Running Head: Suicide Risk Assessment

By

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To the faculty of Washington State University:

The members of the committee appointed to examine the project of TAMMY HOPKINS-HUBBARD find it satisfactory and recommend that it be accepted.

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The Professional and Personal Factors That Impact a Suicide Assessment

Abstract

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Abstract

Suicide is conjectured to be a preventable sentinel event. In hospital settings, particularly emergency rooms and medical-surgical units, suicidal patients are frequently cared for by non-psychiatric nurses. This task can be challenging for nurses especially if they are not trained in conducting suicide assessments. This paper describes the personal and professional factors that can affect nurse’s ability to conduct an accurate suicide risk assessment. While the concepts discussed can be in used in either an inpatient or outpatient setting, the emphasis of this paper is focused on hospital-based nursing care.
The Professional and Personal Factors That Impact a Suicide Risk Assessment

Introduction

According to the National Institute of Mental Health (NIMH), suicide was the 11th leading cause of death in the United States (NIMH, 2008). In statistics recorded by the Center for Disease Control (CDC), the suicide death rate in 2001 was estimated at 30,622, by the year 2003 the rate had increased to 31,655 and for 2005, the latest year there are suicide statistics, showed a yearly death rate of 32,439 in the United States (CDC, 2007). With a yearly death rate of 32,439 this converts to 89 suicides per day with 1 suicide every 16 minutes. This translates to an annual rate of 11.5 per 100,000 in the United States (American Association of Suicidology, 2007).

In 1998 the Joint Commission on Accreditation of Healthcare Organization (JCAHO) instituted sentinel event reporting for any individual who received inpatient treatment. Sentinel event reporting includes suicides and suicide attempts that take place at the time of admission and up to 72 hours after discharge from an inpatient facility. In 2005, a sentinel event alert posted by JCAHO cited 57 cases where suicidal deaths had occurred in inpatient facilities. JCAHO found that the root causes of inpatient suicides were incomplete suicide risk assessments and reassessments, insufficient staff training, orientation, credentialing, inadequate staffing levels, and finally incomplete or infrequent patient observations. The JCAHO analysis identified serious gaps in inpatient care by the professionals responsible for evaluating the risk of suicide. Since the policy’s enactment inpatient suicide has been found to be the number one reported sentinel event (JCAHO, 2005).
Individuals who attempt suicide can be difficult to care for and often create feelings of angst, inadequacy, and tension in the nurses who care for them. These feelings are not isolated to inexperienced nurses alone indicating a much broader extent of the problem in obtaining accurate suicide risk assessments (Neimeyer, Fortner, & Melby, 2001). The purpose of this paper is to discuss the literature regarding the personal and professional factors held by nursing staff and how these factors impact suicide risk assessments.

Statement of the Problem

In the US individuals with mental health disorders struggle with finding adequate care as financial re-imbursements dry up. The decline in mental health resources essentially forces many mentally ill patients to seek health care from non-mental-health care providers. In 1999 a study analyzed 100 patients who had presented to an emergency room following a suicide attempt. All 100 patients required inpatient hospital care prior to being transferred to a psychiatric inpatient facility. The study also revealed that 86 percent of the patients admitted to the hospital had sought care by a clinician prior to their suicide attempt. Of those, “fifty-five patients who had been seen by a clinician reported they had not been asked about their current emotional state or their potential risk for suicide” (Hall, Platt, & Hall, 1999 p. 20). The researchers concluded that often clinicians overlooked the emotional and physical needs of suicidal patients as a result of time constraints and/or inadequate training.

The importance of clinician assessments, or lack of has been further examined by Conwell (1994) who found that 20% of patients who committed suicide in the outpatient setting saw their primary care provider that same day. In addition, 40% of patients saw a
primary care provider within a week of their visit, and 70% within one month. Another study reviewed a survey that polled physicians who had recently lost a patient to suicide, finding that only 38% of patients had a suicide risk assessment completed (Frierson & Melikian, 2002). Further complicating the issue is the decreasing access to mental health services.

With the increase in financial cut backs and lowered reimbursements, many clinicians are conducting suicide risk assessments without adequate training and/or insufficient time to accurately assess patients. Psychiatric services experience greater difficulty with reimbursements than acute care services making it difficult for primary care providers to find alternative placements. As a result, many suicidal patients end up in hospital emergency rooms from other facilities (Hall et al. 1999).

As the number of visits to emergency departments for mental health concerns increase, a collaborative process was initiated to more precisely identify non-fatal self-injurious attacks. The Consumer Product Safety Commission (CPSC), in conjunction with the CDC expanded their National Electronic Injury Surveillance System (NEISS). In July of 2000, all external causes of non-fatal injuries treated in hospital emergency departments in the United States became reportable events. A total of 264,108 patients were treated for self-inflicted injuries in emergency departments across the United States. Of the 264,180 self-inflicted injuries, 158,566 were considered probable suicide attempts, with 27,294 considered possible attempts, and 85,287 attempts requiring immediate hospitalization (CDC, 2004). This issue is compounding the burden on clinicians and nurses who may not be adequately trained to treat this population.
Education in assessing for suicide in a patient population has had a primary focus concentrated on professional factors identified as knowledge, experience, and training in the identification of suicide (Neimeyer et al. 2001). What is lacking is the self-awareness regarding personal factors that may interfere with an accurate suicide risk assessment (Herron, Ticehurst, Appleby, Perry, & Cordlingley, 2001). Personal factors are identified as personal history of suicide, attitudes towards suicide, religious beliefs, and suicide approval. How suicide risk is assessed and managed may be partially due to clinicians’ negative attitudes toward suicide, making them less likely to assess for risk and hence decline education in risk training increasing the risk of an inaccurate suicide evaluation (Herron et al.).

Although applicable to all health care disciplines, the focus of this paper is how personal and professional factors may affect a nurse’s ability to obtain a perceptive suicide risk assessment. As hospitals continue to experience an influx in the number of individuals seeking treatment with mental health concerns, particularly self-destructive behavior, screening for suicide has been identified as a crucial intervention. This is particularly essential for nurses who are often more accessible in the time of crisis (Gould, 2003).

Literature Review

Research completed by Neimeyer et al. in 2001 correlated the relationship between professional and personal factors when assessing for the risk of suicide. The researchers identified interrelated factors impacting the counselors’ ability to obtain an accurate suicide risk assessment. The five primary personal factors that will be discussed are: perception of clinical inadequacy, suicide approval, attitudes towards suicide, a personal
history of suicide, and religious beliefs. The four professional factors to be discussed include: identification of characteristics, education/training, resource availability and experience.

Personal Factors

Variables associated with personal factors for the most part have not been sufficiently researched. These factors identified as perceptions of clinical inadequacy, suicide approval, attitudes toward suicide, a history of suicide, and religion have been selected for discussion. Although evidence linking an awareness of personal factors in nurses to a more accurate suicide risk assessment is inconclusive, discussion on this subject is not without merit (Neimeyer et al. 2001).

Perceptions of Clinical Inadequacy

Educating the clinician to recognize his or her own personal attitudes and values toward suicide is important in eliminating barriers in obtaining an accurate suicide risk assessment. Inadequate knowledge can lead to excessive anxiety, and insecurity in caring for patients who are suicidal for fear of providing inadequate and substandard care that is perceived as potentially harmful to patients (Valente, 2002). The sense of being sufficiently trained to care for suicidal patients is vital to the therapeutic relationship. Feelings of insecurity can undermine the professional’s self-confidence, which is essential to providing appropriate mental health-care. Inadequate professional confidence results in compromised relations between staff and patients compromising an already difficult relationship (Ramberg & Wasserman, 2003). Occasionally these feelings of clinical inadequacy can become so strained that it paralyzes a nurse to the point of total inaction (Valente, 2002).
Contemporaneous to the perceptions of inadequacy is the issue of countertransference. Countertransference may also negatively influence the patient provider relationship, impeding the ability to obtain a relevant suicide risk assessment (Valente, 2002). Countertransference is the emotional transference between the clinician and the patient obscuring the objectivity of the assessment. “Countertransference hate may be experienced because a patient's suicide represents a severe threat to the clinician's competence and raises the spectra of a malpractice suit” (Maltsberger & Buie, 1974, p. 625). Mismanagement due to personal countertransference issues may also lead to an increased risk of patient suicide.

Suicide Approval

Over the last thirty years, there has been a significant societal shift towards suicide acceptance indicating a trend towards increasing suicide acceptance particularly in the setting of terminal illness (Romer & Jamieson, 2003). Namely that one has the right to die by a manner and time of their choosing. This emerging cultural norm may incline some to consider suicide as an acceptable response to life problems (Joe, Romer, & Jamieson, 2007.) “Since people learn to approve of suicide from other individuals and groups, efforts to reduce suicide approval should focus on the socialization process” (Agnew, 1998, p. 223). Although favorable attitudes toward suicide might make the behavior more acceptable, one would expect accepting attitudes to be especially relevant to persons who express feelings of hopeless about the future. Indeed, hopelessness in itself is a strong predictor of suicidal tendencies (Beck, Steer, Kovacs, & Garrison, 1985). According to the CDC there is an increase in the number of people reporting feelings of hopelessness (CDC, 2007).
Efforts to reduce the effects of suicide acceptance and approval might focus on endeavors to raise awareness of the devastating ramifications that completed suicides have on the surviving loved ones. With emphasis on the tragic results that can occur to an individual’s health in the event of a failed suicide attempt and highlighting the fact that there are indeed alternative and effective treatments for the issues that prompt suicidal behavior (Agnew, 1998). Given comparable acceptance levels of suicide across racial-ethnic boundaries, adolescents, and young adults, attitudes toward suicide may be viewed as a reflection of broader social-cultural normative toward human life (Stillion & Stillion, 1998). Interventions in the educational and socialization process of nurses with respect to awareness of suicide approval behavior might have positive results in assessing for suicide risk and reducing suicide attempts.

Providers Attitudes Toward Suicide

Another barrier is the lack of attention given to health care providers own attitudes toward suicide. This is especially applicable to the area of nursing, however little research has been dedicated to this discipline. Educational programs, may often fail to identify personal factors such as attitudes toward suicide that may undermine the ability to obtain a meaningful risk assessment leading to a suboptimal therapeutic response (Valente, 2002). In 2007 a study in Taiwan assessed for the personal attitudes toward suicide in their “casualty nurses”. The research focused on the importance of training and education in regard to attitudes toward suicide. Results of the study indicated that 94% of nurses had not attended educational courses designed to care for suicidal patients. The findings identified that additional education and training were needed with emphasis on relevant research to foster a more positive attitude toward caring for suicidal patients.
The research demonstrated that the greater the level of education held by the nurse, the more understanding and therapeutic the nurse’s attitudes were towards suicidal patients. However the number of inadequately trained graduate level nurses and marginally prepared nurses with master degrees needs to be addressed if nurses are to provide care with authority, accountability and autonomy (Sun, Long, & Boore, 2007).

Personal History of Suicide

A personal history of suicidal attempts or ideation is an area in need of supplemental examination. It was postulated by Neimeyer and colleagues in (2001) that mental health care providers who had a personal history of suicidal ideation or intent were at greater risk of misidentifying suicidal behavior in the patient population. “Results indicated that within this professionally trained subgroup, having relatively more extensive personal history of suicide behaviors predicted poorer suicide counseling skills even more strongly than it did for the sample as a whole” (Neimeyer et al. 2001, p. 78).

Further investigation and research is needed to identify mental health care providers who themselves are at risk of self-harm (Neimeyer et al. 2001). Crisis interventions with discrete strategies to assist and protect the anonymity of counselors who are experiencing or continue to experience suicidal ideation are needed. Additionally the issue also raises into question the safety of the patients who are in the care of health care providers who are compromised emotionally and may be despondent to patient needs, rendering patients at greater risk for suicide. A family history of suicide is an additional personal factor that also affects suicide attitudes (Botega, Reginato, Silva, Cais, Rapell, Mauro, Cecconi, Stefanello, 2005).
Religion

Religion and religious ties can also have profound effects on the risk of suicide. The risks seem to be modified by the nature of the religious community as opposed to the specific beliefs themselves. Religious involvement tends to provide emotional support in the form of network contacts that may lower the risk of suicide. Those communities with a greater degree of social networking within the group along with the greater society in the absence of major crises seem to have the lowest risk. Others with greater individualistic tendencies and who are more isolated from the larger society have an elevated risk. Within Western society, Catholicism and certain Protestant groups were associated with the lowest risks while other Protestant groups such as those from a Pentecostal and fundamentalist origin were associated with an elevated suicide risk (Colucci & Martin, 2008).

Complicating the issue can be the strong religious values held among health care providers; who may judge suicide as ethically wrong making it difficult to discuss the issues of suicide with patients (Valente, 2002). Factors that may also impact thinking include a clinician’s educational level, views toward liberalism and personal religious beliefs that may affect evaluation and obtaining an accurate suicide risk assessment (Agnew, 1998). An article published in 2005, correlated strong Protestant religious values with a negative attitude towards suicide (Botega, et al. 2005).

Professional Factors

Professional factors are practical intervention skills that have developed through a nurse’s education, training and/or experience. In this article, professional factors are defined as identification of characteristics, education/training, resource availability, and
experience. This section will identify basic characteristics of the most common demographics of individuals at greatest risk for suicide. In addition attention will be placed on the importance of education/training and experience as well as briefly discuss resource availability.

Identification of Characteristics

Much research has focused on the identification of characteristics for suicide risk. Even with significant literature available, many health care providers still have limited knowledge regarding the objective features that characterize suicidality. Recognition of the identification characteristics for suicide risk include major depressive disorder contributed by the recent loss of interpersonal relationship, coupled with feelings of hopelessness, helplessness, worthlessness, insomnia, anhedonia, the inability to maintain a job or loss of job, and the recent onset of impulsive behavior (Hall et al. 1999). There is a two to fifteen percent increased risk of suicide in persons with major depressive disorder (National Strategy for Suicide Prevention, 2005). Other characteristics include demographic traits such as age, gender, race and culture, marital status, sexual orientation, and occupation (American Association of Suicidology, 2006). The presence of anxiety and panic disorders, eating disorders, and or co-morbidities can also be substantial risk factors for suicide (Hall et al.). Individuals with personality disorders have three times the increased risk of suicide. In addition, major psychiatric disorders such as bipolar disorder and schizophrenia can include manifestations such as command hallucinations, impulsiveness, and aggression, increasing the risk of suicide. Bipolar disorder has up to a 20% risk and schizophrenia carries up to a 15% risk of suicide (National Strategy for Suicide Prevention, 2005). Alcohol and substance abuse also
dramatically influence the risk for suicide. The presence of alcohol abuse increases the suicide rate by fifty times (Roy, 1998). Psychosocial factors that include a history of childhood sexual or physical abuse, a history of domestic partner abuse also place an individual at increased risk. Other characteristics consist of debilitating physical or medical illness, ineffective coping skills, a family history of suicide, a previous history of suicide attempts, degree of suicidality, and the lethality of the attempt (American Association of Suicidology, 2006). The best individual predictor of a completed suicide is a history of serious suicide attempts (Moscicki, 1998). Finally, the patient’s setting and environment can be an important factor in risk assessment. Inpatient settings, outpatient settings, emergency departments, long-term care facilities and correctional facilities can modify the threat of suicide (American Association of suicidology, 2006).

Education/Training

Successful treatment of the acutely suicidal individual is dependant on staff knowledge of psychiatric and sociological issues in order to address the anxiety and despair in such patients. Without this psychological preparedness a provider’s insecurity may be fatal for the patient (Ramberg and Wasserman, 2003). A study that surveyed 107 nurses included the general attitudes of patients with the intent to commit self-harm. The study found that a large majority of the nursing staff felt the current standards of caring for suicidal patients were deficient. The nurses articulated a desire for additional support and training with respect to therapeutic communication in obtaining a more comprehensive risk assessment (Sidley & Renton, 1996).

The quantification in determining a patient’s conclusive risk of suicide is difficult given the uniqueness of each person’s peculiar thoughts and plans regarding suicidal
intent. “Historically, much attention has been given in the clinical, educational, and research literature to risk factors and clinical formulation” (Shea, 2004, p.385). Little attention has focused on the details of interviewing skills necessary to identify suicidal intent. “It is the validity of this exact information, however, that may limit whether the clinician can assess the patient’s risk successfully” (Shea, 2004, p. 386). It is well-known that two different clinicians can come up with divergent data sets in assessing suicide risk depending on the specific questions asked, the manner of question presentation, the particular timing and sequencing of the questions and the patient’s comfort along with sense of security in discussing the issues of suicidal ideation with an individual interviewer (Shea). The relative absence of research studies in developing the expertise for obtaining a patient’s distinct suicidal intent would lead to a focus on the art of uncovering suicidal ideation and planning.

Educating care providers of the need for assessment of suicide risk is becoming increasingly important. There is no formal assessment of suicidal potential in many patients who are actively suicidal and are discharged from the emergency department (Folse, Eich, & Hall, 2006). Studies have shown that mental health providers often avoid talking to suicidal patients even though the patients have a great need to communicate with staff regarding their feelings (McLaughlin, 1995). Compounding the issue many nurses felt they lacked the knowledge and confidence in effective communication. These feelings of inadequacy can led to reluctance on behalf of nurses to effectively communicate with their patients (McLaughlin, 1995). The educational method should focus on suicidal risk assessment as a process, not an event, as patients are at varying risk for suicide. Suicide risk is a dynamic process that can change rapidly. There is no
standardized prediction scale for the identification of the absolute risk of suicide. Education of care providers in systematic risk assessment would identify modifiable and treatable risk factors that include patient treatment and safety management. Assessment would determine both risk and protective factors in which an overall clinical assessment of low, moderate or high risk is determined and documented (Simon, 2004). Additionally there is no firm predictor of suicide regardless of the quality of intervention. However “the post-discharge period is the time of greatest risk, that patients require careful predischarge assessment and that appropriate follow-up care in an outpatient setting as well as rehospitalization when necessary, may help reduce the risk for individual patients” (Desai, Dausey, & Rosenheck, 2009, p. 317).

A presumed requirement would be further education regarding the use of suicide contracts. Simply obtaining a denial of suicidal ideation, intent or plan by the patient is inadequate for suicide risk assessment (Simon, 2003). Furthermore, specific suicide plans or notes were poor indicators of suicide risk (Hall et al. 1999). The reliance of a no harm contract tends to reduce staff vigilance with out reducing the actual risk of suicide. These contracts have not been demonstrated to reduce the overall rates of suicide (Jacobs, Brewer, & Klien-Benheim, 1999). However, clinically useful and widely utilized, the no harm contract does not substitute for thorough suicide risk assessment (Jacobs, et al. 1999). Often nurses use suicide contracts as a means of protection to deflect legal responsibility believing that this will put the responsibility on the patient. However nurses must show that a comprehensive suicide risk assessment has been completed. Establishing a no self-harm contract can be an indication of a patient at high risk for suicide (Farrow & O’Brien, 2003).
Accurate and comprehensive documentation on the part of the caregivers is a professional factor that can be of great significance on the part of the staff in assessing for suicide risk. It has been found that inadequacies in the documentation of medical data as it relates to suicide risk are common (Malone, Szanto, Corbitt, & Mann, 1995). Other studies have shown the quality of documenting nursing care plans were generally poor. Quantifying the nursing care plans relating to suicide risk showed scores of approximately half of what could be maximally achieved (Neilson & Brennan 2001).

Part of the educational process needs to incorporate training for health care providers regarding more detailed and comprehensive documentation. The lack of proper documentation may compromise effective communication between professionals. This lack of communication may lead to missed nuances of behavior exhibited by the patient or actual verbalized statements of suicide expressed by the patient. A professional taking over the care of the patient may then miss important findings through the lack of documentation and may not be aware of a heightened risk of suicide (Simon, 2004).

Resource Availability

In an era of intense financial pressures for cost containment, financial resources for mental health care are in decline. A non-profit organization NASMHPD Research Institute (NRI) established in 1987 was developed to provide evaluation, analysis, and research for state mental health programs. The NRI assesses areas of system financing, clinical services, staffing, and interactions with other public service systems. This research is then utilized to evaluate the effectiveness of existing programs as well as aid in development of new programs and policies. According to a report by the National Conference on State Legislatures on December 5, 2008, 41 states will be experiencing
cutbacks in federal aid. This decrease in federal tax revenues is a direct result of reduced spending by consumers, as well as an increasing unemployment rate. The NRI also published that 32 states are expecting budget cuts estimated at 4.9% on the average for the year 2009; with additional cuts escalating to 8.2% by 2010. As a result states are asking for a federal stimulus package to make up for the lost revenue (NIR, 2008).

Additionally the current situation of mental health care for Washington State for the years 2009-2011 is experiencing significant cut backs. According the Washington State Hospital Association, Eastern and Western State Hospitals will not be restoring bed capacity it once held for mentally ill patients. In addition community mental health services will see a 48 million dollar decrease in funding (Washington State Hospital Association, 2009). This all comes at a time as federal and state revenue is decreasing while the cost per patient is increasing. In an article presented by the American Foundation for Suicide Prevention, estimated the average medical cost per patient per suicide attempt that resulted in hospitalization was $9,127, with the averaged annual medical cost totaling 1.6 billion dollars (American Foundation for Suicide Prevention, 2009).

With the lack of outpatient psychiatric services frequently psychiatric patients have had no where to turn but to the emergency departments (ED) for care. Compounding the burden to these patients is the lack of insurance or being underinsured, forcing patients once again to seek treatment in the ED (Baraff, 2006). The American College of Emergency Physicians and mental health organizations polled 340 emergency physicians. The results indicated that 67% of physicians stated that mental health services had experienced a decline over the last year in their communities. Congruently 60% noted a
significant increase in the number of psychiatric patients being treated (Baraff, 2006, as cited in American College of Emergency Physicians, National Alliance for the Mentally Ill, American Psychiatric Association, National Mental Health Association, 2004). According to Baraff in 2009, 23% of ED directors have experienced times when they had to send out suicidal patients without any suicide risk evaluation completed.

Additionally 71% identified a need for mental health professionals to be available for patient evaluations, and 76% reported a severe lack of outpatient facilities to refer suicidal patients (Baraff, 2006). Financial constraints limit the resources available for appropriate therapeutic care. The pressure to discharge patients early due to the lack of psychiatric resources, relying on team planning for treatment regimens rather than careful private clinical examinations, and deficient documentation may also increase the suicide risk (Saarinen, Hintikka, & Lehtonen, 1998).

Experience

Inexperience in caring for a suicidal patient can create feelings of insecurity in a nurse, impeding an accurate suicide risk assessment (Botega, et al. 2005). Inexperienced nurses who are assigned to care for suicidal patients may feel anxious and or unprepared when caring for this population. However, the feelings of discomfort were not confined to inexperienced nurses alone. Patients who are suicidal are challenging to care for and may evoke feelings of unease and anxiety, even for experienced and well-trained health care providers (Kirchberg & Neimeyer, 1991). However, increased experience does improve assessment and intervention skills, making it easier for nurses to elicit quality care (Neimeyer et al. 2001).
In summary little work has been performed in studying how professional factors, and to even a lesser extent, personal factors impact the suicide risk assessment as obtained by nurses. However, focusing on this area of research is not without merit (Neimeyer et al. 2001). It remains unanswered whether specific education and training in these areas will impact the suicide risk assessment as obtained by a nurse.

Significance to Nursing

Detection requires asking relevant questions with consistent and appropriate follow through. Nurses often spend the greatest amount of time with patients and can greatly impact the course of a patient’s care.

In order for nurses to provide professional and therapeutic care it is necessary that nurses receive appropriate training. Nursing schools must begin to orchestrate a program of study that address the global issues connected with suicide detection. The sole institution of a gatekeeper program is insufficient to adequately address suicide risk. In order to obtain a more accurate suicide risk assessment, nursing education curriculum should focus on personal biases and clinical inadequacy. Detection of unrecognized biases would require an emphasis on attitudes toward death, personal history of suicide, suicide approval, religious beliefs and communication techniques that go beyond clichéd questions and responses such as “how do you feel about that?” In addition, the curriculum with respect to suicide risk education would emphasize the importance of accurate documentation; addressing both the personal and professional factors while providing the students with supervised demonstration.

The issues of inexperience and lack of knowledge are not isolated to nursing students. Many nurses who have not worked on a psychiatric unit may be just as
uncomfortable and lack specific training. Hospitals, in general, have not provided nurses with additional or adequate training when assessing for suicide in a patient. With suicide being the number one sentinel event in hospitals, the issue warrants serious consideration. Nursing requires mandatory yearly updates to ensure the standards of care are being met. It is proposed during the yearly update a training module focusing on performing a suicide risk assessment, which includes a specific emphasis on personal biases, be incorporated as part of the educational process. This would also include identifying the basic reporting factors for suicide risk.

Each facility decides individually how suicide is assessed and the manner in which a suicidal patient is cared for. Facilitating a standardized suicide risk program may have positive implications for nursing in potentially reducing suicide rates and fostering better mental health care. The incorporation of a standardized suicide risk assessment form would allow for better accuracy in detection. Ideally an admission history and physical examination would incorporate a basic evaluation for suicide risk based on standardized hospital protocol.

This program would also include re-evaluation of suspected risk for suicide based upon changes in a patient’s clinical course or with new information obtained during the care process. Complications for re-evaluation would include, but not limited to a new diagnosis of terminal or chronic illness, concerns brought on by an unexpected lengthy hospital stay, an adverse event, or a nurse’s suspicion of risk based upon clinical observation. In addition every patient treated for suspected risk would be seen by a caseworker or psychiatric clinical specialist at the bedside. Intervention is crucial with additional support services needed. Some examples of support services may include grief
counselors, credit counselors, and or psychiatry. Ultimately a hospital based support
group would be established to provide additional follow up care.

Research Implications for Practice

Educational programs, may often fail to identify personal factors such as attitudes
toward suicide that may undermine the ability to obtain a meaningful risk assessment
leading to a suboptimal therapeutic response (Valente, 2002). Limited research has
demonstrated that the greater the level of education held by the nurse, the more
understanding and therapeutic the nurse’s attitudes were towards suicidal patients (Sun et
al. 2007). Further research should include a clinical study of the professional and
personal factors that impact a suicide risk assessment. This research would first examine
a nurse’s current level of knowledge regarding suicide facts and personal biases currently
held by the nurse. Followed by an educational session that addresses both professional
and personal factors. It is surmised that a majority of health care providers do not
recognize their personal biases when caring for a patient that is suicidal. It is proposed
through continued education and self-actualization of personal biases that health care
providers will more effectively intervene in patient care.

Summary

Personal and professional factors can have a profound impact in obtaining a
suicide risk assessment. Much of the published literature has focused on the professional
factors with few studies evaluating the personal factors in suicide risk assessment. This
lack of self-awareness in regard to personal factors may interfere with accurate intake
information, hindering competent suicide risk evaluation. As hospitals continue to
experience an influx in the number of individuals seeking treatment with mental health
concerns, particularly self-destructive behavior, screening for suicide has been identified as a crucial intervention. This is particularly essential for nurses who are often more accessible in the time of crisis (Gould, 2003). Ultimately the correlation between personal factors and clinical competency deserves further investigation. Health care providers working with suicidal patients "should examine their own attitudes and propensity toward suicide and the extent to which these facilitate or impede their effective engagement with life-threatening clients" (Neimeyer et al. p. 80). The intent of this paper is to bring to the forefront the need for further investigation into this area of study.
Reference:


