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Interprofessional Education Suicide Prevention:
A Course Implementation Guide

Prepared by

Robert J. Cramer, Ph.D.
Associate Professor
Department of Public Health Sciences
University of North Carolina at Charlotte

Amanda C. La Guardia, Ph.D., LPCC-S, NCC
Associate Professor of Counseling
School of Human Services
University of Cincinnati

Jennifer L. Wright-Berryman, Ph.D.
Associate Professor
School of Social Work
University of Cincinnati

Kimberly Adams Tufts, ND, WHNP-BC, FAAN
Professor
School of Nursing
Old Dominion University

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Interprofessional Education Suicide Prevention Course: An Implementation Guide

Overview: Ohio Suicide Prevention Foundation (OSPF) funded a multi-institution effort to design, implement, and revise a suicide prevention course to meet contemporary needs of health professions students. Adopting the World Health Organization's (WHO, 2010) Interprofessional Education approach, the course provides learners an introductory and intermediate set of activities and competencies in suicide prevention. The course content is drawn from multidisciplinary resources and perspectives including, but not limited to, counseling, ethics, law, nursing, medicine, psychology, public health, and social work.

This document is intended to assist university and community-based instructors in implementing and tailoring the suicide prevention course. It serves as a complement to primary course materials that include narrated and non-narrated PowerPoint slide decks, handouts (e.g., case studies), sample rubrics, and a sample course schedule. Further, this guide summarizes course design, objectives, and competencies. Instructional modules are organized according to four areas of competency. Instructional modules are not meant to stand alone and should be clustered within their competency area. Considerations for in-person, blended, and fully online formats are provided. Where in-depth course evaluation may be of interest, a sample, but not exhaustive, set of evaluation tools are recommended. Evaluation recommendations are based on both the empirical literature and course developer experience utilizing evaluation tools in course development.

Course Competencies: Three frameworks informed course competencies. Clinical care suicide prevention competencies were drawn from a review of expert sources (e.g., Joiner, 2005; Rudd, 2006; see Cramer et al., 2013 for full review). Subsequent clinical care skill enhancement has been the subject of academic course, community workshop, and online training program development for healthcare providers (Cramer et al., 2016, 2017, 2019a; La Guardia et al., 2019). Clinical care competencies are augmented broader, multi-level public health models of suicide prevention (Caine, 2013; Cramer & Kapusta, 2017). These models presume a minimum of three layers of influence on suicide risk: structural/community, interpersonal, and individual. Application of public health competencies and a training structure was piloted in an early online version of this course (Cramer & Long, 2018). Clinical care and public health approaches are prefaced by foundational competencies deemed required as an entry point for any professional interested in working in suicide prevention. Finally, interprofessional education competencies (Interprofessional Education Collaborative [IPEC], 2016) were used to account for the changing nature of delivery of holistic, interdisciplinary health services (Fulmer & Gaines, 2014; Olenick et al., 2010; WHO, 2010). The IPEC competencies and training have been widely utilized across disciplines (Visser et al., 2017).

The suicide prevention and interprofessional competencies are (Cramer et al., 2019b):

<u>Area One: Foundational Competencies in Suicide Prevention:</u>
Competency 1: Using contemporary suicide prevention-related terminology
Competency 2: Managing personal attitudes, reactions, and social norms concerning suicide
Competency 3: Knowing evidence-based risk and protective factors, and theories of suicide
Competency 4: Recognizing legal and ethical considerations concerning suicide (IPEC #1)

<u>Area Two: Clinical/Individual (Tertiary Prevention):</u>
Competency 5: Developing and maintaining a collaborative, empathic stance toward persons experiencing suicidality (IPEC #4)

Competency 6: Conducting and documenting a clinical risk assessment
- Including: *Focusing on suicide content, determining risk level, and documentation standards*

Competency 7: Understanding mental health service approaches to suicide prevention

Area Three: Social/Interpersonal & At-risk Group Competencies (Secondary Prevention):

Competency 8: Enacting a collaborative evidence-based plan

Competency 9: Comprehending social support approaches to suicide prevention
- Including: *Engaging in debriefing and self-care*

Area Four: Community-Based Competencies (Primary Prevention & Postvention):

Competency 10: Knowing public health approaches to suicide prevention
- Including: *Gate-keeper trainings, public awareness campaigns, survivor support groups, etc.*

Competency 11: Articulating community organizing and advocacy-based approaches to suicide prevention

Competency 12: Adapting suicide prevention to special population needs (e.g., military, LGBTQ, adolescents)

Competency 13: Framing suicide prevention within a strategic plan

Interprofessional Education (IPE) competencies (IPEC, 2016):

IPEC Competency #1/Area 1: Ethical approach and respect for mutual contribution to provision of care

IPEC Competency #2/Area 2: Roles and responsibilities

IPEC Competency #3/Area 2: Interprofessional communication

IPEC Competency #4/Area 2: Teams and team work

IPE Competency #5/Area 4: Ability to transfer interprofessional learning to the work setting

IPE Competency #6/Area 4: Community engagement and centeredness

Course Design: The course is intended for advanced undergraduate and masters level learners from a variety of disciplines. Course materials are provided for flexible implementation via in-person, blended, or fully online modalities. The course entails basic lecture content, assignments easily integrated to academic technology (e.g., BlackBoard, Canvas), primary source readings, IPE team-based learning and project development, short individual writing assignments, and publicly available exercises. Using both empirical peer-reviewed journal articles and publicly available professional organization resources, the course covers comprehensive knowledge necessary for a beginning health professional to become competent in the four domains of suicide prevention.

Sample Course Schedule: The following table outlines a recommended order to course content coverage. IPE content is both integrated into suicide prevention competencies and covered on its own, where appropriate. Specific course implementation order can be tailored to a particular institution but weekly modules should remain clustered within their respective competency areas. Appended course materials contain readings and handouts for each weekly course module.

Week	Topics/Competencies	Assignments Due
	Foundational Competencies in Suicide Prevention	
1	Course Overview & Introductions (Team Building) Competency 1: *Using contemporary suicide prevention-related terminology* Competency 2: *Managing personal attitudes, reactions, and social norms concerning suicide*	1. Course research pre-test 2. Introductions 3. Quiz 1

2	Competency 3: *Knowing evidence-based risk and protective factors, and theories of suicide*	1. Quiz 2 2. Assign IPE teams in class
3	Competency 4: *Recognizing legal and ethical considerations concerning suicide* IPEC competency #1: *Ethical approach and respect for mutual contribution to provision of care*	1. Quiz 3
Clinical/Individual Competencies (Tertiary Prevention)		
4	IPEC competency #2: *Roles and responsibilities* IPEC competency #3: *Interprofessional communication*	1. Quiz 4 2. Case Study Group Video Report Out 1
5	Competency 5: *Developing and maintaining a collaborative, empathic stance toward persons experiencing suicidality* IPEC Competency #4: *Teams and teamwork*	1. Quiz 5 2. Case Study Group Video Report Out 2 3. Project topic due
6	Competency 6: *Conducting and documenting a clinical risk assessment* • Including: *Focusing on suicide content, determining risk level, and documentation standards*	1. Quiz 6
7	Competency 7: *Understanding mental health service approaches to suicide prevention*	1. Quiz 7
Social/Interpersonal & At-risk Group Competencies (Secondary Prevention)		
8	Competency 8: *Enacting a collaborative evidence-based plan*	1. Quiz 8 2. Literature review due
9	Competency 9: *Comprehending social support approaches to suicide prevention* • Including: *Engaging in debriefing and self-care*	1. Quiz 9
Community-Based Competencies (Primary Prevention & Postvention)		
10	IPE Competency #5: *Ability to transfer interprofessional learning to the work setting* IPE Competency #6: *Community engagement and centeredness*	1. Quiz 10
11	Competency 10: *Knowing public health approaches to suicide prevention*	1. Complete one IPE suicide prevention case simulation (online) 2. Quiz 11 3. Team-based Health promotion/education work product.

12	Competency 11: *Articulating community organizing and advocacy-based approaches to suicide prevention*	1. Quiz 12
13	Competency 12: *Adapting suicide prevention to special population needs*	1. Quiz 13 2. IPE journal/reflection
14	Competency 13: *Framing suicide prevention within a strategic plan*	1. Quiz 14 2. Presentation check-in
15	Suicide Prevention Strategic Planning	1. SPRC Suicide Prevention Training (certificate)
16	Final Exam: Final Team-Based IPE Suicide Prevention Presentations	1. Course research post-test 2. Final team presentations

Pedagogy Summary: Course training activities were selected based on the following principles. First, suicide prevention training strategies were selected from available evidence-based literature (c.f. Cramer et al., in press; Horn et al., 2015 for reviews). Further, a goal of suicide prevention training techniques was to enhance social-cognitive theory of suicide prevention components, namely attitudes, knowledge, stigma, and self-efficacy to engage in suicide prevention efforts (Burnette et al., 2015). Third, in line with best practices in undergraduate education (e.g., Trumbo et al., 2016), emphasis was placed on a series of low stakes assignments (e.g., weekly knowledge checks, journaling), as opposed to traditional high stakes assignments (e.g., midterm/final exam). Such an approach facilities learner ability to more successfully focus on course content and skills. Finally, interprofessional education training and collaborative practice literature informed team-based and self-reflection aspects of the course (e.g., Fulmer & Gaines, 2014; Mosavel et al., 2011).

The following are offered as recommended course assignments. A course instructor may treat this list as a menu of options to be potentially adapted and/or supplemented with assignments suited to the institutional setting or discipline(s) of learners. For instance, additional training modalities such as Observed Structured Clinical Examinations (OSCEs) exist in the health professions literature (e.g., Hung et al., 2012), but are not utilized in this course due to the poor fit with the interprofessional aims and training level of students.

The pedagogical techniques include:

1. **Introductions:** Each student prepares a 2-3 minute video summary introducing themselves to the class. Introductions include name, disciplines/field of interest, an icebreaking fact, and motivations for taking the class.

2. **Knowledge checks/quizzes**: Each week's module includes a 5-question knowledge check via the university virtual platform (e.g., Canvas, Blackboard). Quiz question content is drawn from PowerPoint Lecture and required (but not recommended) readings from that week's module. Each quiz must be completed by the end of that respective week. Quizzes must be taken until all questions are answered correctly and all points are awarded (unlimited attempts).

3. *Case study group activity video report outs (two)*: Interprofessional teams are assigned a case study to analyze. Teams find time to meet virtually or in-person as a group to process the case. Then, the team creates a report out video synthesizing the processing of each case. This video could also include a one-page written summary. More information about this assignment can be found in the appropriate week's module.

4. *IPE Suicide Prevention Project*: The major IPE team-based project is a literature-supported public health or health promotion work product.

The project includes the following components (a-d):

(a) Topic: The suicide prevention health promotion/education topic must be approved by the course instructor. The course instructor may recommend that student teams begin a conversation with the instructor early in the semester. In selecting a group topic, students are advised to consider the various aspects of suicide prevention covered in the course (e.g., policy, competency, risk/protective factors, vulnerable populations) or their own professional disciplines (e.g., counseling, health services administration, social work). The topic should specify the:

 (i) Suicide prevention promotion topic (e.g., warning signs/risk factors for a specific population)
 (ii) Type of work product (e.g., fact/information sheet, pamphlet, PPT slides for an educational intervention, website)
 (iii) Population of focus / summary of the audience (e.g., type of healthcare provider, teachers, defined patient population)
 (iv) Setting of dissemination (e.g., primary care clinic, crisis call center, social media platform[s], college campus)

Example topics may look like:
 1. A fact sheet on statistics and warning signs for peri- and post-partum depression and suicide for expectant mothers to be distributed in obstetrics/gynecology clinics.
 2. A logical model or framework for design of a campus suicide prevention program to be disseminated to campus health staff at the annual conference of the American College Health Association.
 3. A pamphlet concerning the benefits of mental health screening or testing for urban-dwelling outpatients in a community health center.
 4. A set of PPT slides concerning traumatic brain injury, trauma and suicide to be used as part of a presentation/training for new healthcare providers working in the Veterans Affairs Medical Center.
 5. An informational website for community-level prevention efforts specific to at-risk groups (e.g. rural mental health).

Notes: *Students must select a topic that can be supported by a literature review. Therefore, they are advised to search the literature ahead of time. Depending on the topic, it may be advisable to search a range of search engines including, but not limited to, Medline, PubMed, PyscArticles, Psychinfo, PublicAffairs, ERIC, SocIndex, GoogleScholar, and others. Relevant professional organizations are also acceptable sources, but should not be the only ones used.*

(b) Introduction section (i.e., literature review): The group introduction section should provide the necessary detail to inform the health promotion/education work product. As such, it is recommended to contain between five (5) and ten (10) peer-reviewed journal articles or other expert sources (e.g., government or professional organization reports). The total length of the introduction section should be

three (3) to five (5) double-spaced pages 12-point Times New Roman font. Student teams are advised to provide a cover page, introduction section (using APA or AMA format), and full APA or AMA reference section. These parameters can be tailored as necessary.

(c) Health Promotion/Education Work Product Visual: The group Suicide Prevention Health Promotion/Education Work Product will vary in length and format depending on the topic details. However, PiktoChart can accommodate a wide range of work products. There is a PiktoChart instructions document and example picture in the course materials. Student teams can use another presentation venue (e.g., PowerPoint; Video), but are advised to consult with the course professor early on in the process to get this approved. The work product should demonstrate the following: (a) incorporation of relevant empirical and/or expert resource content from your literature review, and (b) application of example course concept(s).

(d) **Suicide Prevention Project Team Presentation:** Each team prepares a 10-15 minute presentation of their whole IPE team suicide prevention project. The presentation should involve active participation of each student team member. Each team presentation should include the following in their presentation: *Overview of the topic, summary of the literature review, example work product, and reflections on what the team learned about interprofessional teams and teamwork.* Teams may, but are not required to, use Kaltura/other Canvas video, Weebly.com pages, FlipGrid.com videos, or other such resources in their presentation.

5. *Online case simulation.* In order to gain expertise in first-hand community gate-keeper, clinical care, or healthcare skills, each student will select one of three possible online case simulations designed by course developers at the University of Cincinnati specifically for this course. A permanent link is available at: http://elmodules.cech.uc.edu/SoHS/SPG_Final/story_html5.html

6. *Individual IPE journaling/reflection***:** Each student completes a 2-3 page double-spaced end-of-semester IPE journal/reflection paper addressing: (1) lessons learned from IPE content and team-based learning, (2) summary and assessment of their role and contribution to the team-based project, and (3) challenges and benefits of participating in the interprofessional and collaborative practice (IPCP) team.
> *Optional Masters Student requirement*: In addition to the written journal/reflection, all masters-level/advanced learners can complete and submit: (a) Interprofessional Education Reflection Tool and (b) IPEC Competency Self-Assessment Tool. An additional level of IPE reflection and assessment can help differentiate undergraduate from graduate level performance.

7. *Suicide Prevention Resource Center Free Online Training***:** An overt goal of this course is to facilitate the independent learning of health professions students including skill building and résumé enhancing. In order to obtain a practical credential, and build on course content, each student is required to complete the Suicide Prevention Resource Center (SPRC) free online training "A Strategic Planning Approach to Suicide Prevention". The SPRC training requires an 80% passing on questions at the end of each module. Students receive immediate feedback on correct answers and explanations. Once the requirements are met, the student receives a certificate of completion.

Implementation Considerations: The following are general implementation guidelines gleaned from two years of course implementation and evaluation. They are offered as a starting point. Any instructor should carefully weigh this guidance against the circumstances of course provision in their own institution. General implementation recommendations:

      1. ***Provide students with an introduction about the course professor***. Humanizing yourself as the instructor is essential to setting the tone and establishing rapport; doing so also mirrors course content focused on rapport building and interprofessional communication. It is recommended that the introduction features professional background, suicide prevention and other expertise/credentialing, and an overview or vision for student success in the course. Note: It is important that the instructor have a level of expertise about suicide prevention suitable to teach the course, address student needs throughout the semester/term, and to support student learning and reflection on the material.

      2. ***Set expectations for team-based learning at the start***. Group work is highly stigmatized among higher education learners, and can result in inequitable contribution and disparate learning. This course contains a handout articulating expectations for team-based learning based on pedagogical literature. It is recommended that the course instructor utilize this document as a starting point. Moreover, each student team should be required to provide a written communication plan and put into writing team expectations for contributions, roles and responsibilities. Drawing up consensus-driven agreement can help heighten accountability and allow learners to more readily focus on the work.

      3. ***Set the context for suicide prevention for learners at the start***. Suicidal behavior can be a difficult topic for many persons, whether possessing lived experience, survivorship, or otherwise. The course professor should acknowledge this fact early in the course. The difference between training-focused efforts and process/group therapy should be covered. Support service information can be provided to students in the syllabus, in course handouts, and throughout the semester via inclusion in course content. The course professor should also address the subject of purpose-driven self-disclosure. That is, given the subject matter of the course, self-disclosure germane to the education and training purpose should be acknowledged and differentiated from therapeutic intent.

      4. ***Train learners on conducting a professional literature revie***w. Today's learners do not necessarily possess the experience or prior skills to conduct literature reviews or discern empirically-supported from other web-based information. It is recommended that the course instructor work with their institutional subject matter librarian or other relevant personnel to develop a brief introduction to conducting a literature review. Such an informational resource may also include basic information on the levels of empirical evidence (i.e., case study to randomized experimental investigation), as well as examples of reliable professional organization resources juxtaposed against random websites.

      5. ***Conduct an updated search for changes to the suicide prevention literature***. Suicide prevention research and practice are constantly evolving. Instructors should always consider supplementing this course with an updated literature review and supplemental state-of-the-art content. We have included much of the seminal work in the field (Schneidman, Joiner) which provides a comprehensive foundation for the newer findings in the field.

      6. ***Tailor the content to your audience***. Several topics are intentionally nimble so as to be tailored to each unique set of learners. For example, suicide prevention competency 12, adapting suicide prevention to special population needs, provides an instructor the opportunity to select high-risk groups of most germane to the setting or set of learners. For example, suicide prevention approaches may differ based on whether the setting is urban or rural, whether someone is a veteran, LGBTQ, or a member of another minority group. It is important to consider both your student audience and those they will be serving in the field.

      7. ***Avoid forcing learner public participation with the larger group***. Forced participation with sensitive course subject matter has the potential to create significant learner discomfort. Rather, the course professor is encouraged to provide learners various in-person and web-based personal reflection and

participatory opportunities that may only be shared with the course professor. Examples include the IPE journal assignment.

8. ***Employ engaging, practical learning strategies***. Of the variety of methods provided with this guide, the following have been the most consistently favored by learners: the SPRC training certificate, team-based project, and course-specific gate-keeper training exercises (e.g., Cramer et al., 2019b). All of these strategies share in common the practice of real-world skills beyond the in-person or virtual classroom. They can also be framed as resume and career development building activities.

9. ***Help learners go beyond the course***. Design of this course purposefully focused on preparation of healthcare professionals equipped with real-world interprofessional and suicide prevention skills. In the two-year pilot of the course, several individual students and teams were afforded the opportunity to use their skills or work products beyond the classroom. For instance, the course instructor may build in opportunities to learn about student jobs and internships to help students think through how course content can be taken beyond the classroom. Further, the course instructor may guide student teams to select work products with high potential for real world distribution. For example, teams in the two-year pilot prepared websites, social media campaigns, and psycho-educational infographics that course professors were able to facilitate referral to community partners for ecological implementation.

10. ***Provide supplemental resources***. This set is a recommended minimum set of supplemental resources for syllabus or other course provision. It should also be supplemental for campus and regional mental health and suicide prevention agencies and resources.

- [American Foundation for Suicide Prevention (AFSP)](#)
- [American Association of Suicidology (AAS)](#)
- [Centers for Disease Control and Prevention (CDC) suicide prevention resources](#)
- [Crisis Text Line (Text 'Home' to 741741)](#)
- [National Suicide Prevention Lifeline (1-800-273-Talk)](#)
- [Ohio Suicide Prevention Foundation](#)
- [Suicide Prevention Resource Center (SPRC)](#)
- [World Health Organization (WHO) suicide prevention resources](#)
- [World Health Organization (WHO) interprofessional education and collaborative practice](#)

Course Format: The two-year pilot included delivering the course in three formats: in-person, blended, and online-only modalities. Pilot course evaluation data across participating universities strongly support the value of in-person contact for engaging and effective learner experiences. This may be accomplished through both in-person and blended formats. Course developers recognize that current circumstances may exist where an online option is the only or most practical option. Below are modality specific considerations:

In-person course: In-person instruction offers the easiest opportunity to incorporate institutional or regional experts into the course. This strategy offers students the benefits of learning from other experts in the field and to network. When employing guest experts, the course professor should take the time to orient the guest to the course objectives, interprofessional audience, and goals of the visit. Guest experts may be used in online formats as well, but with heightened course orientation and review to ensure fit and attainment of objectives.

Blended course: It is recommended that mixed delivery be carefully considered with respect to what content is addressed in-person versus online. A guiding principle is making these decisions is that, if the skills or competency of focus is wholly person-to-person (e.g., establishing rapport, interprofessional communication), it is likely best addressed via live and/or synchronous instruction. Course activities that are more skill-building (practice) are recommended for in-person instruction if possible. Additionally, plan to use the in-class setting to check in with students about content understanding and topic reflections.

Online course: Pilot course evaluation outcomes suggest the absence of direct learner-to-learner and learner-to-instructor contact detracts from the impact of interprofessional education content (e.g., Cramer et al., 2019b). To ameliorate the potential loss of the experience, the course instructor may consider the following: First, the course instructor should provide regular email, virtual office hour, interactive opportunities, and inclusive (where possible) visual connection with students (i.e. synchronous sessions). Second, a greater degree of structure, support, and recording student team meetings may benefit student team experiences. Third, any opportunities for learners to review and provide feedback on work products may enhance the sense of interaction and satisfactory engagement.

Example evaluation resources: The following guidance is provided for instructors interested in advanced assessment of course outcomes. Based on the social-cognitive model of suicide prevention training, evaluation of key outcomes include suicide prevention self-efficacy/perceived competency, stigma, attitudes, knowledge, and intervention behaviors. IPE assessment would benefit from coverage of core skills outlined by WHO: values and ethics, roles and responsibilities, interprofessional communication, and teams and team works.

Suicide prevention self-efficacy/perceived competency. The Suicide Competency Assessment Form (SCAF; Cramer et al. 2013, in press) provides self- or observer-rating of the 10 core clinical care competencies, as well as a global rating of suicide prevention competency. The SCAF has been adapted to map on to public health-focused skills as well (Cramer & Long, 2018; Cramer et al., 2019b). The psychometric properties of the SCAF are consistently strong.

Suicide stigma. The Stigma of Suicide Scale (SOSS; Batterham et al., 2013a, 2013b) full and short forms have been used in early phase evaluation of this course. However, poor psychometrics and validity concerns arose. For instance, it is questionable whether the Depression/Isolation subscale is a valid metric of stigma, as opposed to a measure of sensitization to suicide risk factors in a training context. The Suicide Opinion Scale (SOS; Domino et al., 1982, 1988) may be an alternative, but suffer from outdated phrasing and content. Other suicide-related stigma measures, but are specific to certain populations such as the military (e.g., VanSickle et al., 2016). At present, there is no single best practice for the evaluation of general suicide/prevention stigma. Consistent with approach taken by Muehlenkamp and Thoen (2019), it may be best for instructors carefully consider existing measures and select or adapt items fitting the course at hand.

Suicide attitudes. The Suicide Behaviors Attitude Questionnaire (SBAQ; Botega et al., 2005, 2007) and Attitudes toward Suicide Prevention Scale (ASP; Herron et al., 2001) were used to assess impacts on suicide attitudes in the two-year evaluation of this course. While seemingly appropriate because they were developed on health service providers, both instruments demonstrated poor internal consistency across evaluation efforts. The SBAQ Right to Die subscale is also unclear with respect to direct of impact of training to be expected. In line with the notable limitations in the assessment of suicide stigma, general and prevention-specific attitudes may be difficult to capture using existing instruments. It is recommended that instructors consider devising set for pilot studies prior to course evaluation aimed at developing site-specific suicide stigma measure.

Suicide prevention knowledge. Basic suicide prevention knowledge can be effectively assessed using the Literacy of Suicide Scale (LOSS; Batterham et al., 2013a). This instrument displayed appropriate properties in the evaluation of the IPE course. Additionally, course-specific, advanced knowledge can be assessed using the suicide knowledge quiz (Cramer et al., 2016, 2019b),

provided that all multiple-choice questions are covered in the course content. Tailoring of multiple-choice knowledge assessment was also successfully implemented by other researchers (Muehlenkamp & Thoen, 2019).

Intervention behaviors. A simple metric used in the assessment of this course and its precursors comprises a series of items of intent to use course content, either overall or listing specific course resources. Such items are designed in line with principles of theory of planned behavior scale construction (Ajzen, nd) in order to assess likelihood of intended engagement in application of course content. Alternatively, as the course addresses gate-keeper training, instructors may use the Gatekeepers Behaviors Scale (Albright et al., 2016), which provides three subscales of preparedness, likelihood, and self-efficacy to intervene with someone at risk for suicide.

ICPC skills and attitudes. A comprehensive, psychometrically sound approach to assessing IPE-related perceived skill is the Interprofessional Education Collaborative Competency Self Efficacy Tool (IPECC-SET; Hasnain et al., 2017). While the instrument is rather long, it offers a comprehensive assessment of the four primary IPEC competencies and demonstrated utility in the pilot evaluations of this course. As a complement to the IPEEC-SET, instructors may also consider the Interprofessional Socialization and Valuing Scale (ISVS; King et al., 2016); designed in a 9- or 21-item version, the varying ISVS formats specifically serve as pre-post intervention/training assessment of attitudes toward IPE.

Additional outcomes. Suicide prevention advocacy was evaluated positively as a result of a different suicide prevention course (Muehlenkamp & Thoen, 2019). Objective skill performance may be gleaned from pre-post responses to gate-keeper behavior or clinical care decision scenarios. Instructors may also consider outcome unique to the learners and institutional setting of course implementation.

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