based questions considered self-perceived ability and confidence, as discussed in the development of the Skills, Confidence, & Preparedness Index (SPCI) for diabetes management (Mbuagbaw et al., 2017). Questions were screened for content, clarity, and redundancy by expert staff in the behavioral health and nurse education departments of the project site. Time commitment was taken into consideration when evaluating length of survey.

Data Analysis

Quantitative data analysis of survey responses was performed using paired t-tests. Changes in knowledge questions are displayed in Figure 1 and Figure 2. Changes in confidence are displayed in Figure 3 and Figure 4. Changes in individual confidence levels and overall change in average confidence levels are displayed in Figure 5 and Figure 6. Additionally, paired T-tests were performed to detect statistical significance of survey responses and are displayed in Table 1.

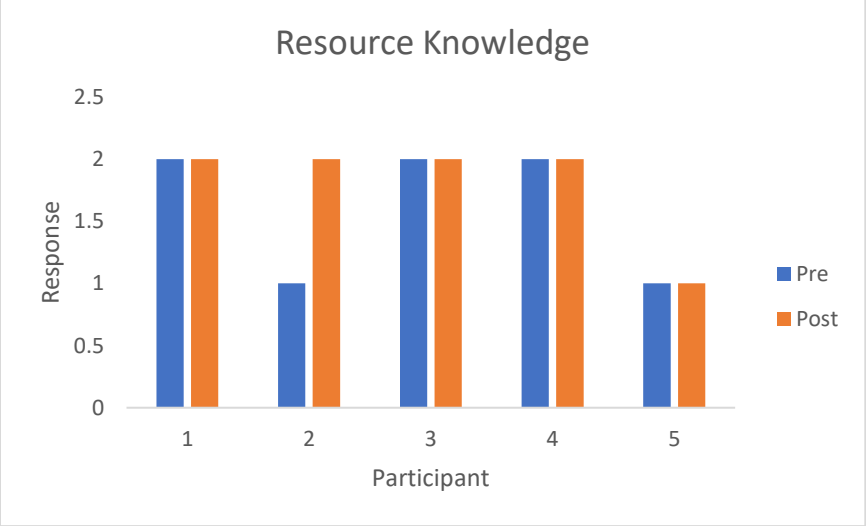
Correct responses to knowledge-based questions were coded to receive a higher point value. For example, the correct response to true/false questions were valued at 1 point, and the incorrect answer was valued at 0 points. The point values were transposed into a bar graph. Likert-scale confidence question responses were coded to show higher agreement rating as

follows: 1 point for “strongly disagree,” 2 points for “somewhat disagree,” 3 points for “neither,” 4 points for “somewhat agree,” and 5 points for “strongly agree.”

Results

Consent to participate voluntarily was obtained at the beginning of the survey and was required to advance. The pre-intervention survey received 15 responses and the post-intervention survey received 8 responses. A unique identifier was used to match pre- and post-survey responses and 5 of these matched, allowing for paired analysis.

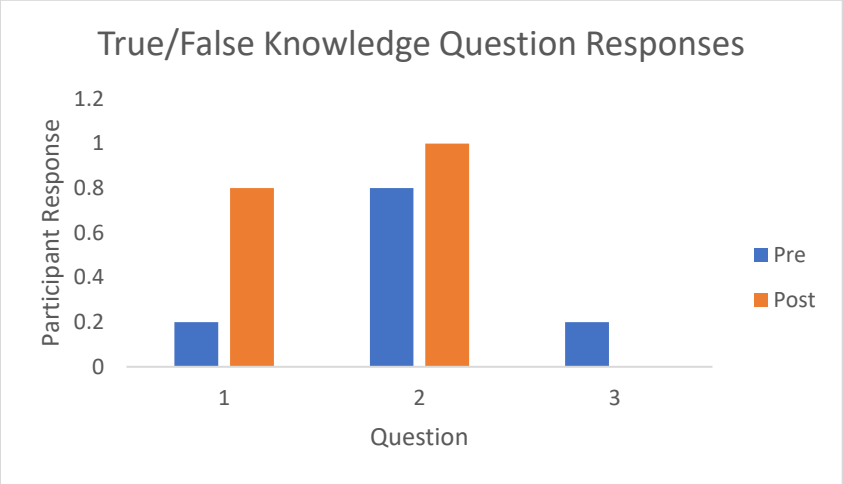
Figure 1. Resource Knowledge Survey Responses



Key to Figure 4

1 Do you know where to find resources to provide to patients experiencing S/I?. No = 0 Maybe = 1 Yes = 2

Figure 2. Knowledge-Based Survey Response Averages



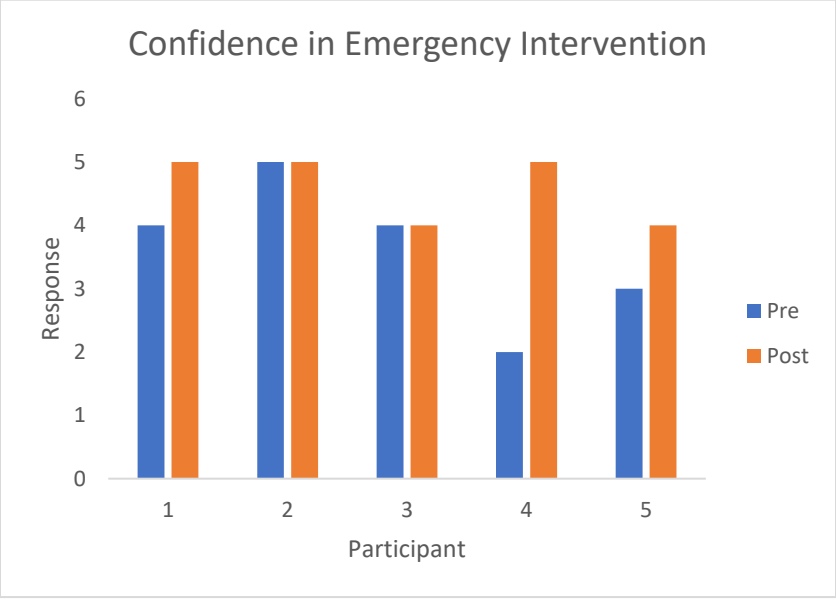
Key to Figure 2

1 In the state of Washington, individuals in crisis can be detained on a psychiatric hold by the police. T = 0 F = 1

2 A score above 10 on the PHQ-9 clinically indicates a diagnosis of depression. T = 1 F = 0

3 The C-SSRS is another tool used to measure symptoms of depression. T = 0 F = 1

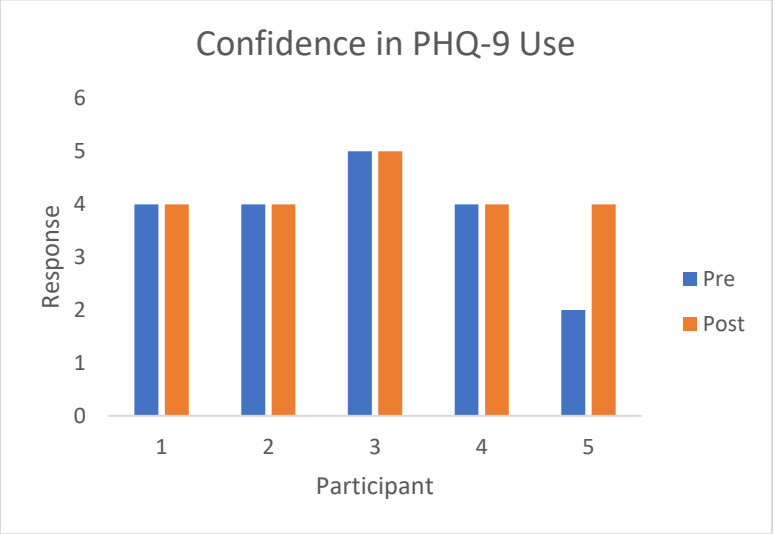
Figure 3. Confidence-based Survey Responses



Key to Figure 3

1 I am able to determine when a patient expressing suicidal ideation needs emergency intervention.

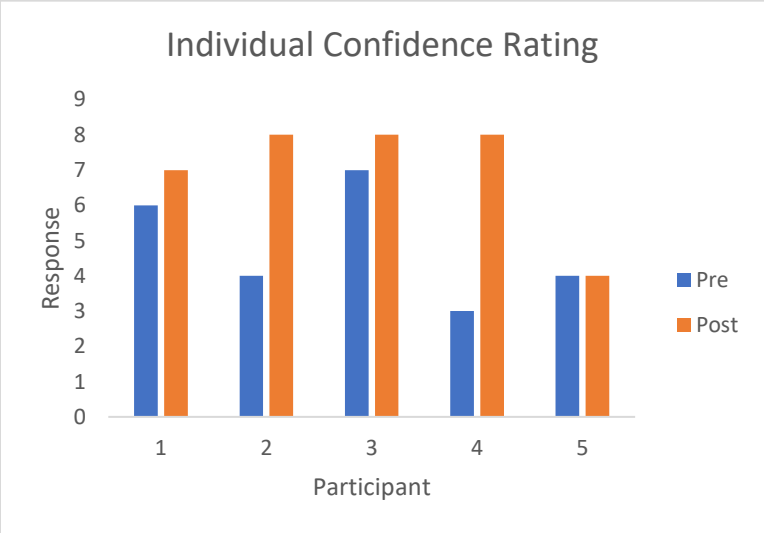
Figure 4. Confidence-based Survey Responses



Key to Figure 4

1 When I receive a positive PHQ-9 from a patient, I feel prepared to triage them effectively.

Figure 5. Survey Response, Individual Confidence Ratings Pre- and Post-Intervention



Key to Figure 5

1 Confidence in Assisting a Suicidal Patient, on a scale of 0-10.

Figure 6. Survey Response, Average Confidence Ratings Pre- and Post-Intervention

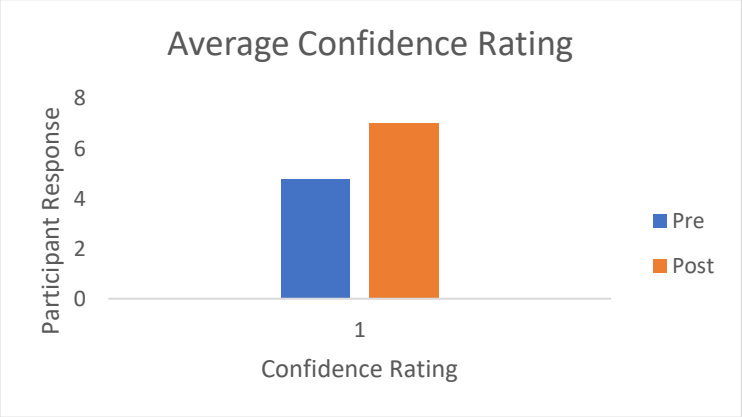


Table 1. Paired T-Tests

	Q3		Q4		Q5		Q6		Q8		Q9		Q10	
	Pre	*Post*	*Pre*	*Post*	*Pre*	*Post*	*Pre*	*Post*	*Pre*	*Post*	*Pre*	*Post*	*Pre*	*Post*
Mean	1.6	1.8	0.2	0.8	0.8	1	0.2	0	3.6	4.6	3.8	4.2	4.8	7
Variance	0.3	0.2	0.2	0.2	0.2	0	0.2	0	1.3	0.3	1.2	0.2	2.7	3
Observations	5	5	5	5	5	5	5	5	5	5	5	5	5	5
df	4		4		4		4		4		4		4	
t Stat	-1		-2.45		-1		1		-1.83		-1		-2.27	
P(T<=t) one-tail	0.187		0.035		0.187		0.187		0.071		0.187		0.043	
t Critical one-tail	2.132		2.132		2.132		2.132		2.132		2.132		2.132	

Key to Table 1

"Q" = question number. A P value < 0.05 indicates statistical significance.

Discussion

The goal of this quality improvement project was to quicken response time and reduce rate of death by suicide by improving primary care nurse knowledge and confidence regarding suicidality triage skills and resource utilization. Data collected show this intervention met the project aims. The following is a discussion of key findings, barriers, limitations, and recommendations for future practice.

Survey questions three through seven analyzed participant knowledge. Question three measured participant knowledge of the resources for patients experiencing suicidal ideation, allowing them to answer “no,” “maybe,” or “yes.” Of the participants who did not respond “yes” in the pre-test, 50% of the responses improved after the intervention. As displayed in Table 1, the p-value resulting from the paired t-test analysis was greater than 0.05 ($p=0.187$), indicating it was not statistically significant.

Questions four, five, and six analyzed participant knowledge of suicidality triage tools and county policies for detainment through true/false questions. Question four showed improvement in participant knowledge with statistical significance ($p=0.035$), while question five showed improvement without statistical significance ($p=0.187$), and question six showed a decrease in knowledge without statistical significance ($p=0.187$). Results from question six may be due to survey question limitations.

Question eight analyzed participant confidence in their ability to determine the necessity of emergency intervention using the Likert scale. Prior to the intervention, 20% strongly agreed, 40% somewhat agreed, 20% felt neither way, and the remaining 20% somewhat disagreed. After the intervention, 60% strongly agreed, and 40% somewhat agreed, though it was not statistically significant ($p=0.071$).

Question nine analyzed participant confidence in their ability to triage a patient with a positive PHQ-9 score utilizing the Likert scale. Prior to the intervention, 20% strongly agreed with this statement, 60% somewhat agreed, and 20% somewhat disagreed. After the intervention, 20% strongly agreed, and 80% somewhat agreed, though it was not statistically significant ($p=0.187$).

The final question asked participants to rank confidence in their ability to assist a suicidal patient, from zero to 10, with zero being not at all confident and 10 being extremely confident. Prior to the intervention, 20% of participants ranked themselves an eight, 20% at six, 40% at four, and 20% at a confidence level of three. Post-implementation reported confidence levels increased to 60% of participants rating themselves at eight, 20% at seven, and 20% at four. These data support the positive impact of the intervention and were found to be statistically significant ($p=0.043$).

Barriers

The training design took into consideration the impact of COVID-19 on employee full-time/part-time/remote status. Implementation was planned during a regularly occurring nurse education meeting to promote participant attendance and engagement, however, problems with technology presented a barrier for some. The online format may have contributed to poor attention and limited discussion or inquiry, similar to the physicians from the Lithuanian study. An in-person event may have provided opportunity for an enriched learning experience.

Additionally, delay in contracting and coordination led to a shortened window of time for participants to complete the initial survey. Participation may have increased given more time and opportunities to send survey reminders.

Limitations

Limitations included a small sample size, limited accessibility, and incomplete surveys. While the training was open to nine primary care clinics operating under a large healthcare system, there were relatively few participants, and not every participant who completed the post-intervention survey matched with a pre-survey identifier. This may be due to misunderstanding the instructions and, in one case, a participant left the identifier blank.

Only one virtual event was offered in real-time during the bi-monthly nurse meeting. While this meeting is generally well-attended, the content is sometimes broadcast to individuals who are not logged on to their computers. Thus, several attendees heard the presentation, but were unable to see the information and resources provided visually. This may have contributed to decreased efficacy of intervention and fewer post-intervention survey responses. It would be beneficial to repeat this intervention in-person with the option of distributing paper surveys prior to and after completing the training.

Lastly, there were limitations to the survey questions. Results from the multiple-choice question unanimously indicated participants had prior knowledge related to dismissive or minimizing language. Nurses in this health system were offered a behavioral health training approximately eight months prior to the execution of this project which may have impacted the data. The question could have been written with more nuance to gain additional information. Additionally, the survey question showing a decline in knowledge is likely due to a misunderstanding of the question and should be taken into consideration when analyzing the data.

Recommendations

Providing specialized training to nurses working in a primary care setting has the potential to improve primary care nurses' knowledge and confidence in triaging patients experiencing suicidal ideation, which may translate into quicker response times and more apt resource utilization for patients in crisis. Ultimately, tracking response times for triage calls after receiving positive PHQ-9 scores would be useful in determining if a training effects clinical practice.

Repeating this intervention after modifying survey limitations may yield more useful results. A larger sample size and in-person training offered more than once may also lead to better results. This training should be updated and repeated annually by future behavioral health staff to stay current with changes in county detainment policies and resources. It may also be reasonable to include a pre-recorded training or presentation in orientation for primary care nurses.

Conclusion

Suicide is preventable. The number of patients experiencing suicidal thoughts, depression, and mental health crises is increasing, leading to a higher prevalence of cases being seen in non-specialized fields such as primary care. This project aimed to assess whether a 20-minute training could increase primary care nurse knowledge and confidence in triaging patients who may be suicidal. Results showed this project met those aims. Further research should be conducted to evaluate whether results can be replicated on a larger scale. Instituting annual training on suicidality triage in primary care and other non-psychiatric areas of healthcare could increase staff knowledge and confidence, which will lead to more efficient use of resources and decrease completed suicide.

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Appendix A

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

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Appendix B

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

RISK ASSESSMENT VERSION	Past Month	
Ask questions that are in bold and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: *Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.* **Have you wished you were dead or wished you could go to sleep and not wake up?** If yes, please explain:		
2) Non-Specific Active Suicidal Thoughts: *General non-specific thoughts of wanting to end one's life/die by suicide without general thoughts of methods, intent, or plan.* **Have you had any actual thoughts of killing yourself?** If yes, please explain:		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Active Suicidal Ideation with Any Methods/Means (Not Plan) without Intent to Act: *Person endorses thoughts of suicide and has thought of at least one method. e.g. "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it....and I would never go through with it."* **Have you been thinking about (how) you might do this?** If yes, how? (means) If yes, do you have access to the methods/means?		
4) Active Suicidal Ideation with Some Intent to Act, without Specific Plan: *Active suicidal thoughts of killing oneself and reports having some intent to act on such thoughts.* *e.g. "I have the thoughts but I definitely will not do anything about them."* **Have you had these thoughts and had some intention of acting on them?** If yes, please explain:		
5) Active Suicidal Ideation with Specific Plan and Intent: *Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.* **Have you started to work out or worked out the details of how to kill yourself?** If yes, do you intend to carry out this plan? If yes, do you have a timeframe (when)? If yes, do you have a location (where)?		
6a) Preparatory Acts or Behavior: *Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.* **Have you done anything, started to do anything, or prepared to do anything to end your life?** If yes, please explain: **6b) If yes, ask: Was this within the past 3 months?**	**Lifetime** **Past 3 Months**	

Appendix C

Suicidality Triage Survey

1) How long have you been a practicing RN?

< 2 years, 2-5 years, > 5 years

2) At which clinic do you work primarily?

Beacon Hill, Canyon Park, Federal Way, First Hill, Lynnwood, Northgate, Puyallup, Renton, Totem Lake

3) Do you know where to find resources to provide to patients experiencing suicidal ideation?

No/Maybe/Yes

4) In the state of Washington, individuals in crisis can be detained on a psychiatric hold by the police.

True/False

5) A score above 10 on the PHQ-9 clinically indicates a diagnosis of depression.

True/False

6) The C-SSRS is another tool used to measure symptoms of depression.

True/False

7) When triaging a patient who has expressed suicidal ideation, all of the following are appropriate EXCEPT:

a) Show support for their courage to call.

b) Ask directly about suicidal thoughts.

c) Try to cheer the patient up by making jokes.

d) Utilize friends and family as support.

8) I am able to determine when a patient expressing suicidal ideation needs emergency intervention:

strongly agree/somewhat agree/neither agree nor disagree/Somewhat disagree/strongly disagree.

9) When I receive a positive PHQ-9 from a patient I feel prepared to triage them effectively.

strongly agree/somewhat agree/neither agree nor disagree/somewhat disagree/strongly disagree.

10) Please rate, from 0 to 10, how confident you feel about your ability to assist a suicidal patient (0 = not at all confident, 10 = extremely confident).