# Utilizing The Self Efficacy to Avoid Suicidal Action

Tool to Recommend a Policy for Disposition of Suicidal Patient in any Adult Inpatient Mental Health Facilities:

A Quality Improvement Project

Oluwasegun David, RN, BSN, PMHNP DNP Student

The College of Saint Scholastica

In Partial Fulfillment of the Requirements for the Doctor of Nursing Practice

Dr. Rhea Ferry

April 16, 2022

## Table of Contents


Title Page 1

Table of Contents 2

The Problem Identification/Available Knowledge 3
- PICO Question 7
- Literature Review, Matrix (table) Development, and Literature Synthesis 7
- Organizational Project Information 9
- The Gap Analysis 11
- Needs Assessment 12
- Strengths, Weakness, Opportunities, and Threats Analysis 13
- Guiding/Theoretical Framework and Change Theory 13

Aims/Goals/Objectives Clarified 15
- Goals and SMART Objectives 15
- Gantt Chart 17
- Work Breakdown 17
- Communication Matrix 17
- Logic Model 18
- Budget 18

Methodology and Analysis 18
- Intervention Plans 20

IRB/Ethical Considerations 20

Implementation 21
- Results from Data Collection 21
- Discussion of Data/Outcomes Interpretation 22
- Dissemination 23
  - Abstract 23
- Conclusion 25

References 27

Appendices 31

Suicide is an intentional or voluntary act of taking one's own life from the belief that doing so will solve any present and pressing emotional pain or conflicts (Cammer, 2016). The manifestation may be isolation, hopelessness, mood changes, withdrawal, pessimism, preoccupation with death, and impulsivity (Cammer, 2016). Suicide is an epidemic in the United States (U.S.). The healthcare impact of suicide in the U.S cannot be overstated since suicide in the U.S. is the 10th leading cause of death and is higher than annual auto crashes. The incidence of suicide has increased drastically by 24% since 1999, and on average, 115 people commit suicide in the U.S. every day (Graves et al., 2018).

In 2013, the estimated suicide and suicide attempt patients' national health care cost was $93.5 billion (Canady, 2016; Suicide Prevention Resource Center, 2020). On average, it costs the U.S economy $1,329,553 for one suicide; about 97% of the cost is due to loss of productivity, while the other 3% is for medical treatment. However, for every $1 spent on suicide prevention intervention, it saves the U.S economy $2.50 for the cost of suicide (Suicide Prevention Resource Center, 2020). Because improving the nation's health is essential, this proposal will address a quality improvement project related to suicidal patient outcomes in an urban health agency in Minnesota by writing a health care policy recommendation for a policy change as in Appendix E.

## The Problem Identification/Available Knowledge

In a common lay term, some people refer to suicidal tendencies to describe someone who may be at risk for suicide. However, this isn't true because the word suicide is not a feature that people would have a tendency toward. Nonetheless, those at risk of suicide may have suicidal feelings or thoughts. It is these suicidal thoughts or feelings that typically lead to suicide. It is expected that when people have suicidal thoughts or feelings, they may have been feeling

worthless and hopeless for some time. These hopelessness or worthless thoughts or feelings usually overwhelm the individual to the point that they may feel they don't have control of their bodies. Sadly, no one is immune to suicidal feelings or thoughts. It can affect anyone regardless of age, gender, culture, and background. Life difficulties, challenges, and circumstances can cause anyone to have suicidal feelings. The list is exhaustive, and a few of the situational causes of suicidal feelings could be an abuse of any kind, mental health problems, relationship issues, loss of a loved one, uncertainty in sexual or gender orientation, and certain medications (Mind, 2021).

Therefore, those who struggled with the above causative factors could present with suicidal thoughts or feelings in the hospital. While the patients are in the hospital, the provider will assess the patient for any underlying mental health problems and the incident leading to the hospital admission. The first step of treatment is to ensure that the patient is safe from hurting themselves and anyone. Patients often get treated with medication and counseling from a therapist, and social workers coordinate with the patients if they lack social resources that could help them (Mind, 2021). The average length of stay in the hospital is different for each patient based on their discharge need and how readily available those needs are.

Often when patients are admitted into the unit regardless of their diagnosis, the standard practice for many organizations is to ask about suicidality using the COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS). The C-SSRS is an evidence-based tool that addresses the patient suicide risk, protective factors, the severity of the risk, and the immediacy of the risk (Posner et al., 2008). But when patients are discharged from inpatient treatment, nurses and providers at mental health facilities often do not have measures to ascertain inpatient treatment

effectiveness. Also, many facilities do not have an instrumental scale to predict a patient's future suicide attempt.

However, using the SEASA scale, providers could identify a vulnerable patient who may be at risk for the next suicide attempt (Czyz et al., 2014). In other words, while the C-SSRS assesses the patient's past and immediate risk of suicide, the SEASA assesses and or predicts the future risk of suicide. If healthcare clinicians had the means to identify patients discharging from healthcare facilities which may be at continued risk for a suicidal attempt, this would prompt clinicians to seek out appropriate interventions and resources within the community for the individual before discharge.

Suicide is the 10th leading cause of death, killing over 45000 people annually in the United States (Centers for Disease Control and Prevention, 2021). According to Cepeda et al. (2020), the rate of rehospitalization of suicide ideation (SI) or suicide attempt (SA) is about 11%. The risk is even higher in the first month, with about 50% of the rehospitalization rate in the first three months of discharge. Also, as an employee, this writer has observed a cycle of readmission of suicidal patients in the inpatient treatment unit at a major local hospital in the Twin Cities of Minneapolis, Minnesota.

According to the National Action Alliance for Suicide Prevention (2019), suicidal patients discharging from the mental health unit have a suicide rate that is 300 times higher in the first week. They also have a 200 times higher suicide rate in the first month than the general community who has not undergone inpatient treatment for SI/SA in the same period. The following facts were reported by Suicide Facts & Figures: Minnesota 2020 (n.d) that there is a suicide death every 12 hours in Minnesota. Seven times more people died of suicide in 2018 than alcohol-related car accidents. Suicide is the 8th leading cause of death in Minnesota, higher than

the national figure as the 10th leading cause of death. More importantly, suicide is the 2nd, 3rd, and 4th leading cause of death among 10-34, 35-44, and 45-54 years of age. In 2010 suicide death caused Minnesota's state about $749,527,000 in a combined lifetime medical and labor loss, which is an average of $1,236,843 per suicide death ("Suicide Facts & Figures: Minnesota 2020," n.d).

On the national level, there was 48,344 suicides in 2018. The main methods of suicide in 2018 were firearms, suffocation, and poisoning. Among men and women, firearms and suffocation were the most common method of suicide in 2018, with which men had 55.9% and 28.3%, while women had 31.5% and 29.9%, respectively ("National Institute of Mental Health," n.d). In 2019, the estimation was that about 4.8% of adults aged 18 and above, which is about 12 million adults had serious thoughts of suicide. Of these adults, 3.5million proceeded to make a suicide plan, while 1.4 million attempted suicide. In 2019, 1.2 million adults planned and attempted suicide, while 217,000 adults made no plans but attempted suicide.

The proposed solution in response to avoiding suicidal action upon discharge from the inpatient mental health treatment is to recommend a policy change in the discharge process by utilizing the SEASA tool. The registered nurses will use the SEASA tool to assess the patient's risk level before discharge. Since the social workers and the providers coordinate the discharge process, they will both use the SEASA score to find the appropriate discharge placement or disposition for the patient in view of reducing the probability of the patient engaging in suicidal action after discharge.

Typically, patients will be discharged to their home, group home, homeless shelter, chemical dependency treatment centers, crisis residence, or Intensive Rehabilitation Treatment Services (IRST) regardless of their discharge diagnosis. But with the utilization of SEASA, the

patient at risk of future suicide action based on their score will be best sent to an IRTS, where they can receive a structured, supervised, tailored treatment than to a homeless shelter or home where no tailored treatment will be given.

**PICO Question**

Currently, most mental health administrators, social workers, and clinicians use their judgment and intuition to decide the disposition of a patient in an adult mental health unit who was admitted with suicide ideation (SI) or suicide attempt (SA). The PICO question for this quality improvement project is below.

Among adult suicidal patients in the inpatient mental health unit (P), how will the recommendation of a policy to use self-efficacy to avoid suicidal action guidelines to professional experts (I), impact discharge disposition at the time of discharge as compared to current interventions (C)?

The SEASA tool, Appendix B, would assist the registered nurses in identifying patients who may not be able to avoid suicidal action after discharge and prompt the social workers and providers to find a suitable discharge disposition for the patient.

**Literature Review, Matrix (table) Development, and Literature Synthesis**

The literature review was conducted using the databases provided by St Scholastica, such as CINAHL, MEDLINE, and SOLAR. The writer also used the Google Scholar search engine. The search terms that the writer used were suicide ideation, suicide attempt, self-efficacy, suicide, SEASA, AND prevention. The CINAHL came in handy due to familiarity from previous semesters. The writer used advance search to narrow the search using the All Text in the Field section. Several thousand results came forward. The results were limited by publication year by excluding all articles over ten years old but included adult population and inpatient settings. The

writer also defines it by mental health services subject area and by the academic peer-review journal. Preference was given to full text only, and the result became a few hundred. The writer also eliminated some articles by their title and then reviewed dozens of journals and ultimately selected those used for the project.

The literature used as supporting evidence for this project is itemized below in a matrix table in Appendix A. Each literature article is summarized by purpose, design, sample intervention, and the study or research result. The table helps to provide a glance and concise review and understanding of the literature that is utilized one way or the other in the project.

Self-efficacy theory has become an essential concept in all works of life to reinforce an individual's desire to achieve a positive goal. In 1986 Bandura developed the self-efficacy theory as part of the cornerstone of his social cognitive theory-a method of shared responsibilities to achieve a greater purpose beyond an individual effort (Wulfert, 2019). The SEASA is an assessment scale that measures an individual self-efficacy that could prohibit them from engaging in suicidal action. Self-efficacy (SE) is a theoretical concept of an individual's judgment on their capabilities to organize and execute courses of action to achieve the desired positive type of performance (Crain, 2016).

Because the self-efficacy construct can apply in arrays of fields, the researcher used it in mental health in a study among people suffering from substance use disorder (SUD) in a treatment center. The study's findings show that the self-efficacy tool can help avoid suicidal action even though those with SUD are at greater risk of suicide than any other vulnerable population (Czyz et al., 2014). Similar results were found when researchers investigated the link between SI and SE using the tool among 139 psychiatrically hospitalized military men. The study's authors inferred that the severity of all suicidal behaviors was related to lower SE scores

(Daruwala et al., 2018). Other authors used the scale among 60 patients in an addiction program using a pre-and post-treatment questionnaire for a month. The authors indicated that the test group had fewer relapses of addiction quitting than the control group (Heydari et al., 2014).

Addressing the issue of suicidality is a complex problem, but simple approaches can go a long way in ensuring that suicide is being prevented. One of these approaches is using the right identification tool to assess for suicidality. Daruwala et al. (2018) surmise that lower SEASA is not only significantly associated with a severe form of suicidal ideation but could lead to multiple suicide attempts. The findings are like the result of Czyz et al. (2014) study that people with more severe suicide ideation and severe form suicide attempts were found to have low SEASA. More importantly, the latter study deduces higher convergent validity with SEASA when used to measure the potential for suicidal behavior among people with substance use disorder.

**Organizational Project Information**

Inpatient mental health providers must know that some primary care organizations' do not perceive suicide care as a crucial responsibility they can mitigate. Therefore, those organizations thought suicide was a tragedy, and perhaps it could not be avoided (National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group, 2018). Additionally, many healthcare professionals wrongfully believe that asking people about suicide may encourage the act of suicide. As a result, primary care providers may not ask about suicide in a primary care setting. This belief explains why 50 percent of those who commit suicide have seen their primary care provider in the month preceding their death (National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group, 2018).

The project setting is the College of St. Scholastica (CSS), established in 1912 as an independent private college with a main campus in Duluth, Minnesota. The college educates nearly 4000 students annually and has graduated over 29000 students. (The College of St. Scholastica, 2021). It is one of the leading colleges in the Duluth area, and it overlooks Lake Superior. This college, as the agency, will be able to support the project's focus with her faculty members in the Doctor of Nursing practice program since the faculty are vast in developing and evaluating policy change in healthcare.

The mental health population is a vulnerable patient population, particularly those suffering from suicidal thoughts or suicidal ideation/attempts (SI/SA). While most people with SI/SA may have an underlying mental health condition, many do not have a pre-existing mental illness (National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group, 2018). The population of interest in this project is all inpatient mental health patients ages 18 - 75 years of age at risk for suicide in the metro area of Minneapolis and St Paul.

This project is being done in association with CSS as the agency and not in the clinical facility. As a result, the inclusion criteria are:

- Experts in policy development.
- Being a practitioner of mental health.
- Clinical administrators.
- Social workers.
- All inpatient mental health patients ages 18 - 75 with risk for suicide.

The exclusion criteria from this project are:

- The emergency room mental health patient population.
- Primary care visits mental health patient population.

- Inpatient mental health patients without SI diagnosis.

The project participants are the five professional experts who will evaluate the drafted policy. The experts are:

- A CSS faculty member.
- A psychiatric practitioner or provider.
- A clinical nursing manager.
- A social worker.
- A registered nurse.

The stakeholders involved in this quality improvement are the CSS, adult mental health facilities in the metro areas of Minneapolis and St Paul, mental health providers, mental health treatment placements, and centers. The College of St. Scholastica (CSS) is the agency that will oversee this project.

The mission of CSS is to "provide intellectual and moral preparation for responsible living and meaningful work" (The College of St. Scholastica, 2021). This project aims to develop a policy guideline that will enable the patients who are suffering from suicidal thoughts and ideation and attempt to have an appropriate discharge disposition from inpatient admission. This process will allow the patients to live freely, productive, and comfortably in the community and not be entrapped in suicidal thoughts after discharge from the hospital.

**The Gap Analysis**

The literature review of SEASA surmises clinical implications for suicide prevention when utilized in any mental health setting. This reason is that the SEASA assessment tool could inform the treatment team of the needs of a suicidal patient since it could provide specific information about the level of patient self-efficacy that could result in suicidal behavior

(Daruwala et al., 2018). The writer has worked in two different inpatient mental health unit hospitals in the metro area of Minneapolis, Minnesota. It is easy for me to decipher that there is no means to assess the probability of patients engaging in suicidal action before discharge from the inpatient mental health unit. Therefore, this tool will be justified as a process improvement project. It will inform the discharge disposition treatment plan for inpatient suicidal patients within a mental health unit before discharge to the community, hence addressing the knowledge gap in the clinical process.

**Needs Assessment**

Measures to prevent suicide at every opportunity should be explored by every institution, either in businesses, schools, hospitals, emergency rooms, clinics, or every other place where the opportunity arises. Given the nature of this project, the solution that this project presented must be explored to circumvent the growing concerns of suicidal death in our society. There are urgent organizational needs in all institutions regarding suicide prevention.

The reasons are that suicide is the eighth leading cause of death in Minnesota instead of the nation's tenth leading cause of death. Moreover, every eleven hours, someone dies of suicide in Minnesota. However, there is a general opinion that Minnesota is a safe place to raise a family compared to other states due to its low crime rate. But the suicide crisis has trumped the homicide crisis as six times as many people die of suicide in Minnesota annually than by homicide (American Foundation for Suicidal Prevention, 2021).

The project setting is the College of St. Scholastica (CSS), established in 1912 as an independent private college with a main campus in Duluth, Minnesota. The college educates nearly 4000 students annually and has graduated over 29000 students. (The College of St. Scholastica, 2021). It is one of the leading colleges in the Duluth area, and it overlooks Lake Superior. The college

offers three doctorate programs: Doctors in Nursing Practice (DNP), Educational Leadership, and Doctors in Physical Therapy (DPT). The DNP program offers three tracks: Adult-Gerontology Acute Care Nurse Practitioner, Family Nurse Practitioner, and Psychiatric and Mental Health Nurse Practitioner. 83% of the graduate students are Caucasian, while the other is the remaining 17% (College Factual, 2021).

**Strengths, Weaknesses, Opportunities, and Threats Analysis**

One of the college's strengths as the agency concerning this project is that the college faculty members in the Doctor of Nursing Practice program are vast in developing and evaluating policy change in healthcare. One weakness that the organizations have is that it will be practically impossible to convince every graduate student to do their project in mental health and suicide prevention. Nonetheless, the organization will savor the opportunities they have in that more and more people are going into the mental health program. And they could potentially be involved in either writing policy or implementing a change that will prevent suicide death in the state of Minnesota across any health institution. One of the college's threats is that the college is situated in a colder area of the state, but the long-distance study could limit the threat.

**Guiding /Theoretical Framework and Change Theory**

A theoretical framework is a phenomenon that helps us understand a particular concept. For example, suicidology is a complex field of study, and to understand it, we will need the help of a theoretical framework. So, when it comes to suicide prevention, one of the leading theories is the integrated motivational-volitional (IMV) model. IMV model is a framework that uses multiple factors to conceptualize his position and consider defeat and entrapment as the main factors of suicide ideation (De Beurs et al., 2019). IMV model has three phases.

The pre-motivational phase is when the personal background, environment, and triggering events precede suicide ideation. The motivational phase is the formation of suicidal ideation and intention phase. This phase is driven by defeat and entrapment that result from a lack of social problem-solving skills and coping mechanisms. The last is the volitional phase. This phase is where the suicide behavior occurs because the individual is driven by access to means, fearlessness about death, impulsivity, suicide exposure, and past behavior (De Beurs et al., 2019). The entrapment of the IMV model is either internal or external, in which the former is more predictive of suicidal ideation than the latter. Entrapment is when the individual is hopeless and powerless to endure and escape the horror of defeat and rejection.

A group of researchers performed a research study in Germany in a psychiatric inpatient hospital to validate the motivational phase of the IMV model. Using a cross-sectional method, the researchers examined 308 high-risk mental health patients admitted with suicide ideation or attempt. The researchers observed a significant mediation relationship between entrapment and defeat, leading to suicidal ideation in the admitted patients to the hospital (Lucht et al., 2020). This result is like another cross-sectional study of over 3500 young adults done by De Beurs et al. 2019 as the researchers explore the psychology of suicide ideation. The authors surmise that some people may develop suicide ideation because they have been defeated and trapped by overwhelming, painful thoughts and feelings and lack of social support from the triggers. While others may not develop suicide ideation when exposed to the same stimuli.

The IMV model aligns with this project's focus because the missing element in people with lower self-efficacy is their submission to defeat, which is cardinal to IMV. That defeat could be physical, emotional, psychological, or social entrapment since SEASA assesses one's ability and belief to persevere and not succumb to suicide actions when in crisis; therefore, the

IMV theory is a synergy to the direction and focus of this project. The IMV theory helps to emphasize the magnitude at which self-defeat and entrapment of a person could lead to lower self-efficacy and, therefore, suicidal action.

## Aims/Goals/Objectives Clarified

This project aims to create a health policy for the discharge disposition of adult patients in an inpatient mental health unit. This health policy will emphasize the utilization of the SEASA assessment tool by clinicians to aid in the adequate discharge disposition. The focus of this project will not be on the actual implementation of the SEASA assessment tool but on indicating the significance of the instrument as evidenced by literature reviews.

### Goals and SMART Objectives

Objective 1

By month 1 of the project initiation, the writer will solicit the participation and consent of five expert participants. The writer will solicit the experts through email and phone conversation to evaluate the recommended guideline for a policy change to use the SEASA instrumental scale in an inpatient or transitional adult mental health unit for an adequate disposition of suicidal patients.

*Outcome Measures*

The project leader will measure this objective by the number of consents forms he can obtain and how many attempts from potential participants.

*Data Analysis Approach*

No analysis is needed at this time of the objective.

Objective 2

By month 2, the same five expert participants will receive the initial drafted policy recommendation change made by the writer for their expert evaluation.

*Outcome Measures*

The project leader will send a follow-up email a couple of days after sending the original email to verify the receipt of the initial email.

*Data Analysis Approach*

The project leader will use Intellectus to analyze the received data from the expert participants.

Objective 3

By month 3, the writer will collate the feedback from the five expert participants and revise the policy and send by email to the experts for another feedback.

*Outcome Measures*

The project leader will send a follow-up email a couple of days after sending the original email to verify the receipt of the initial email.

*Data Analysis Approach*

The project leader will use Intellectus to analyze the received data from the expert participants.

Objective 4

By month 4, the writer will synthesize all the feedback and revise and complete the policy change recommendation to use the SEASA instrumental scale in any adult inpatient mental health unit.

*Outcome Measures*

The project leader will measure this objective by observing the variation that may have taken place in the initial drafted policy to the completed final evaluated policy.

*Data Analysis Approach*

The project leader will use Intellectus to analyze the received data from the expert participants.

**Gantt Chart**

The Gantt chart is illustrated in Appendix D below. The project timeline is to take about five months. The most challenging part of the activities is the initial creation of the SEASA policy. Without creating the policy, the professional experts will not be able to make any evaluation. Once the policy was created, revising the policy after the experts gave their evaluations was also a challenge.

**Work Breakdown**

The work plan for this project implementation is pictured in the Gantt chart Appendix D, Table 1, and Table 2, the Logic Model. The activities involved in the former table are creating an evaluation form Appendix C, creating a PowerPoint slide, creating SEASA policy, meeting with the participant, sending and receiving the evaluation form from the participant, and completing the manuscript and presentation to the CSS board. The later table represents the shared relationships among the activities regarding input, output, outcomes, and impacts.

**Communication Matrix**

The stakeholders involved in this quality improvement are:

- The CSS.
- Adult mental health facilities in the metro areas of Minneapolis and St Paul.
- Mental health providers.

- Mental health treatment placements and centers.
- The five professional experts.

The CSS is the project agency and one of the five professional experts. The use of email is the primary mode of communication between the project leader and the professional experts' participants. The other stakeholders are not active stakeholders involved in the project, but they could benefit from the project as public stakeholders should the project get published.

**Logic Model**

The Logic Model is illustrated in Appendix D, Table 2. It is a visual presentation of the shared relationships among the activities in the project regarding input, output, outcomes, and impacts. The model also identifies the project focus, goal, and the situation that warranted the need for the project. The Logic Model also described the assumptions and the external factors that may affect the project's success.

**Budget**

This project will not involve the incurment of any expenses, so there would be no need to create any budget. The only resource needed for this project is the time commitment, which would be the loss that could be incurred if the project did not go as planned.

## Methodology and Analysis

The methodology is essential in every project as it suggests how the project will be structured and performed. More so, it may also highlight what factors influence the use of such a method. This project has been divided into methodology categories: pre-implementation, implementation, and post-implementation.

Pre-Implementation

In the pre-implementation phase of this project, the primary investigator will verify and ensure that human subjects are protected should the project involve human subjects. This project, however, does not include human subjects, and no patient data will be collected. Therefore, violating the Health Insurance Protection and Portability Act (HIPPA) will not be a concern. To wrap up the pre-implementation phase, the primary investigator will create a data collection tool that includes answering a modified Appraisal of Guidelines for Research and Evaluation II (AGREE II) Appendix C. The response to the questions by the experts' evaluators will be in the form of (1) Strongly Agree, Agree, Neutral, Disagree, and Strongly Disagree. (2) In the form of a descriptive written response to some questions.

## Implementation

This second phase is where the primary investigator will engage the professional experts' evaluators through email exchanges. The experts will review the policy recommendation guideline and then evaluate it using the modified AGREE II form. The experts will be required to evaluate the guidelines twice. The first time is the initial attempt. The second time will be done after sending their first evaluation to the primary investigator. On receiving it, the primary investigator will also review the guidelines and rewrite the policy based on the experts' feedback, and then send it back to the expert evaluators for their final review.

## Post-Implementation

The final phase of the implementation is when the primary investigator analyzes the data received from the data collection tool. The data will be analyzed using descriptive statistical analysis plotted into a bar chart and a pie chart. The quantitative data will be described and plotted into the bar chart, while the qualitative data will be described and plotted into the pie chart. This process will occur in the Intellectus Statistics provided by the College of St.

Scholastica. The reason for choosing this kind of statistical method is that it will simplify the collected descriptive data into a visual format. The foreseeable challenges to this method will be the ability to adequately use the Intellectus Statistics to generate the desired graphical presentation of the data.

**Intervention Plans**

The intervention plans for this project are like the work breakdown. The plans were created back in December during the submission of the IRB application and the final IRB approval. The interventions for this project went live in January and will end in May. The things to be considered are:

- Creation of the SEASA policy.
- Meeting with the Participants.
- Sending the project document to the experts for evaluation.

Also, the project leader is to receive the evaluation document from the Participants, review it and resend the project document to experts' participants for the second evaluation.

## IRB/Ethical Considerations

This project will undergo a thorough review by St Scholastica's Internal Review Board (IRB) to ensure it will not violate any HIPPA and human subject protection rights in Appendix I. The only information that will be in the care of the primary investigator is the name and email contacts of the professional experts that will review and evaluate the policy recommendation guideline that the primary investigator will create. These contacts' information will be kept in the primary investigator's personal computer, secured with passwords only known to the primary investigator. In a nutshell, this project is bound to strictly follow the ANA code of ethics and the 45 CFR 46 on the use of human subjects in research.

## Implementation

This implementation section is like the method and analysis section. It contains the same information. This project is unique because it is not a typical community project that involves patients directly where data needed to be obtained from patients and then analyzed. Instead, this project is about writing a health policy by the project leader and then having professional experts evaluate the policy. As a result, the project leader is the sole implementer of this project to engage the professional experts through correspondence and reviewing the evaluated policy done by the experts.

### Results from Data Collection

The quantitative result of the Likert scale evaluation of the policy is listed below.

Does the document identify the intended patient population?

Seventy-five percent of the professional experts strongly agree, while twenty-five percent agree.

Does the document provide information on when in the workflow process will the policy be utilized? Hundred percent of the professional experts strongly agree.

Does the document describe suicide in unambiguous term? Hundred percent of the professional experts strongly agree.

Does the document describe the Self Efficacy to Avoid Suicidal Action (SEASA) instrumental scale intervention in unambiguous term? Seventy-five percent of the professional experts strongly agree, while twenty-five percent agree.

Does the document outline using the pre-existing available resources of each facility to mitigate the outcome of the SEASA intervention? Seventy-five percent of the professional experts strongly agree, while twenty-five percent agree.

Can I find the major recommendation of the document? Hundred percent of the professional experts strongly agree.

Does the document had clear headings and sections to identified major topic discussed? Hundred percent of the professional experts strongly agree.

The qualitative results of the evaluation of the policy are listed below through a few of the evaluator statements.

What changes would you make to this recommendation? “Yes. I think it makes for a good guideline.” Was there enough convincing data for you to agree to this recommendation? Why or why not?

“Yes. The information presented is thorough and clearly outlined in an understandable manner. Given the lack of instrumental scales to evaluate suicidal ideation at many facilities, this tool could provide many beneficial outcomes”

Does this recommendation seem feasible to implement within an adult inpatient mental health facility in the metro area Why or why not?

“Yes. However, the one element that could be a hindrance is patient’s willingness, but that does not change the hospital recommendation.”

The above result is also conveyed in a bar and pie chart for the quantitative and qualitative result in Appendix F.

**Discussion of Data/Outcomes Interpretation**

As seen in the result section, the data from this project are the evaluator's feedback. The five professional experts evaluated the policy on two occasions. After the expert's first evaluation, the project leader revised the policy and sent it back to the experts for the final review. The above data is the result of the last evaluation of the experts. Most of the experts gave

positive, constructive feedback in the qualitative section of the evaluation. All experts strongly agree with the Likert questions 2, 3, 6, and 7. Seventy-five percent of the experts chose strongly agreed with the Likert question 1, 4, and 7, while the other twenty-five percent of the experts chose agreed with the quantitative result. Overall, the policy has excellent convincing data and seems feasible to be implemented in any adult inpatient mental health facility.

**Dissemination**

Since this project is not a typical direct patient-care data collection project in a clinical facility but instead an evaluation of a policy, this project will not be disseminated to any clinical agency. However, CSS faculty may have a copy of the completed final paper as the agency for this project. Also, the project leader can submit the scholarly paper of this project to the Sigma Repository and or the Doctoral Project Repository. The project leader will also disseminate this project via a DNP project poster in Appendix G and a 3MT presentation in Appendix H as required for the project completion. In such doing, other students and the public could access the project results and have insight into the clinical problems the project attempted to solve.

**Abstract**

***An Inpatient Mental Health Policy for Discharge Disposition of Suicidal Patient***

Suicide is an epidemic in the United States and the 10th leading cause of death (Graves et al., 2018). Suicidal patients discharging from the inpatient mental health (IMH) unit have a suicide rate that is 300 times higher in the first week (National Action Alliance for Suicide Prevention, 2019). There is no existing tool to predict patient future suicide attempts (SA) after discharge. This project objective is to develop a policy that emphasizes the utilization of the Self Efficacy to Avoid Suicidal Action (SEASA) tool before discharge in adult patients with a history of SI.

**Synthesis and analysis of supporting literature:**

The SEASA measures an individual self-efficacy (SE) that could prohibit a patient from engaging in suicidal action. When researchers used the SEASA tool among substance use disorder patients, it was deciphered that people with more severe suicide ideation and suicide attempts have low SE, with the tool having a higher validity (Czyz et al., 2014). The integrated motivational-volitional model is a suicide prevention framework that highlights entrapment and defeat as a factor in SI of mental health patients admitted to the hospital (Lucht et al., 2020).

**Project implementation:**

The principal investigator developed an IMH policy for the discharge disposition of suicidal patients using literature evidence. Five experts evaluate this policy: an academia, psychiatrist, nurse manager, social worker, and a registered nurse.

**Evaluation criteria:**

The five experts evaluated the utilization of the SEASA policy with an evidence-based questionnaire using the AGREE II template. The experts completed the AGREE II form, which is a Likert-scale and open-ended question, on two separate occasions following the review of the first evaluation by the principal investigator.

**Outcomes**:

100% of the experts completed their evaluations with constructive feedback using open-ended questions, and most strongly agree using the Likert scale.

**Recommendations:**

The use of the policy will inform the IMH unit treatment team of the needs of suicidal patients since it provides specific information about the level of patient SE that will result in SA upon discharge.

KEYWORDS: *SELF-EFFICACY, SEASA, AGREE II, SUICIDE, SUICIDE IDEATION, SUICIDE ATTEMPT*

**Conclusion**

Suicide is an epidemic in the United States at the national and local levels, causing society a great deal of economic burden. Although inpatient mental health hospitals provide a temporary safe place for patients admitted with suicidal ideation or attempt, many facilities do not have an instrumental scale to predict a patient's future suicide attempt upon discharge. If healthcare clinicians had the means to identify patients discharging from healthcare facilities which may be at continued risk for a suicidal attempt, this would prompt clinicians to seek out appropriate interventions and resources within the community for the individual before discharge. The strengths of this policy stem from the variation and quality of the interdisciplinary professionals' stakeholders that evaluated the policy, giving it a vital implication for future uses in a clinical setting.

Therefore, the SEASA assessment tool could inform the treatment team of the needs of a suicidal patient since it could provide specific information about the level of patient self-efficacy that could result in suicidal behavior. Hence, the need to implement a SEASA policy that will guide the adoption of the SEASA assessment tool in the inpatient mental health units. Moreover, the findings from the project suggested that the stakeholders agreed to the recommended discharge dispositions of patients to either Involuntary hospitalization (Delayed Discharge), Intensive Residential Treatment Services (IRTS), or Residential Crisis Stabilization (RCS), or the patient home based on the patient SEASA scores.

Since the focus of this project is to develop the health policy using the evidence from the literature, project succession and future direction must focus on implementing the health policy

in a mental health clinical unit. Notwithstanding, the implication is that it is better to use the SEASA tool to know the level of patient self-efficacy that may enable them to avoid suicidal action upon discharge and to use the recommendation on the policy to guide discharge disposition.

References

American Foundation for Suicidal Prevention. (2021) *AFSP Minnesota.* https://afsp.org/chapter/minnesota

America's Health Ranking. (2021). *Suicide.* https://www.americashealthrankings.org/explore/annual/measure/Suicide/state/ALL

Appraisal of Guidelines for Research & Evaluation II. (2017). AGREE II Instrument. https://www.agreetrust.org/wp-content/uploads/2017/12/AGREE-II-Users-Manual-and-23-item-Instrument-2009-Update-2017.pdf

Augustine, J. J. (2020) By the Numbers: Mental Health Visits Are Increasing https://www.acepnow.com/article/by-the-numbers-mental-health-visits-are-increasing/

Banerjee, D., Kosagisharaf, J. R., & Sathyanarayana Rao, T. S. (2021). 'The dual pandemic' of suicide and COVID-19: A biopsychosocial narrative of risks and prevention. *Psychiatry Research*, *295*, 113577. https://doi.org/10.1016/j.psychres.2020.113577

Canady, V. A. (2016). Economic costs of suicides and attempts higher than previous estimates. *Mental Health Weekly*, *26*(15), 1–7. https://doi-org.akin.css.edu/10.1002/mhw.30571

Cammer, M. (2016, November 16). Pathophysiology of Suicide. Retrieved from https://prezi.com/ivsqojvp778m/pathophysiology-of-suicide/

Centers for Disease Control and Prevention. (2021). *FastStats – Suicide and Self-Inflicted Injury.* https://www.cdc.gov/nchs/fastats/suicide.htm.

Centers for Disease Control and Prevention. (2021a). *Leading Causes of Death.* https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm

Centers for Disease Control and Prevention. (2021b). *Fast Facts*

https://www.cdc.gov/suicide/facts/index.html

Cepeda, M. S., Schuemie, M., Kern, D. M., Reps, J., & Canuso, C. (2020). Frequency of rehospitalization after hospitalization for suicidal ideation or suicidal behavior in patients with depression. *Psychiatry Research*, *285*, 112810. https://doi.org/10.1016/j.psychres.2020.112810

Chung, D. T., Ryan, C. J., & Hadzi-Pavlovic, D. (2017). Suicide rates after discharge from psychiatric facilities: a systematic review and meta-analysis. *JAMA Psychiatry*, *74*(7), 694.

College Factual. (2021) *The College of Saint Scholastica.* https://www.collegefactual.com/colleges/the-college-of-saint-scholastica/student-life/diversity/chart-graduate-students-racial-ethnic-diversity.html

Crain, W. C. (2016). *Theories of development: concepts and applications* (6th ed.). London: Routledge, Taylor & Francis Group

Czyz, E. K., Bohnert, A. S., King, C. A., Price, A. M., Kleinberg, F., & Ilgen, M. A. (2014). Self-efficacy to avoid suicidal action: factor structure and convergent validity among adults in substance use disorder treatment. *Suicide & Life-Threatening Behavior*, *44*, 698–709. Doi:10.1111/sltb.12101

Czyz, E. K., Berona, J., & King, C. A. (2016). Rehospitalization of Suicidal Adolescents in Relation to Course of Suicidal Ideation and Future Suicide Attempts. *Psychiatric Services*, *67*(3), 332–338. https://doi.org/10.1176/appi.ps.201400252

Daruwala, S. E., LaCroix, J. M., Perera, K. U., Tucker, J., Colborn, V., Weaver, J., …Ghahramanlou-Holloway, M. (2018). Suicide ideation and self-efficacy to avoid Suicidal action among psychiatrically hospitalized military personnel. *Psychiatry*

*Research,* 270, 1131–1136. https://doi-org.akin.css.edu/10.1016/j.psychres.2018.10.023

De Beurs, D., Fried, E. I., Wetherall, K., Cleare, S., O' Connor, D. B., Ferguson, E., O'Carroll, R. E., & O' Connor, R. C. (2019). Exploring the psychology of suicidal ideation: A theory driven network analysis. *Behaviour Research and Therapy*, *120*, 103419. https://doi.org/10.1016/j.brat.2019.103419

Doran, C. M., Ling, R., Gullestrup, J., Swannell, S., & Milner, A. (2016). The Impact of a Suicide Prevention Strategy on Reducing the Economic Cost of Suicide in the New South Wales Construction Industry. *Crisis*, *37*(2), 121–129. https://doi.org/10.1027/0227-5910/a000362

Gao, T., & Gurd, B. (2019). Hospital size. Chart. *BMC Health Services Research*, 19(1), 6. https://doi-org.akin.css.edu/10.1186/s12913-019-3907-6

Graves, J. M., Mackelprang, J. L., Van Natta, S. E., & Holliday, C. (2018). Suicide Prevention Training: Policies for Health Care Professionals across the United States as of October 2017. *American Journal of Public Health*, *108*(6), 760–768. https://doi-org.akin.css.edu/10.2105/AJPH.2018.304373

Hasking, P. (2017). Differentiating non-suicidal self-injury and risky drinking: A role for outcome expectancies and self-efficacy beliefs. *Prevention Science: The Official Journal of The Society for Prevention Research*, 18, 694–703. https://doi-org.akin.css.edu/10.1007/s11121-017-0755-7

Heydari, A., Dashtgard, A., & Moghadam, Z. E. (2014). The effect of Bandura's social cognitive theory implementation on addiction quitting of clients referred to addiction quitting clinics. *Iranian Journal of Nursing and Midwifery Research*, *19*(1), 19–23.

Holliday, S. B. (2018, March 2). The relationship between mental health care access and suicide.

https://www.rand.org/research/gun-policy/analysis/essays/mental-health-access-and-suicide.html.

Mind. (2021). *Suicidal Feelings*. https://www.mind.org.uk/information-support/types-of-mental-health-problems/suicidal-feelings/causes-of-suicidal-feelings/

National Action Alliance for Suicide Prevention. (2019). *Best practices in care transitions for individuals with suicide risk: Inpatient care to outpatient care.* https://www.samhsa.gov/sites/default/files/suicide-risk-practices-in-care-transitions-11192019.pdf

National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. (2018). Recommended standard care for people with suicide risk: Making health care suicide safe. https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf

National Institute of Mental Health. (n.d). *Suicide.* https://www.nimh.nih.gov/health/statistics/suicide.shtml

NHS Education for Scotland. (2021). *Quality Improvement Zone.* https://learn.nes.nhs.scot/4046/quality-improvement-zone/qi-tools/histogram

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; & Mann, J. (2008) Columbia-Suicide Severity Rating Scale. https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf

Sheffler, J. L., Joiner, T. E., & Sachs-Ericsson, N. J. (2021). The Interpersonal and Psychological Impacts of COVID-19 on Risk for Late-Life Suicide. *Gerontologist*, *61*(1), 23–29. https://doi-org.akin.css.edu/10.1093/geront/gnaa103

Sollecito, W. A, & Hardison, D. (2020). Understanding variation, tools, and data sources for CQI in health care. In J. K. Johnson & W. A. Sollecito (Eds.), *McLaughlin and Kaluznys continuous quality improvement in health care.* (5th ed., pp. 107-142). Burlington, MA: Jones & Bartlett Learning

Suicide Awareness Voice of Education. (2021). *Suicide Facts*. https://save.org/about-suicide/suicide-facts/

Suicide Facts & Figures: Minnesota 2020. (n.d). Retrieved from https://aws-fetch.s3.amazonaws.com/state-fact-sheets/2020/2020-state-fact-sheets-minnesota.pdf

Suicide Prevention Resource Center. (2020). *Costs of Suicide.* https://www.sprc.org/about-suicide/costs

The College of St. Scholastica. (2021) *Mission Statement*. https://www.css.edu/about/mission-and-values/

Wulfert, E. (2019). Social learning according to Albert Bandura. *Salem Press Encyclopedia of Health.*

## APPENDIX A: LITERATURE MATRIX TABLE

| Reference | Purpose/Question | Design | Sample | Intervention | Results | Notes |
|---|---|---|---|---|---|---|
| De Beurs, D., Fried, E., Wetherall, K., Cleare, S., O' Connor, D., Ferguson, E., . . . O' Connor, R. (2019). Exploring the psychology of suicidal ideation: A theory driven network analysis. *Behaviour Research and Therapy,120*, 103419. doi:10.1016/j.brat.2019.103419 | To use psychological theories to understands suicidal ideation. | Cross-sectional data | Includes 3508 young adults (18–34 years) that completed a battery of psychologic . . al measures. | Interviews using Computer Assisted Personal Interviewing (CAPI) and including a Computer Assisted Self Interviewing (CASI) module | The result confirms that suicide ideation is the result of the interplay of many different factors, of which some have a direct relationship with suicide ideation and others an indirect relationship | Will be used as framework |
| Lucht, L., Höller, I., Forkmann, T., Teismann, T., Schönfelder, A., Rath, D., Paashaus, L., Stengler, K., Juckel, G., & Glaesmer, H. (2020). Validation of the motivational phase of the integrated motivational-volitional model of | The aim of this study was to test the motivational phase of the IMV model cross-sectionally in a German sample of psychiatric inpatients. | A cross-sectional study | A total of 308 psychiatric inpatients (53% female) aged 18 to 81 years ($M$ = 36.92, $SD$ = 14.30) were included in the study and investigated within 14 days after psychiatric admission due to suicide attempt (53%) or acute suicidal crisis (47%). | Psychiatric inpatients were interviewed on Beck scale for suicide ideation, German version of the interpersonal needs questionnaire, German version of the defeat scale, German version of the entrapment scale within 14 days after admission to a psychiatric ward due to attempted suicide or acute suicidal crisis. | Results demonstrate a simple mediation of defeat via entrapment (total, internal and external entrapment) on suicidal ideation. The interaction between thwarted belongingness and perceived burdensomeness was confirmed as | Additional resources as a framework |

| | | | | | | |
|---|---|---|---|---|---|---|
| suicidal behavior in a German high-risk sample. *Journal of Affective Disorders*, *274*, 871–879. https://doi-org.akin.css.edu/10.1016/j.jad.2020.05.079 | | | | | a motivational moderator. | |
| Czyz, E. K., Bohnert, A. S., King, C. A., Price, A. M., Kleinberg, F., & Ilgen, M. A. (2014). Self-efficacy to avoid suicidal action: factor structure and convergent validity among adults in substance use disorder treatment. *Suicide & Life-Threatening Behavior*, *44*, 698–709. doi:10.1111/sltb.12101 | The purpose of this article is to provide psychometric data about a new scale, the Self-Efficacy to Avoid Suicidal Action (SEASA), designed to assess perception of one's capacity to refrain from attempting suicide. | Data were collected from 2008 to 2009 as part of a pilot randomized controlled trial of a cognitive behavioral intervention designed to address suicide risk in adults with SUDs led by one of the coauthors | Participants included 305 men (65.73%) and 159 women (34.27%) over 18 years of age (M = 34.59; SD = 0.51) enrolled in a residential substance use disorder treatment program in southeastern Michigan. The racial/ethnic composition of the sample included 286 (61.64%) Caucasian, 133 (28.66%) African American, 17 (3.66%) Hispanic/Latino, 14 (3.02%) American Indian, and 3 Asian (0.65%) participants; 10 (2.16%) participants self-identified as "Other." Approximately 64% of participants were unemployed, 16% were unemployed due to disability, 18% were employed full- or part time, and 1% were retired. | Psychometric data about the Self-Efficacy to Avoid Suicidal Action (SEASA) Scale within a sample of adults seeking SUD treatment (N = 464) is provided. | Approximately 19% of participants (n = 88) reported one previous suicide attempt in their lifetime and 14% (n = 64) two or more attempts. A total of 103 (22.20%) participants reported current suicidal ideation, defined as the active desire to kill oneself or unwillingness to take steps to avoid death in a life- | Will be used for intervention |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | threatening situation | |

| Reference | Purpose/Question | Design | Sample | Intervention | Results | Notes |
|---|---|---|---|---|---|---|
| Canady, V. A. (2016). Economic costs of suicides and attempts higher than previous estimates. *Mental Health Weekly*, *26*(15), 1–7. https://doi-org.akin.css.edu/10.1002/mhw.30571 | To show lawmakers that economic costs of suicides and attempts are higher than previous estimates | Researchers incorporated the variation in costs among states with publicly available age- and gender specific numbers of fatal and nonfatal suicide-related injuries | According to researchers, the comparison between the SAMHSA survey data and official reporting by the CDC suggests that even the increasing official statistics underestimate the full magnitude of this problem. | To look at the indirect effects of suicide attempts, the lost time on jobs, hospital and ER costs, and costs involved in transporting individuals from home [following suicide] attempts and taking them to hospitals and emergency rooms. | The estimates by researchers incorporated several methodological refinements over previous studies, they said. The $93.5 billion estimate of the 2013 national cost of suicide and suicide attempts, adjusted for underreporting, is 2.1 times the latest previous study — the CDC's estimate for 2010 of $44.7 billion. The researchers' 2013 estimate is 2.8 times the latest comprehensive peer-reviewed publication | Will be used for problem consequences |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | of $33.3 billion for 2000. | |
| Graves, J. M., Mackelprang, J. L., Van Natta, S. E., & Holliday, C. (2018). Suicide Prevention Training: Policies for Health Care Professionals across the United States as of October 2017. *American Journal of Public Health*, *108*(6), 760–768. https://doi-org.akin.css.edu/10.2105/AJPH.2018.304373 | To identify and compare state policies for suicide prevention training among health care professionals across the United States and benchmark state plan updates against national recommendations set by the surgeon general and the National Action Alliance for Suicide Prevention in 2012. | Descriptive design study methodology | These included psychiatrists, psychologists, social workers, counselors, behavior analysts, psychiatric and mental health nurse practitioners, and occupational therapists. General health care professionals included physicians, nurse practitioners, certified nurse specialists, physician assistants, certified nurse midwives, certified registered nurse anesthetists, physical therapists, medical assistants, licensed practical nurses, and registered nurses. | To document the status of state suicide prevention plans across the United States and examined policies mandating suicide prevention training for health care professionals. | The result revealed that in the United States, as of October 9, 2017, 10 (20%) states had passed legislation mandating health care professionals complete suicide prevention training, and 7 (14%) had policies encouraging training. | Additional resources for problem consequences |
| Cepeda, M. S., Schuemie, M., Kern, D. M., Reps, J., & Canuso, C. (2020). Frequency of | To determine the frequency of rehospitalization with diagnosis of suicidal ideation or suicide attempt (SI/SA) within a year and how often patients had multiple | Conducted a retrospective cohort study of adults with depression using 4 US health claims databases. | Included patients 18 years or older with a prior diagnosis of depressive disorder and with 180 days of continuous prior observation in the database. The three most common included disorders were: major | Calculated rates of rehospitalization monthly by counting the patients at risk during that month and the number of patients who had a rehospitalization. We report the rate of hospitalization for | We found that the frequency of rehospitalization within a year ranged from 7.96% to 11.24%. | Will be used for problem identification |

| | | | | | | |
|---|---|---|---|---|---|---|
| rehospitalization after hospitalization for suicidal ideation or suicidal behavior in patients with depression. *Psychiatry Research, 285*, 112810. https://doi.org/10.1016/j.psychres.2020.112810 | rehospitalizations; 2. To identify the time period for which the risk of rehospitalization is highest; and 3. To determine the characteristics of patients with multiple rehospitalizations | | depression, single episode, moderate recurrent major depression and depressive disorder. We excluded people with psychosis, schizophrenia, bipolar disorder, or dementia. | each month and the entire year. The number of patients who had 2 or more rehospitalizations was also calculated. Additionally, we calculated rates of rehospitalization within a year separately for SI and for suicidal behavior. | The risk of having a rehospitalization with SI or SA was highest during the first month after the initial hospitalization, and around 50% of hospitalizations with SI or suicidal behaviors occurred during the first 3 months after the initial hospitalization. | |
| Banerjee, D., Kosagisharaf, J. R., & Sathyanarayana Rao, T. S. (2021). 'The dual pandemic' of suicide and COVID-19: A biopsychosocial narrative of risks and prevention. *Psychiatry Research, 2* | To draw global perspectives on the association of suicidality and pandemics, and to hypothesizes neuroimmunity and immune based risk factors as possible links between the psychosocial vulnerabilities and suicide during outbreaks like COVID-19. | Narrative reviews | Comparing the case fatality rate of Covid 19 with Severe Acute Respiratory Syndrome, SARS and Middle East Respiratory Syndrome MERS, the Spanish Flu of 1918-19, and the Ebola infection. | Propositions of increased suicidal risk during pandemics based on the theories of suicide. Proposition of risk factors and contributors for suicide during pandemics. Proposition of suicide prevention strategies during pandemics. | Suicide itself is considered to be a pandemic. Suicide prevention by early detection of risks is the main strategy. Suicide prevention responses need to be comprehensive and they need to be backed up | Will be used for problem significance |

| | | | | | | |
|---|---|---|---|---|---|---|
| *95*, 113577. https://doi.org/10.1016/j.psychres.2020.113577 | | | | | by increased surveillance of COVID-19 specific risk factors | |
| **Reference** | **Purpose/Question** | **Design** | **Sample** | **Intervention** | **Results** | **Notes** |
| Daruwala, S. E., LaCroix, J. M., Perera, K. U., Tucker, J., Colborn, V., Weaver, J., … Ghahramanlou-Holloway, M. (2018). Suicide ideation and self-efficacy to avoid suicidal action among psychiatrically hospitalized military personnel. *Psychiatry Research*, *270*, 1131–1136. https://doi org.akin.css.edu/10.1016/j.psychres.2018.10.023 | The goal of this study was to explore the link between suicide ideation and self-efficacy to avoid suicidal action among a high-risk group of psychiatric inpatients. | Randomized controlled trial | As of June 2017, 373 patients were eligible for the study, of which 222 consented, and 172 were enrolled and randomized to a treatment condition As of June 2017, 373 patients were eligible for the study, of which 222 consented, and 172 were enrolled and randomized to a treatment condition | Assessment of Self-Efficacy to avoid suicidal action (SEASA), The 19-item Scale for Suicide Ideation, The Columbia Suicide Severity Rating Scale | Results indicated that more severe suicide ideation at the worst time point was significantly associated with lower levels of self-efficacy among military personnel psychiatrically hospitalized following a suicidal crisis. Individuals reporting some current suicide ideation also reported significantly lower levels of self-efficacy than those reporting no current | Will be used for intervention |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | suicide ideation, and individuals with a history of multiple actual, interrupted, and/or aborted suicide attempts reported significantly lower levels of self-efficacy than individuals with a single lifetime attempt. | |
| Hasking, P. (2017). Differentiating non-suicidal self-injury and risky drinking: A role for outcome expectancies and self-efficacy beliefs. *Prevention Science: The Official Journal of The Society For Prevention* | This is a study that apply social cognitive theory to explore how outcome expectancies and self-efficacy expectancies differentially relate to non-suicidal self-injury (NSSI) and risky alcohol use amongst a sample of young adults | Survey design study | The samplecomprised389 undergraduate students (283 females) aged between 18 and 30 years (M = 20.90, SD = 2.36). | Participants' completed Section I of the Inventory of Statements About Self-Injury, Alcohol Use Disorders Identification Test, NSSI Expectancy Questionnaire, Self-Efficacy to Avoid Suicidal Action, Drinking Expectancy Questionnaire—Revised, Drinking Refusal Self-Efficacy Questionnaire—Revised, and Depression Anxiety Stress Scales | Elevated ability to resist drinking in opportunistic circumstances, but reduced self-efficacy to resist for emotional relief, and in social situations were associated with risky drinking. Being aware that people | Additional resources for intervention |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Research*, 18, 694–703. https://doi-org.akin.css.edu/10.1007/s11121-017-0755-7 | | | | | hold outcome and self-efficacy expectancies—specifically related to NSSI—provides another as yet untested avenue for clinicians to explore when addressing NSSI. | |
| Heydari, A., Dashtgard, A., & Moghadam, Z. E. (2014). The effect of Bandura's social cognitive theory implementation on addiction quitting of clients referred to addiction quitting clinics. *Iranian journal of nursing and midwifery research,* | This study was conducted with an aim to examine the effect of Bandura's social cognitive theory implementation on addiction quitting of clients referred to Imam Reza Hospital addiction quitting clinic. | This experimental study is a before-after two-group design. | Sixty eligible addict clients were selected from Imam Reza Hospital clinic in Mashhad, Iran. Addiction confirmation by physician, history of addiction less than 10 years, lack of recurrence more than two times, no drug dependency other than opium, and no chronic and psychiatric disease were the study eligibly criteria. The clients were assigned randomly to two groups of test and control (30 each for test and control groups). | Intervention was carried out for the test group based on Bandura's social cognitive theory during eight 60-90 min sessions according to the steps of the model, which were run by group discussion | The findings of the study showed that implementing educational program based on Bandura's theory had a significant effect on successful quitting.<br><br>Findings reveal that as both cigarette smoking and addiction are behavioral disorders, high self- | Additional resources for intervention |

| | | | | | | |
|---|---|---|---|---|---|---|
| *19*(1), 19–23. | | | | | efficacy could lead to increased quitting and prevention of recurrence of these disorders. | |
| **Reference** | **Purpose/Question** | **Design** | **Sample** | **Intervention** | **Results** | **Notes** |
| Chung, D. T., Ryan, C. J., & Hadzi-Pavlovic, D. (2017). Suicide rates after discharge from psychiatric facilities: a systematic review and meta-analysis. *JAMA Psychiatry*, *74*(7), 694. | To quantify the rates of suicide after discharge from psychiatric facilities and examine what moderates those rates.<br><br>What is the suicide rate after discharge from psychiatric facilities, and what factors influence it? | The meta-analysis adhered to Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) and Meta-analysis of Observational Studies in Epidemiology (MOOSE) guidelines. | The 100 studies with 183 samples reported 17 857 suicides during 4 725 445 person-years | Using random-effects model was used to calculate a pooled estimate of post discharge suicides per 100 000 person-years. | The immediate post discharge period is a time of marked risk, but rates of suicide remain high for many years after discharge. Patients admitted because of suicidal ideas or behaviors and those in the first months after discharge should be a particular focus of concern. Previously admitted patients should be able to access long-term care | Will be use in the problem section |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | and assistance. | |
| | | | | | | |
| **Reference** | **Purpose/Question** | **Design** | **Sample** | **Intervention** | **Results** | **Notes** |
| Czyz, E. K., Berona, J., & King, C. A. (2016). Rehospitalization of Suicidal Adolescents in Relation to Course of Suicidal Ideation and Future Suicide Attempts. *Psychiatric Services*, *67* (3), 332–338. https://doi.org/10.1176/appi.ps.201400252 | This study examined the association between rehospitalization within three months of index hospitalization and subsequent suicide attempts and suicidal ideation among adolescents. | Randomized clinical trial of a psychosocial intervention | Participants were 373 youths (13–17 years old) hospitalized because of suicide risk, and they were followed for one year. | Using Cox regression, the investigators examined rehospitalization within three months of index hospitalization as a predictor of time to suicide attempt during the subsequent nine months. Using latent-class growth modeling, they also examined whether rehospitalization predicted a change in the nine-month course of three suicidal ideation trajectories (subclinical, elevated but fast declining, and chronically elevated). | Rehospitalization predicted a more severe course of suicide ideation for most of the adolescents, but it was protective for only a smaller subgroup with subclinical levels of ideation at index hospitalization. Our findings also suggest that rehospitalization is a strong indicator of future risk of suicide attempt. These findings | Will be use in the problem section. Also, will use this article in the Need and Gap section. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | have important implications for intervening with rehospitalized adolescents. | |
| Doran, C. M., Ling, R., Gullestrup, J., Swannell, S., & Milner, A. (2016). The Impact of a Suicide Prevention Strategy on Reducing the Economic Cost of Suicide in the New South Wales Construction Industry. *Crisis*, *37*(2), 121–129. https://doi.org/10.1027/0227-5910/a000362 | To quantify the eco- nomic cost of self-harm and suicide among New South Wales (NSW) construction industry (CI) workers and to examine the potential economic impact of implementing Mates in Construction (MIC). | Suicide data were obtained from the National Coronial In- formation System (NCIS) for the period 2001–2012. | Only male subjects were included in this study because of the small numbers of women in the CI who suicided and con- sequent confidentiality issues with reporting small sample sizes. | The potential economic impact of implementing MIC in the NSW CI is derived by comparing the economic sav- ings from fewer suicide and suicide attempts with the cost of implementing the program. | The CI is the fourth major contributor to Australia's eco- nomic output at over AU $100 billion each year, close to 8% of gross domestic product (Australian Bureau of Sta- tistics, 2012). Our analysis has quantified the average cost of a CI male worker dying from suicide at AU $2.14 mil- lion, with each worker losing an average of 27.3 years of potential productive employment | Will be use in the prob lem secti on |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | and 42 years of potential life lost. The total economic cost of suicide and suicide behavior to the NSW CI alone was estimated at AU $527 million in 2010. | |

## Appendix B: SEASA ASSESSMENT FORM

**Figure 1**: *SEASA Form*

Please read each of the statements below carefully and circle the number which best fits how certain you are about how you would act in each of the following situations

| | Very uncertain | | | | | | | | | Very certain |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. How certain are you that you will not attempt suicide in the future? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 2. If at some point in the future you had suicidal thoughts, how certain are you that you could resist making a suicide attempt? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 3. If at some point in the future you had suicidal thoughts, how certain are you that you could resist making a suicide attempt if you were using alcohol or other drugs? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 4. How certain are you that you could control future thoughts of suicide if you were experiencing physical pain? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 5. How certain are you that you could control future suicidal thoughts if you lost an important relationship? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 6. How certain are you that you could control future suicidal thoughts if you lost a job, could not find employment, or suffered a financial crisis? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

(Gao & Gurd, 2019)

## Appendix C: EVALUTION FORM

Based on your professional expertise, please answer the following questions regarding this Self-efficacy evidence-based practice policy recommendation for suicidal patient disposition.

1. Does the recommendation identify the intended patient population?

   Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

2. Does the recommendation provide information on when in the workflow process will the policy be utilized?

   Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

3. Does the document describe suicide in unambiguous term?

   Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

4. Does the recommendation describe the Self Efficacy to Avoid Suicidal Action (SEASA) instrumental scale intervention in unambiguous term?

   Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

5. Does the recommendation outline using each facility available resources to mitigate the outcome of the SEASA intervention?

   Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

6. Can I find the major recommendation of the document?

   Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

7. Does the document had clear heading headings and section to identified major topic discussed?

   Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

8. What changes would you make to this recommendation?
9. Was there enough convincing data for you to agree to this recommendation? Why or why not?
10. Does this recommendation seem feasible to implement within an adult inpatient mental health facility in the metro area Why or why not?

(AGREE II, 2017)

## Appendix D: GANNT CHART

**Table 1**

*Gantt Chart*

| Objective | December 2021 | January 2022 | February 2022 | March 2022 | April 2022 | May 2022 |
|---|---|---|---|---|---|---|
| Create Evaluation Form | | | | | | |
| Create Power Point Slide | | | | | | |
| Create SEASA Policy | | | | | | |
| Meeting with Participants | | | | | | |
| Send project document to participant for evaluation | | | | | | |
| Received Evaluation document from Participants | | | | | | |
| Resend project document to participants for 2nd Evaluation | | | | | | |
| Received 2nd Evaluation Form & Data Evaluation and Policy Revision | | | | | | |
| Complete Project Implementation Manuscript | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Present and Defend Project Implementation to CSS | | | | | | |

# Appendix D: LOGIC MOEL

## Table 2

*Logic Model*

**Logic Model Visual Representation**

**Implementing SEASA Risk Tool Policy**
Oluwasegun David

**Program:** Implementation of a policy for inpatient suicidal patient disposition using SEASA tool
**Situation:** No measures of self-efficacy to avoid suicidal action of inpatient suicidal patients at Inpatient mental health in the metro area of the state before discharges
**Goal:** Is to get inpatient mental health to use SEASA assessment tool on suicidal patients before discharges

| **Inputs** | **Outputs** | | **Outcomes -- Impact** | | |
|---|---|---|---|---|---|
| | *Activities* | *Participation* | *Short* | *Medium* | *Long* |
| DNP Timeline and Curriculum:<br><br>**Time invested by:**<br><br>*Project leader<br>*Professional expert<br><br>**Constraints:**<br>*Time frame<br>*Professional expert agreement and cooperation | *Baseline Data of Literature review<br><br>*Develop educational PowerPoint presentation<br><br>*Develop SEASA Policy and guidelines for suicidal patients' disposition.<br><br>*Train professional experts on the use of SEASA tool policy guideline.<br><br>*Professional experts to evaluate the policy<br><br>*Review and follow up on the evaluation of the professional experts | *Project leader<br><br>*Professional experts | *Increase facility awareness of SEASA tool policy<br><br>*Ascertain suicidal patient SEASA risk<br><br>*Leads to meaningful use of discharge disposition of suicidal patients. | *Decreases patients rate of suicide or suicidal action after discharges<br><br>*Decreases the rate of patients 30-days rehospitalization after discharges<br><br>*Decreases Healthcare expenditures | *Increases patients' quality of life<br><br>*Increases patient's productivity<br><br>*Increases overall patients' self-efficacy |

**Assumptions:**
*Assumes inpatient mental health facility would like to measure the SEASA risk of their patient.
*Assumes healthcare providers will see the need to implement the SEASA risk assessment tool
*Assumes social workers will use SEASA risk score in their patient's disposition placement

**External Factors:**
*DNP Timeline
*Facility approval of implementing SEASA policy
*Staff compliance with SEASA assessment tool

# APPENDIX E: HEALTH POLICY

Oluwasegun David

RN, PMHNP DNP Student

The College of St Scholastica

***An Inpatient Mental Health Policy for Discharge Disposition of Suicidal Patient***

*Title:* **Utilizing the Self Efficacy to Avoid Suicidal Action Tool to Recommend a Policy for Disposition of Suicidal Patient in any Adult (18 - 75 years old) Inpatient Mental Health Unit**

*Date*: **January 27, 2022**

*Organization/Department:* ***Minnesota Inpatient Mental Health***

*Audience details:* **Mental Health Providers, Social Workers, Registered Nurses, Nursing Managers, and Academic Personnel**

## SITUATION/SUMMARY

- Suicide is a serious, common, epidemic, and yet preventable event.[7]
- Research confirms that identification of at-risk inpatient suicidal patient before discharge is warranted for best discharge disposition.[3]
- Nurses should be educated and supported to use Self-Efficacy to Avoid Suicidal Action (SEASA) tool to assess inpatient mental health patient before discharge.
- Inpatient mental health patient who scored 18 or less on SEASA assessment tool is at high risk for suicide after discharge
- Inpatient mental health providers are encouraged to mitigate high risk suicidal patient with appropriate discharge disposition.

## BACKGROUND

### *Suicide*

- *Suicide* is an intentional or voluntary act of taking one's own life from the belief that doing so will solve any present and pressing emotional pain or conflicts.[1]

- The manifestation of suicide may be isolation, hopelessness, mood changes, withdrawal, pessimism, preoccupation with death, and impulsivity.[1]

- Suicide is an epidemic in the United States (U.S.) and is the 10th leading cause of death.[8]

- The rate of rehospitalization of suicide ideation (SI) or suicide attempt (SA) is about 11%.[2]

- The risk is even higher in the first month, with about 50% of the rehospitalization rate happening in the first three months of discharge.[2]

- Over twenty-five percent of suicide actions occurs in the first month after discharge from hospital, the rate increases to over forty percent within three months, and over seventy percent within one year.[6]

- Suicidal patients discharging from the mental health unit have a suicide death rate that is 300 times higher in the first week.[11]

- Suicidal patients discharging from the mental health unit have a 200 times higher suicide death rate in the first month than the general community who has not undergo inpatient treatment for SI/SA in the same period.[11]

***Self-Efficacy to Avoid Suicidal Action (SEASA)***

- The SEASA is a validated six-item questionnaire with a score of 6 or less indicating severe risk, 12 – 24 indicating high risk, 30 – 42 indicating a medium risk, and 48 – 54 indicating a low risk for suicide actions.
- SEASA is a psychometric tool designed to assess the perception of one's capacity or self-efficacy to refrain from attempting or engaging in suicide when in crisis.[3]
- SEASA measures a patient's level of self-efficacy which has been shown in the literature to influence suicidal action in those individuals who are at a known risk for suicide.[4]
- The severity of all suicidal behaviors is related to lower SEASA scores.[3]
- Lower SEASA is not only significantly associated with a severe form of suicidal ideation but could lead to multiple suicide attempts.[4]
- SEASA scale was significantly correlated with **suicidal** ideation as measured by Beck Suicidal Scale (BSS) in the expected direction with $p < .0001$ in identifying patient at risk for suicide action.[3]

## ASSESSMENT

- Currently, most mental health administrators, social workers and clinicians use their own personal judgement and intuition to decide the disposition of a patient in adult (18 - 75 years old) mental health unit who was admitted with SI or SA.
- Many facilities do not have an instrumental scale to predict a patient's future suicide attempt once they are discharge.

- Some people may develop suicide ideation because they have been defeated and trapped by overwhelming, painful thoughts and feelings and lack of social support from the triggers.[5]
- There is a relationship between entrapment and defeat, leading to suicidal ideation of the admitted patients to the hospital.[9]
- The following are SEASA questionnaire:[7]
  i. How certain are you that you will not attempt suicide in the future?
  ii. If at some point in the future you had suicidal thoughts, how certain are you that you could resist making a suicide attempt?
  iii. If at some point in the future you had suicidal thoughts, how certain are you that you could resist making a suicide attempt if you were using alcohol or other drugs?
  iv. How certain are you that you could control future thoughts of suicide if you were experiencing physical pain?
  v. How certain are you that you could control future thoughts of suicide if you lost an important relationship?
  vi. How certain are you that you could control future suicide thoughts if you lost a job, could not find employment, or suffered a financial crisis?

- **Intensive Residential Treatment Services (IRST):** This program is mainly set up for those who need psychiatry stability, personal and emotional adjustment, independent living skills development, and self-sufficiency.[10] It is a long-term 24-hour structured program that offers mental health services for no more than 90 days in a residential setting.[10]
  - It offers crisis assistance, and crisis prevention plans, and assistance with transition to community-based services and housing.[10]
- **Residential Crisis Stabilization (RCS):** is a residence that offers 24 hours of stabilization for a patient in crisis, particularly those who do not meet the criteria for acute inpatient treatment but still need assistance for transitioning to the community.[10]
  - These patients could benefit from connecting with a case manager and setting up outpatient services.[10]
  - The patient also benefits from supportive counseling and skills training related to the crisis.[10]

## RECOMMENDATION

- SEASA assessment tool will inform the treatment team of the needs of a suicidal patient since it provides specific information about the level of patient self-efficacy that will result in suicidal behavior.[4]
- This recommendation is for policy purpose, actual implementation of the SEASA in practice can be another project on its own.
- Inpatient mental health unit would adopt the use of SEASA instrumental scale.
- Mental health providers and administrators would educate registered nurses on using SEASA scale to assess patient's risk before discharge.
- Social worker and mental health providers would use SEASA score in the decision making of discharge disposition of suicidal patients.

- This recommendation will use the pre-existing available community resources of the facility such as IRTS and RCS as an intervention to mitigate the outcome of the SEASA assessment.
- A score of 6 or less on the SEASA instrumental scale indicated severe-risk patient and the recommendation is to delayed discharge and have the patient remain in the hospital for further stability.
- A score of 12 - 24 on the SEASA instrumental scale indicated high-risk patient and the recommendation is to discharge to IRTS.
- A score of 30 – 42 on the SEASA instrumental scale indicates medium risk patient and the recommendation is to discharge to RCS.
- A score of 48 or more on the SEASA instrumental scale indicated low-risk patient and the recommendation is to discharge to home.
- Since IRTS & RCS are some of the available options to which patients can be discharged, the attending provider writes the referral order.
- The social worker is to follow through on the referral order written by the provider to ensure the patient is placed in that facility.
- At the time of discharge, if the recommended SEASA disposition facility is not available, the patient could continue to wait in the hospital until a bed is available.
- To ensure completion of the SEASA instrumental scale, upon admission to the unit, the assessment form is recommended to be put in the electronic medical record as part of the after-visit summary and discharge checklist.

**Discharge Disposition Recommendations Table:**

| **SEASA Score** | **Disposition Recommendations** | **Rationale** |
|---|---|---|
| 0 – 6 (Severe Risk) | **Involuntary hospitalization** (Delayed Discharge) | The Patient is still medically/psychiatrically unstable to have insight into their condition and be relatively safe for discharge. |
| 12 – 24 (High Risk) | Intensive Residential Treatment Services **(IRTS)** | The Patient has an insight into their condition. Need outpatient psychiatry stability. Will benefit from personal and emotional adjustment, independent living skills development, and self-sufficiency assistance. |
| 30 – 42 (Medium Risk) | Residential Crisis Stabilization **(RCS)** | Relatively psychiatrically stable but still need assistance for transitioning to the community. Will benefit from supportive counseling, skill training, case manager |

| | | |
|---|---|---|
| | | connection, and setting up outpatient appointments. |
| 48 – 54 (Low Risk) | **Home** | Medically and psychiatrically stable. The Patient has an insight into their condition. The Patient can articulate and have contingencies plan when in crisis. |

*SEASA Form*

Please read each of the statements below carefully and circle the number which best fits how certain you are about how you would act in each of the following situations

| | Very uncertain | | | | | | | | | Very certain |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. How certain are you that you will not attempt suicide in the future? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 2. If at some point in the future you had suicidal thoughts, how certain are you that you could resist making a suicide attempt? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 3. If at some point in the future you had suicidal thoughts, how certain are you that you could resist making a suicide attempt if you were using alcohol or other drugs? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 4. How certain are you that you could control future thoughts of suicide if you were experiencing physical pain? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 5. How certain are you that you could control future suicidal thoughts if you lost an important relationship? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 6. How certain are you that you could control future suicidal thoughts if you lost a job, could not find employment, or suffered a financial crisis? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

**Evidence-Based Practice Recommendation Survey**

*Based on your professional expertise, please answer the following questions regarding this document of SEASA tool to recommend a policy for disposition of suicidal patient in any adult* (18 - 75 years old) *inpatient mental health unit.*

1. Does the document identify the intended patient population?

Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

2. Does the document provide information on when in the workflow process will the policy be utilized?

Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

3. Does the document describe suicide in unambiguous term?

Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

4. Does the document describe the Self Efficacy to Avoid Suicidal Action (SEASA) instrumental scale intervention in unambiguous term?

Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

5. Does the document outline using the pre-existing available resources of each facility to mitigate the outcome of the SEASA intervention?

Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

6. Can I find the major recommendation of the document?

Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

7. Does the document had clear headings and sections to identified major topic discussed?

Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

8. What changes would you make to this recommendation?

9. Was there enough convincing data for you to agree to this recommendation? Why or why not?

10. Does this recommendation seem feasible to implement within an adult inpatient mental health facility in the metro area Why or why not?

## References

1. Cammer, M. (2016, November 16). Pathophysiology of Suicide. Retrieved from https://prezi.com/ivsqojvp778m/pathophysiology-of-suicide/

2. Cepeda, M. S., Schuemie, M., Kern, D. M., Reps, J., & Canuso, C. (2020). Frequency of rehospitalization after hospitalization for suicidal ideation or suicidal behavior in patients with depression. *Psychiatry Research, 285*, 112810. https://doi.org/10.1016/j.psychres.2020.112810

3. Czyz, E. K., Bohnert, A. S., King, C. A., Price, A. M., Kleinberg, F., & Ilgen, M. A. (2014). Self-efficacy to avoid suicidal action: factor structure and convergent validity among adults in substance use disorder treatment. *Suicide & Life-Threatening Behavior, 44*, 698–709. Doi:10.1111/sltb.12101

4. Daruwala, S. E., LaCroix, J. M., Perera, K. U., Tucker, J., Colborn, V., Weaver, J., …Ghahramanlou-Holloway, M. (2018). Suicide ideation and self-efficacy to avoid Suicidal action among psychiatrically hospitalized military personnel. *Psychiatry Research,* 270, 1131–1136. https://doi-org.akin.css.edu/10.1016/j.psychres.2018.10.023

5. De Beurs, D., Fried, E. I., Wetherall, K., Cleare, S., O' Connor, D. B., Ferguson, E., O'Carroll, R. E., & O' Connor, R. C. (2019). Exploring the psychology of suicidal ideation: A theory driven network analysis. *Behaviour Research and Therapy, 120*, 103419. https://doi.org/10.1016/j.brat.2019.103419

6. Forte, A., Buscajoni, A., Fiorillo, A., Pompili, M., & Baldessarini, R. J. (2019). Suicidal risk following hospital discharge: A Review. *Harvard Review of Psychiatry, 27*(4), 209–216. https://doi.org/10.1097/hrp.0000000000000222

7. Gao, T., & Gurd, B. (2019). Hospital size. Chart. *BMC Health Services Research*, 19(1), https://doi-org.akin.css.edu/10.1186/s12913-019-3907-6

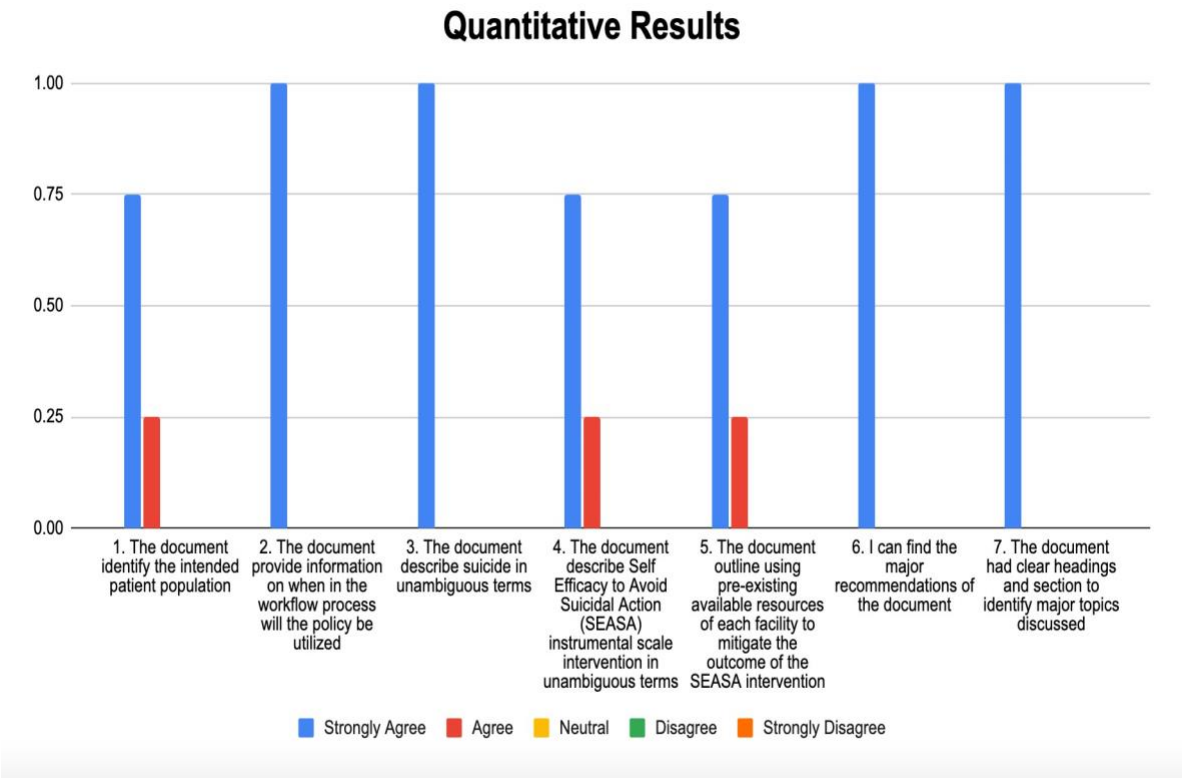
8. Graves, J. M., Mackelprang, J. L., Van Natta, S. E., & Holliday, C. (2018). Suicide Prevention Training: Policies for Health Care Professionals across the United States as of October 2017. *American Journal of Public Health*, *108*(6), 760–768. https://doi-org.akin.css.edu/10.2105/AJPH.2018.304373

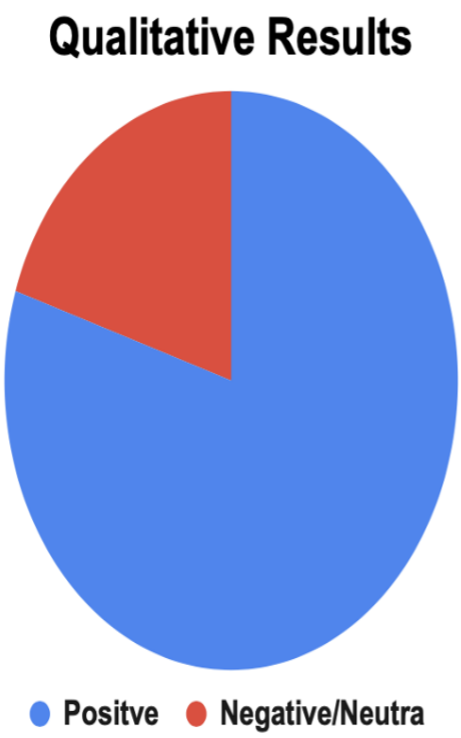
9. Lucht, L., Höller, I., Forkmann, T., Teismann, T., Schönfelder, A., Rath, D., Paashaus, L., Stengler, K., Juckel, G., & Glaesmer, H. (2020). Validation of the motivational phase of the integrated motivational-volitional model of suicidal behavior in a German high-risk sample. *Journal of Affective Disorders*, *274*, 871–879. https://doi-org.akin.css.edu/10.1016/j.jad.2020.05.079

*10.* Minnesota Department of Human Services. (2019). *Adult Mental Health Residential Treatment Services.* https://mn.gov/dhs/people-we-serve/people-with-disabilities/health-care/adult-mental-health/programs-services/irts.jsp

*11*. National Action Alliance for Suicide Prevention. (2019). *Best practices in care transitions for individuals with suicide risk: Inpatient care to outpatient care.* https://www.samhsa.gov/sites/default/files/suicide-risk-practices-in-care-transitions-11192019.pdf

## APPENDIX F: RESULT BAR & PIE CHART






8. What changes would you make to this recommendation

9. Was there not enough convincing data for you to agree to this recommendation? Why or why not?

10. Does this recommendation seem feasible to implement within an adult inpatient mental health facility in the metro area? Why or why not?

**"Yes. I think it makes for a good guideline."**

**"Yes. The information presented is thorough and clearly outlined in an understandable manner. Given the lack of instrumental scales to evaluate suicidal ideation at many facilities, this tool could provide many beneficial outcomes"**

**"Yes. However, the one element that could be a hindrance is patient's willingness, but that does not change the hospital recommendation."**

## APPENDIX G: DNP PROJECT POSTER

The College of St. Scholastica

### Utilizing the Self Efficacy to Avoid Suicidal Action Tool to Recommend a Policy for Disposition of Suicidal Patient in any Adult (18 - 75 years old) Inpatient Mental Health Unit (IMHU)

Oluwasegun David, BSN, RN, BC
Project Chair: Rhea Ferry, DNP, APRN, FNP-C, NE
College of Saint Scholastica

#### Problem Statement

- Over 25% of suicide actions occurs in the first month after discharge from hospital.
- In the US, there are 48,344 suicide deaths in 2018.
- There is a suicide death every 12 hours in Minnesota.
- Currently, there is no standardize tool to predict patient future suicide attempt (SA) after discharge from the hospital.
- Currently, most clinicians use their own personal judgement to decide the disposition of a patient.

#### Methods

Initial policy revision developed based on extensive literature review.
Policy revision evaluation form based on Appraisal of Guidelines for Research & Evaluation II (AGREE II).
Email seeking feedback sent to five experts.
Five surveys received back. Experts included an RN, social worker, nurse manager, faculty academia, and psychiatrist.

#### Discussion

Strong support for the policy recommendation.
Experts agreed on the utilization of the SEASA tool.
Experts agreed on the addition of SEASA tool to the EMR
Experts agreed on patient disposition based on SEASA score

#### Purpose/Goals

To develop a policy that emphasize the utilization of the Self Efficacy to Avoid Suicidal Action (SEASA) tool at the time of discharge in adult patients (18 - 75 years old) with a history of SI in an IMHU.

#### Results

80% of the experts made their first evaluation.
100% of the expert made their second evaluation
100% of the expert added valued contribution to the policy

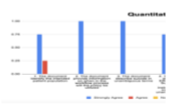
#### Conclusions

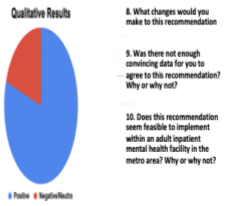
Use of the SEASA Policy will inform treatment team in IMHU on safely disposition of suicidal patients.

Future project to pursue the Implementation of the SEASA tool in an IMHU

#### References

HEALTH POLICY





**APPENDIX H: 3MT**

## APPENDIX I: IRB APPLICATION

THE COLLEGE OF ST. SCHOLASTICA
INSTITUTIONAL REVIEW BOARD
APPLICATION FORM

Research activity involving human participants will be reviewed by the College of St. Scholastica Institutional Review Board. **The Institutional Review Board policy** for review and approval of proposed research is in keeping with federal policies relative to the protection of the rights and welfare of human participants (Code of Federal Regulations 45 CFR Part 46).

Principal Investigator (and co-investigators): Oluwasegun David- Project Leader

If student project, name of faculty member who has read and approved the IRB application for this research project: Dr Rhea Ferry

Departmental/Program Affiliation: School of Nursing Doctoral Program- Psychiatric Mental Health Nurse Practitioners

Project Title: Utilizing the Self Efficacy to Avoid Suicidal Action (SEASA) Tool to Recommend a Policy Change for The Disposition of Suicidal Patient in Adult Inpatient Mental Health Facilities: A Quality Improvement Project

Respond to each item below by typing in the space provided (do not attach proposals):

1. A brief description of the research in **non-technical language**. Include in your description:
   a) the purpose or main aim of the project:

The purpose of this quality improvement project is to create a policy for a practice change that can be used on any adult inpatient mental health facility for the disposition of suicidal patients. This will be a policy that has the potential to aid a provider's assessment of the likelihood of a patient at risk for suicidal tendencies of performing suicide once discharged from an inpatient clinical setting through the determination of the patient's level of self-efficacy.
Generally, when people admitted with suicide ideation are to be discharged from an inpatient mental health hospital, there is no instrumental scale that assesses their risk of avoiding or engaging in suicidal action in the community. These patients are usually discharged to crisis residence, intensive residential treatment services (IRTS), chemical health treatment center, homeless shelter, group home, or their own home. Without a means of knowing who may be at risk of engaging in suicidal action, these patients may be discharged to a place that may not provide them with the resources they need to thrive and develop self-efficacy. Hence, the reason for this project. If this policy is adopted, nurses will assess these patients using the Self Efficacy to Avoid Suicidal Action (SEASA) tool (Gao & Gurd, 2019) (Appendix A) before discharge.

Then the provider and the social worker will be able to use the patient's SEASA risk level to find patients the appropriate discharge disposition. This action will make meaningful use of resources and prevent the patient from suicide actions.

b) definitions of key terms/concepts:

*SEASA: Self-Efficacy to Avoid Suicidal Action is a psychometric tool designed to assess the perception of one's capacity or self-efficacy to refrain from attempting or engaging in suicide when in crisis. This tool has been used in different settings, such as for adults in substance use disorder treatment centers and psychiatrically hospitalized military personnel. It can be implemented to fit any mental health setting for individuals at risk for suicide ideation because it measures a patient's level of self-efficacy which has been shown in the literature to influence suicidal action in those individuals who are at a known risk for suicide.

* Crisis: In mental health, a crisis is any situation in which a person's course of actions or patterns of behaviors causes them to be at risk of inflicting harm on themselves or others. It is also a situation whereby the harm they cause to themselves, or others prevents them from being productive and effectively caring for themselves in the community.

* Crisis Residence is a residence that offers 24 hours of stabilization for a patient in crisis, particularly those who do not meet the criteria for acute inpatient treatment but still need assistance for transitioning to the community. These patients could benefit from connecting with a case manager and setting up outpatient services.

* Intensive Residential Treatment Services (IRST): This program is mainly set up for those who need psychiatry stability, personal and emotional adjustment, independent living skills development, and self-sufficiency. It is a long-term 24-hour structured program that offers mental health services for no more than 90 days in a residential setting.

* Chemical Health Treatment: This is a type of treatment that focuses on individuals with chemical dependency, examples include opioid, alcohol, tobacco, stimulant, cannabis use disorder. These programs could be in the form of outpatient or inpatient setting, with varied duration from 28 days to 90 days.

*Homeless shelter: This service provides a temporary residence for homeless individuals for safety, economic and weather purposes.

* Group homes living: This is a kind of permanent living residence for seniors and people with disabilities that offers 24 hours supportive home environment, but not as a place of treatment or a medical facility. Those with mental health will go from this group home living for their appointment and return to it as their residence.

* Self-Efficacy: It is an integral phenomenon to someone's attitude, abilities, and cognitive skills that they could use when facing a challenge in life and could determine their resolve. It is an indication that someone could rise to the occasion and accomplish a desirable goal or succumb in self-defeat. It is generally what defines us in every situation that we will encounter. It is a phenomenon that has been used in all works of life to measure people's abilities and desires to set and accomplish their goals. So, in terms of its applicability to mental health, it measures what an individual thinks, feels, and does about a crisis. The individual with higher self-efficacy is bound to believe in their ability to exercise control in the course of action to produce a positive result, but the individual with lower self-efficacy is bound to have a negative result.

c) a statement justifying the need for this project:

The literature review of SEASA surmises clinical implications for suicide prevention when utilized in any mental health setting. This is because the SEASA assessment tool could inform the treatment team of the needs of a suicidal patient since it could provide specific information about the level of patient self-efficacy that could result in suicidal behavior (Daruwala et al., 2018).

Therefore, this tool will be justified as a process improvement project given it will inform the discharge disposition treatment plan for inpatient suicidal patients within a mental health unit prior to discharge to the community, hence addressing a gap in a clinical process.

d) a statement indicating what impact the results may have on society; provide research questions and/or hypotheses if relevant:

The project is designed to change nursing practice on a single inpatient mental health unit at a single clinical agency. It is not intended to change society. Instead, the hope is to create a sustainable, evidence-based change in health care practice within one health care unit. This quality improvement project does not pose a research question, test hypotheses, or generate generalizable knowledge. However, it will likely have a substantial economic impact on society by reducing the economic burden on the society because the financial cost of suicide and attempts continues to rise as it rose from $44.7 billion in 2010 to $93.5 billion in 2013.

e) a statement about whether this a quality improvement project or a research study with the intent to produce generalizable knowledge:

This quality improvement project is designed to change the disposition of suicidal patients in an inpatient mental health unit. This process improvement cannot be generalized and will not be implemented or applied elsewhere.

f) a declaration of whether this project is funded, and if so, provide the funding agency:

This project is not funded by any entity.

2. A description of the participants, how they will be selected, and an estimate of the total number to be recruited. Indicate explicitly whether any are vulnerable participants (e.g., minors, prisoners, elderly, disabled). Include recruitment flyers or letters with this application.

This project will involve five participants. These participants are professional experts who work either as providers, faculty members, social workers, nurse managers, or clinical administrators. These participants are not vulnerable and are individuals with whom the project leader has a professional working relationship. These participants are selected through verbal consent to participate in the project and serve as experts in mental health care and policy development. Whereby their expert opinion will influence the development of this policy in the form of policy revision feedback.

3. A description of the procedures involving the participants. In this section, be specific when explaining all activities, the participants will be asked to perform if they agree to participate in this study. This includes not only what participants will do, but when and how often; provide an estimate of the total amount time the participant will be involved in the study. Any questionnaire, survey form, interview guide, specific assessment or cover letter must be attached.

The role of the participants in this project is to evaluate the policy that the project leader will develop and provide feedback using a survey form attached below. The participants will be involved with this project for three months. The project leader will use the first month to solicit

the consent of the participants through phone conversations and email exchanges and schedule a video conference educational session with them using PowerPoint slides. The intent is to inform the selected experts in the field that they will be evaluating a policy developed by the project leader to effect a change in the disposition of suicidal patients using the SEASA instrumental scale in an inpatient or transitional adult mental health unit. The five expert participants will receive the initial drafted policy through email from the project leader for their expert evaluation in the second month. In the third month, the expert participants would have submitted their first evaluation to the project leader in the second month. In the third month, they would be receiving the revised version from the project leader based on their initial evaluation for the second review. The defined turnaround time frame to complete each evaluation will be no more than three weeks. The participants will not be left guessing as to how they will evaluate the policy, but they will use a revised evidence-based evaluation form called Appraisal of Guidelines for Research & Evaluation II (AGREE II) (AGREE II, 2017) (Appendix B)

4. A description of the benefits of the research to the human participants in the proposed study, if any, and of the benefits to human or scientific knowledge.

This quality improvement project offers no direct benefits to participants. However, patient self-efficacy to avoid suicidal action may increase once they discharge from the hospital by giving them the appropriate disposition. The provider will also be able to identify patients with higher or lower SEASA.

5. A description of the risks and discomforts, if any, to the participants. Risks or discomforts may be physical, psychological, or social. Some research involves neither risks nor discomforts, but rather violations of normal expectations of daily life. Such violations, if any, should be specified.

This quality improvement project poses no risk to the participants. However, there could be discomfort from them taking time from their schedule to attend the PowerPoint video educational session and complete the survey and evaluate the policy.

6. A description of the means to be taken to minimize each risk or violation, including the means by which the participant's personal privacy is to be protected and confidentiality of information received maintained (e.g., disposition of questionnaires, interview notes, recorded audio or video tapes, etc.)

There are no actual physical, psychological, or social risks involved in this project with the participants. However, the project leader will still ensure that the risk of violation of confidentiality will be mitigated by using no personal identifiers on data collection forms and by locking data in a secure location or on a password-protected computer system for at least three years.

7. Consent, as a process, is successful when: 1) a potential participant is provided with **all the information** that is needed to make an informed decision about whether to participate; 2) the information is provided such that the individual **fully comprehends** the research activity including details about what they will be asked to do; and 3) the individual's decision to participate is **voluntary**.

A copy of the consent form that is to be used with the participants must be attached. This may be an adult consent form, parental permission form, children's assent form, or some combination. The College of St. Scholastica should appear as a heading on the form; include the project title at the top of the form. Include a description of the study procedures in nontechnical language. It should also include statements about benefits and risks; if risks are present, describe steps that will be taken to minimize those risks. Also, provide a statement informing the participant that they may withdraw their participation without consequences at any time. Note also the steps taken to protect participant's personal identity and treat collected information with confidentiality. For research involving physical and emotional risks, a statement as to the availability or non-availability of treatment for injuries, infections, illness resulting from the research must be provided. Consent forms and data must be retained securely for a minimum of three years. See the required list of basic elements of all consent forms below.

Included see Appendix C

8. Copies of letters of affiliation or permission. The most common letter of affiliation is that obtained from an authority figure at the site (e.g. hospital administrator or school principal) who is capable of granting permission to conduct research at their institution. This form is required when research activity (data collection) occurs away from The College of St. Scholastica campus. This form must be signed and turned in prior to receiving IRB approval.

Not Applicable

9. If deception of participants is viewed as necessary, a justification for such deception must be provided. Debriefing must also be included in the methodology.

There will be no deception of participants. Weekly reminder will be sent to the participants to remind them of their commitment and their evaluation feedbacks.

10. Provide the name of any professional document(s) that will guide your ethical responsibilities to protect participants in this research project.

This project will adhere to the professional ethics of the Nursing profession, specifically, the American Nurses Association's (ANA) Code of Ethics (ANA, 2015).

# References

Appraisal of Guidelines for Research & Evaluation II. (2017). AGREE II Instrument. https://www.agreetrust.org/wp-content/uploads/2017/12/AGREE-II-Users-Manual-and-23-item-Instrument-2009-Update-2017.pdf

American Nurses Association (ANA). (2015). Code of ethics for nurses with interpretive statements. Silver Spring, Maryland: American Nurses Association.

Daruwala, S. E., LaCroix, J. M., Perera, K. U., Tucker, J., Colborn, V., Weaver, J., ... Ghahramanlou- Holloway, M. (2018). Suicide ideation and self- efficacy to avoid suicidal action among psychiatrically hospitalized military personnel. *Psychiatry Research*, *270*, 1131–1136. https://doi org.akin.css.edu/1 0.1016/j.psychres. 2018.10.023

Gao, T., & Gurd, B. (2019). Hospital size. Chart. *BMC Health Services Research*, 19(1), 6. https://doi-org.akin.css.edu/10.1186/s12913-019-3907-6

## APPENDIX A

Please read each of the statements below carefully and circle the number which best fits how certain you are about how you would act in each of the following situations

| | Very uncertain | | | | | | | | | Very certain |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. How certain are you that you will not attempt suicide in the future? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 2. If at some point in the future you had suicidal thoughts, how certain are you that you could resist making a suicide attempt? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 3. If at some point in the future you had suicidal thoughts, how certain are you that you could resist making a suicide attempt if you were using alcohol or other drugs? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 4. How certain are you that you could control future thoughts of suicide if you were experiencing physical pain? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 5. How certain are you that you could control future suicidal thoughts if you lost an important relationship? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 6. How certain are you that you could control future suicidal thoughts if you lost a job, could not find employment, or suffered a financial crisis? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

(Gao & Gurd, 2019)

## APPENDIX B

Based on your professional expertise, please answer the following questions regarding this Self-efficacy evidence-based practice policy recommendation for suicidal patient disposition.

11. Does the recommendation identify the intended patient population?

    Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

12. Does the recommendation provide information on when in the workflow process will the policy be utilized?

    Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

13. Does the document describe suicide in unambiguous term?

    Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

14. Does the recommendation describe the Self Efficacy to Avoid Suicidal Action (SEASA) instrumental scale intervention in unambiguous term?

    Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

15. Does the recommendation outline using each facility available resources to mitigate the outcome of the SEASA intervention?

    Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

16. Can I find the major recommendation of the document?

    Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

17. Does the document had clear heading headings and section to identified major topic discussed?

    Strongly disagree____ Disagree____ Neutral____ Agree____ Strongly Agree____

18. What changes would you make to this recommendation?
19. Was there enough convincing data for you to agree to this recommendation? Why or why not?
20. Does this recommendation seem feasible to implement within an adult inpatient mental health facility in the metro area Why or why not?

(AGREE II, 2017)

APPENDIX C

**The College of St. Scholastica School of Nursing**

*Utilizing the Self Efficacy to Avoid Suicidal Action (SEASA) Tool to Recommend a Policy Change for The Disposition of Suicidal Patient in Adult Inpatient Mental Health Facilities in The Metro Area:*

**Consent Document**

You are invited to participate in a quality improvement project focused on utilizing the SEASA tool to recommend a policy change for the disposition of suicidal patient in adult inpatient mental health facilities. The clinical project leader is Oluwasegun David RN, BSN, a graduate nursing student at the College of St. Scholastica. You were selected as a possible participant because you are an expert in your role either as an academia or as healthcare professionals. I ask that you read this form and ask any questions you may have before agreeing to participate.

**Project Purpose**

The purpose of this quality improvement project is to develop a policy for a practice change that can be used in any adult inpatient mental health facilities for the disposition of suicidal patient to improve their self-efficacy to avoid suicidal action in the community.

**Project Procedure**

You will be asked to participate in this project in the following ways:

1. To participate in a virtual power point educational presentation about the project.
2. After the presentation you will receives some of documents via email to evaluate by a set time a policy designed by the project leader on the subject matter using a structured evidence-based evaluation form.
3. To submit your evaluation form after completion by a set time.
4. To evaluate by a set time the revised policy by the project leader based on your recommendation and evaluation.
5. To return your second evaluation form of the policy in the fourth month by a set time.
6. To be involved in the project for a period of three to four months to give you plenty of time to and not to infringe too much on your busy time.

**Confidentiality**

All information received will be stored in a password protected computer by the project leader

**Voluntary Nature of the Project**

Participation in this project is voluntary. Your decision whether to participate in this project will not affect your current or future relations with project leader, The College of St. Scholastica as

the agency or employer of the project leader-though not the agency site. If you decide to participate in this project, you are free to withdraw at any time without affecting those relationships.

*If you consent to this project, you also have the option to consent to inclusion of your name and title in the final paper of this project should it get published.*

The clinical project leader is Oluwasegun David RN, BSN, a doctoral student at The College of St. Scholastica and an employee of Abbott Hospital. You may ask any questions you have now, or if you have questions later, you are encouraged to contact Oluwasegun David RN by phone, (763-528-1406), or email odavid@css.edu

If you have any questions or concerns regarding this project and would like to talk to someone other than the project director, you are encouraged to contact the following individuals:

Project Advisor: Rhea Ferry, DNP, APRN, FNP-C, NE; (218)-791-5052; rferry@css.edu

Graduate Nursing Department Chair: Patti Senk, PhD, RN; (218) 723-2211; psenk@css.edu
School of Nursing Dean: Sheryl S. Sandahl, DNP, APRN, CPNP-PC, FNP-BC, MPH, MSN; (218)-723-6390; ssandahl@css.edu
Institutional Review Board: Nicole Nowak-Saenz, Ph.D., nnowaksaenz@css.edu

Chair of College Institutional Review Board: Nicole Nowak-Saenz, Ph.D., nnowaksaenz@css.edu

You may also contact any of the above mentioned in writing or in person at The College of St. Scholastica, 1200 Kenwood Ave, Duluth, MN 55811.

_____

Printed Name of Participant

_____

Signature of Participant Date of Signature

_____

Signature of Project Leader Date of Signature

I consent to this project

I consent to my name and title possibly being used in a publication