

Primary Care and Mental Health Staff Perspectives on Universal Suicide Risk Screening and Care Coordination

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Little is known about staff or patient perspectives on suicide risk screening programs. The objectives of this study were to characterize Veterans Health Administration (VHA) primary care and mental health staff perspectives regarding the VHA Suicide Risk Identification Strategy screening and assessment program and to describe coordination of suicide prevention-related care following positive screening results. Qualitative interviews were conducted with 40 primary care and mental health staff at 12 VHA facilities. An inductive-deductive hybrid approach was used to conduct a thematic analysis. Several key themes were identified. Primary care and mental health staff participants accepted having a structured process for screening for suicidal ideation and

conducting risk assessments, but both groups noted limitations and challenges with initial assessment and care coordination following screening. Mental health staff reported more concerns than primary care staff about negative impacts of the screening and assessment process on treatment. Both groups felt that better training was needed for primary care staff to effectively discuss and evaluate suicide risk. The results suggested that additional modifications of the screening and assessment process are needed for patients already known to have elevated risk of suicide or chronic suicidal ideation.

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Suicide rates in the United States have increased during the past several decades (1), and suicide accounted for more than 45,000 deaths in 2019. Some investigators have recommended universal (referred to here as “population-based”) screening for suicide in pediatric settings, and there have been calls to implement population-based screening in emergency room settings as well (2). Half of individuals who die by suicide are seen in primary care during the month prior to death (3, 4), and the majority do not have contact with specialty mental health (4), suggesting the value of creating mechanisms in primary care to detect individuals at risk of suicide.

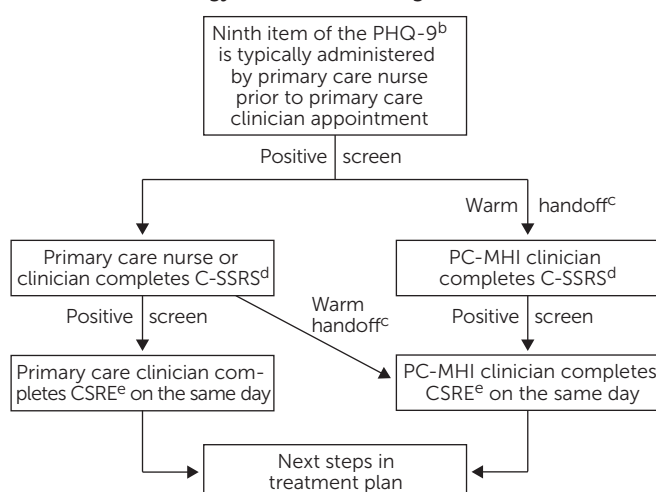
Although the evidence to support the impact of population-based screening on suicide-related outcomes (attempts and deaths) among adults in ambulatory settings remains limited (5), some organizations, including the Veterans Health Administration (VHA), have implemented population-based screening across multiple settings, including primary care (6, 7). Veterans are 1.5 times more likely to die by suicide compared with nonveterans (8), and standardized screening for elevated suicide risk represents one of several VHA core suicide prevention strategies.

In regard to population-based screening for suicide, the 2019 U.S. Department of Veterans Affairs (VA)/Department

of Defense clinical practice guidelines (9) suggested that a validated screening tool be used to identify individuals at risk and that comprehensive risk assessment include attention to multiple risk factors. Consistent with these guidelines, the VHA updated its screening processes in late 2018 to produce a multistage suicide risk assessment

HIGHLIGHTS

- Primary care and mental health staff accepted having a structured process for screening for suicidal ideation and conducting risk assessments but noted limitations and challenges with assessment and care coordination following a positive screen.
- Mental health staff were more concerned than primary care staff about potential negative impacts of the screening and assessment process on treatment; both groups felt that better training was needed for primary care staff to effectively discuss and evaluate suicide risk.
- Modifications to screening and assessment are needed for patients already known to have elevated risk of suicide or chronic suicidal ideation.

FIGURE 1. Veterans Health Administration (VHA) Suicide Risk Identification Strategy (Risk ID) screening and assessment^a

^a CSRE, Comprehensive Suicide Risk Evaluation; C-SSRS, screen version of the Columbia–Suicide Severity Rating Scale; PC-MHI, Primary Care–Mental Health Integration; PHQ-9, nine-item Patient Health Questionnaire.

^b When information was collected for this study, Risk ID consisted of three screening stages, with the ninth item of the PHQ-9 administered in the first stage: “Over the past 2 weeks, how often have you been bothered by thoughts that you would be better off dead, or thoughts of hurting yourself in some way?” A response of several days or more was considered a positive response, which triggered administration of the C-SSRS.

^c A key component of the VHA’s PC-MHI initiative is the capacity to conduct warm handoffs when a primary care clinician has concerns about mental health conditions or treatment. A warm handoff is defined as a direct transfer of care, in real time, of an individual from one clinician to another.

^d The C-SSRS is administered if the ninth item of the PHQ-9 is positive. The C-SSRS is positive if the patient responds yes to items 3, 4, 5, or 6b.

^e If the C-SSRS is positive, then a clinician completes the CSRE.

protocol called the VHA Suicide Risk Identification Strategy (Risk ID). Risk ID is an evidence-informed (9), multistage suicide risk screening and evaluation process (Figure 1). When we conducted this study, the Risk ID process consisted of three stages: all veterans receiving VHA care were screened annually with the ninth item of the nine-item Patient Health Questionnaire (PHQ-9) (10). Those who screened positive on the PHQ-9 were administered the screen version of the Columbia–Suicide Severity Rating Scale (C-SSRS) (11), and those who screened positive on the C-SSRS were administered the VHA’s Comprehensive Suicide Risk Evaluation (CSRE). The CSRE is a structured clinical tool addressing evidence-based factors critical to assessing suicide risk (9). CSRE domains include assessment of suicidal ideation, plan, intent, and behaviors, as well as risk and protective factors.

In 2018, national webinar training programs were developed to educate providers on the Risk ID process and suicide risk assessment. Providers were generally instructed to attend training programs relevant to their scope of practice. A national Risk ID implementation team also provided weekly technical assistance calls to address specific Risk ID

implementation questions and to disseminate practical tools and resources to help providers in their screening and evaluation efforts. In early 2021 (after we completed data collection), the Risk ID process was modified to include only two stages (the C-SSRS and CSRE).

Although Risk ID screening can occur in any care setting, most screens are done in primary care and mental health specialty settings. In the VHA, the Primary Care–Mental Health Integration (PC-MHI) initiative provides onsite mental health specialist support to primary care teams; PC-MHI staff are often called to assist with risk assessment (e.g., CSRE) and to facilitate follow-up when patients screen positive on the C-SSRS. Thus, primary care and colocated mental health teams often must coordinate their efforts to provide an appropriate clinical response for individuals at risk of suicide.

Although current evidence supports the notion that suicide risk screening may facilitate detection of patients at elevated risk (9), less is known about other impacts of suicide risk screening programs, including the perspectives of patients and staff. Our prior research on VHA’s first iteration of suicide risk screening, implemented almost a decade ago (12), suggested that veterans generally accept the rationale for the suicide risk screening and appreciate that the screening process is straightforward. On the other hand, some veterans find the discussions very difficult, or are unsure or fearful of what might follow disclosure of suicidal ideation. Other studies (13–17) have found that individuals perceive suicide risk screening or other behavioral health screening to be acceptable overall and that there are minimal unintended negative consequences for the respondents. However, we have identified almost no literature pertaining to staff perspectives on population-based suicide risk screening.

In early 2020, we initiated a study to understand patient and staff perceptions of Risk ID and how screening processes and perceptions of screening may affect subsequent care. The objective of the current qualitative analysis was to characterize primary care and mental health staff perspectives regarding the Risk ID screening program and to describe coordination of suicide prevention–related care among primary care and mental health clinicians following positive screens.

METHODS

This study was reviewed and approved by the joint institutional review board of the VA Portland Health Care System and Oregon Health & Science University. A waiver of written informed consent was approved; all participants provided verbal consent to be recorded prior to being interviewed. Some of the study’s methods have been previously described (18).

Qualitative interviews were conducted with primary care and mental health staff at 12 VHA facilities across the United States between April and September 2020. These facilities were purposively identified from a larger pool of 171 VHA facilities in the United States to reflect a range of

characteristics, including regional and geographic variability, operative complexity level, size (patient capacity), and adherence to the Risk ID initiative (as determined by several VHA performance measures). Facility directors were contacted via e-mail to inquire about inviting their staff to participate. After receiving leadership permission, the study team contacted primary care and mental health leaders to disseminate recruitment e-mails to their staff. Staff interested in participating contacted our project coordinator to schedule interviews.

The study team developed a semistructured interview guide (see the online supplement to this article) informed by our overall study research questions. All interviews were audio recorded and transcribed. Transcriptions were analyzed with Atlas.ti software by four coders: two primary coders and two secondary coders. This interdisciplinary coding team consisted of two research assistants and two experienced qualitative researchers (one sociologist and one social psychologist). Using the interview guide and research questions, the coding team created an initial codebook. Next, to implement a conventionally directed hybrid approach for thematic analysis (19), each coder used the initial codebook to independently review three transcripts; together, they then discussed and refined the first iteration of the codebook. Codes were then added or amended to capture themes not previously defined. All coding team members met weekly to discuss, and come to agreement on, emerging themes and new code categories and consulted coauthors with expertise in psychiatry and clinical psychology during the thematic analyses.

RESULTS

Of the 57 participants who contacted us, 40 completed interviews. Eighty-three percent of the participants self-identified as women (N=33), 68% as non-Hispanic White (N=27), 15% as African American (N=6), 8% as Asian American (N=3), 5% as Hispanic White (N=2), and 5% as Middle Eastern White (N=2). The average length of time participants had worked for the VHA was 7 years (range 2 months to 32 years), and the average time elapsed since training was 14 years (range 1–41 years). Table 1 shows participant occupation by practice setting.

Several main themes arose from this analysis: both primary care and mental health staff reported acceptance of the process of screening for suicidal ideation and conducting suicide risk assessments; both groups noted important limitations and challenges with the process and with care coordination following positive screens, including how to work with individuals with chronic suicidal ideation; mental health clinicians more often reported concerns about negative impacts of the screening and assessment process on treatment; and both groups reported that better training was needed for primary care staff to have effective conversations about suicide risk.

TABLE 1. Participants (N=40), by occupation and practice setting

Occupation	Primary care setting	Specialty mental health setting
Primary care physician	6	
Primary care nurse practitioner	5	
Licensed practical nurse	3	
Primary care registered nurse	2	
Physician's assistant	1	
Medical support assistant	1	
Psychiatrist	1	1
Mental health nurse practitioner	1	2
Mental health registered nurse	1	3
Psychologist	2	5
Social worker		5
Peer support specialist		1
Total	23	17

Risk Assessment Acceptance

Across primary care and mental health treatment settings, staff said they understood the importance of assessing patients for suicide risk, noting the high rate of suicide among veterans. Staff dedication to patient safety was apparent. With few exceptions, staff were supportive of having a structured process for screening and assessment and reported that the process was well integrated into the clinical workflow. No staff suggested that the process be eliminated. The staff also perceived patients to be accepting of the process, suggesting that the veterans were used to being asked about suicidal thoughts and rarely complained or refused to answer the questions. The staff noted that some veterans welcomed the questions, because they were concerned about suicide risk among their fellow veterans.

The system is set up where if somebody has a positive PHQ item 9, then you follow up with the C-SSRS and if that's positive, you follow up with the CSRE. I found that to be really useful and most of the veterans that I encountered . . . they were familiar with the fact that this could happen, and they weren't, like, upset about it, because they knew that that's what would happen. So, I found that to be useful, the fact that it was routinized in that way. (psychologist, mental health setting)

I think there's a general sense that everyone's on board. It's kind of old hat at this point. Our nurses do a basic screen for depression and PTSD [posttraumatic stress disorder] and if it's positive, I'm [notified], and I discuss it further in my visit. (primary care physician)

A lot of times, veterans, when they see the items, they're like, "I'm glad the VA is screening for this." Or, "Suicide's a problem among the veteran population, and so I'm glad we're being asked these questions." So, a lot of times the veterans even are very aware that suicide is an unfortunate problem. So, it's not just to ask them for the sake of asking, but really what we're getting at [is] to really ensure no veteran is falling through the cracks who may be in need of care. (psychologist, mental health setting)

Limitations and Challenges

Initial screening and assessment. Despite general acceptance of the process, participants described a number of challenges and limitations. Across facilities, staff described variation in assessment processes, depending on the level of mental health integration in their clinic (e.g., availability or workload of mental health clinicians). Although many staff noted that suicide prevention was a top priority, some noted limitations in the assessment process and in what staff could do to prevent suicide. Some staff described being acutely aware that the assessment process could not predict who would attempt suicide.

But the goal of the screening is to pick up some cases and hopefully engage people, and, you know, we hope that done over thousands of people that this will prevent some cases of suicide. However, we're realistic about the fact that we're not going to pick up all cases. We don't have the science yet to do better. It's better than nothing. But we shouldn't kid ourselves that it's more than it is. (psychiatrist, primary care setting)

Utility of the process was also noted to depend on patient honesty in disclosing suicidal thoughts. For example, staff sometimes worried that when suicide screening was included with many other required screenings, it might inhibit veterans from being honest, thus requiring additional probing from clinicians. One provider described a strategy used to engage the patient.

I think . . . if you're just going through the questions, because they have a million clinical reminders, it can be very redundant. So, sometimes someone will just say no, no, no. But, like, if they're in the room with me, and I'm getting a little bit more of the history, finding out, like, their military experience, I'll find other positives. (nurse practitioner, primary care setting)

In addition, staff were sensitive to the risk of over-screening. Staff were concerned, for example, that if patients had recently been assessed for suicide risk in another setting, bringing it up again might be harmful.

They could have just seen somebody for mental health the week before, yet the reminders are still up. So, then I feel uncomfortable, because sometimes the patient doesn't like me dredging up things again. (nurse practitioner, primary care setting)

Overscreening was a concern for both primary care and mental health staff, who cited the possibility of irritating the veterans.

I have a patient that I see . . . for chronic pain and go through the protocol with him on that, but he also sees a provider to address PTSD. And he also has a prescriber. And so, with that, every appointment that he goes to, he's having to go through all, not only just the PHQ-[9]. But then also the C-SSRS, and then [the] comprehensive [CSRE], if it's appropriate at that time. And so basically, it can agitate the veteran. I think that when there's multiple providers involved in that way, that can be counterproductive to the processes that we're really trying to address to reduce the ideation. (social worker, mental health setting)

Primary care staff expressed fewer concerns about the screening and assessment process compared with mental health staff. Mental health staff expressed concerns about the time needed for assessments decreasing the time available for treatment and about the potential of this process to negatively affect patient engagement. Mental health staff also expressed stronger concern that the structured assessments were not appropriate for all patients, especially those who frequently experienced suicidal ideation. Among these patients, the risk assessment process was seen as redundant and as cutting into the time needed in-session to address patient needs.

I have a lot of clients that are having chronic suicidal thoughts, that's their baseline. You never have any time to talk about the things they need to talk about, so that perhaps they won't have this chronic [suicidal ideation] anymore. You never really get to actually do real treatment. You're basically every single session safety planning with them and assessing them for suicide. You're going to lose rapport [with] your patients, too, if that's all that your sessions are about. They're going to think you don't care. (social worker, mental health setting)

Some mental health staff also noted that the C-SSRS and CSRE were cumbersome and overlapped. Moreover, many mental health staff noted that the formal assessment process was not necessarily an improvement on what they had previously done to assess patient risk.

So, maybe I sound like an old fogey, or sound like a laggard, but it's been a really frustrating process from my perspective to see this very long, very extensive, very complicated multitiered assessment process rolled out, and I don't really think that it's making our veterans safer. Or, at least, I haven't seen any evidence that it's making our veterans safer, compared to the perhaps less regimented but still comprehensive stuff that we were doing before. (psychologist, mental health setting)

Care coordination. Participants also noted postscreening care coordination challenges. Primary care staff reported that they usually conducted the initial phase of risk assessment and then handed off patients to mental health clinicians when indicated. This screening coordination process varied across sites, was associated with varying levels of staff satisfaction with it, and raised the question of who owned the assessment process.

The mental health providers don't seem to think that those reminders are their business. It's primary care's business. And that shouldn't be, because they have that relationship already with the patient. You know? (nurse practitioner, primary care setting)

Primary care staff felt caught in a perilous situation if they had a patient with a positive initial screen but who did not have access to a mental health clinician for follow-up. Many spoke about the lag time involved in reaching a mental health clinician. Those with easier access to a mental health

clinician to initiate follow-up were more comfortable with the screening process.

I just don't know if they get the message and if they're going to come and visit me or what's going to happen. So, the way of alerting somebody, that would be the thing I would improve. (primary care physician)

So, it's almost like I'm trying to figure out how to stop the conversation before I can get ahold of the doctor, if we're both working remotely. Stuff like that. If I am thinking it's going to be a positive. (licensed practical nurse, primary care setting)

I would love it if mental health immediately was involved, versus me. (registered nurse, primary care setting)

To reduce potential overlap of assessments by mental health and primary care staff, as well as to reduce the time lag and improve continuity of care, some staff felt that all assessment components should be handled by one person. Perceived restrictions on who was allowed to do which part of the process were felt to be unnecessarily confusing.

We can do the safety plan, and we . . . do the initial screening, but after that, it's out of our hands. And so, we can't see that person through. And so, that is one area, that to me would be helpful, if I could do it from beginning to end. (registered nurse, primary care setting)

The three-tiered process, I think it needs to be done with one person. Does that make sense? I wouldn't mind being that person. I just think it needs to be one person as opposed to so many different kinds of people. (registered nurse, mental health setting)

Staff preparation for assessment. Both primary care and mental health staff reported that better training was needed for primary care staff to have effective conversations with patients about suicide risk. Specifically, staff desired better understanding of risk levels and when it is appropriate to consider a patient as having high risk. Some mental health staff felt that some primary care staff had lower thresholds for defining high risk and therefore referred more patients to them than necessary.

So, in primary care clinics, when you call something high risk, they think that—wow, this person's going to kill themselves. Whereas in my mind—oh, they got labeled high risk? I know—oh, that means there's a 99% chance that they'll be alive 3 months from now. (psychiatrist, primary care setting)

Perceived inadequate training of primary care staff was also felt to lead to poorer patient care.

Honestly, I think that, from what I've seen, when I've had providers in the past actually do [screening], they will tell me that it's positive when it actually is not. And so, it becomes kind of this chaotic thing where the patient is not actively having any problems or difficulties, or it's not to the severity in which they are reading it. And so, it ends up causing an impact, in my opinion, to the patient, where we're now being pulled in as mental health [providers] and [we say], 'Oh, my

goodness, you're suicidal, we need you to get scooped up and helped,' and so it just kind of creates this extra chaos that isn't necessarily needed. (psychologist, mental health setting)

DISCUSSION

To our knowledge, Risk ID is the largest population-level suicide risk screening program in any U.S. health care system to date (6). Our findings suggested that overall, Risk ID was accepted by staff and integrated into the workflow of primary care and mental health settings. On the other hand, the individuals we interviewed reported a number of key challenges and limitations with the initial assessment and care coordination processes. These included gray-area scenarios where staff had difficulty determining level of risk or identifying next steps in care. Primary care staff sometimes felt underprepared to adequately determine risk, particularly for patients experiencing chronic suicidal thoughts. Both primary care and mental health staff reported that more training for primary care staff in suicide prevention would help reduce unnecessary handoffs to mental health staff that often frustrated the patient and consumed valuable mental health clinician time. In a qualitative study of primary care and mental health teams, Wittink et al. (20) found that the role of primary care providers in suicide prevention was often unclear. Together with our findings, Wittink et al.'s (20) results suggest that training and role definition within care teams are critical components of effective suicide prevention in primary care settings.

Mental health staff reported more concerns than did primary care staff about potential negative impacts of the Risk ID screening process. Specifically, mental health staff reported challenges to providing comprehensive treatment for patients, particularly those with chronic suicidal ideation; using a structured approach to assessing risk with these patients felt redundant and cut into the clinical time that was needed to address problems that might contribute to suicide risk. Repeated screening was also reported to, at times, hamper clinician-patient rapport. Several authors (21–23) have recently raised concerns about potential unintended consequences of required structured risk assessments, because of the time required to administer assessments and in the context of limited evidence to support the value of structured assessment in reducing suicide behaviors compared with traditional approaches. Espeland et al. (23) also noted potential negative impacts on staff and patients: clinical staff focus has shifted away from safety and treatment toward completing mandatory risk assessments to avoid liability or administrative reprisals. More work needs to be done to understand the impacts and value of conducting structured or templated risk assessments in a fairly rigid process, compared with a more traditional open-ended and flexible clinical assessment.

Our results also highlighted the value of colocation of mental health care with primary care. At sites where there were ongoing working relationships among primary care

and mental health staff, and clearly defined roles, primary care staff felt comfortable with the assessments and perceived care coordination to function well. Both primary care and mental health staff expressed concerns about potential negative consequences of repeated screening and screening by multiple individuals (handoffs) in response to a positive screen. In these situations, staff were concerned about the risk of patient disengagement and reduced likelihood of honest responses during follow-up screens. Although some literature supports the finding that screening or asking about suicidal thoughts is not associated with an increase in suicidal behaviors (24–26), suicide assessment has been shown in one study to decrease positive affect (26); negative perceptions related to repeated screening and assessment have the potential to negatively affect subsequent care engagement. More research is needed to examine relationships between repeated screenings, handoffs, disclosure of suicidal ideation, and suicide behaviors over time.

Because this was qualitative work, the findings were more hypothesis-generating than definitive. There were other potential limitations as well. This study was conducted within the VHA, potentially limiting generalization of the findings to other organizations. On the other hand, the VHA's multistage process is likely not dissimilar from those implemented or likely to be implemented (a brief screen followed by more in-depth evaluation) by other organizations. As noted above, the screening process has changed since these data were collected, from three stages to two. Thus, some of the concerns expressed about overscreening may have been at least partially addressed. Indeed, since the Risk ID initiative began, the VHA has continued to modify Risk ID tools and processes in response to feedback from the field. It is important to note that the individuals who volunteered to participate came from a large pool of primary care and mental health staff at 12 facilities; as such, the participants may have had strong feelings (positive or negative) regarding Risk ID processes. Finally, these data were gathered during the ongoing COVID-19 pandemic, so participant experiences with assessment were likely shaped by social distancing policies as well as by the technological and staffing challenges faced at many sites (18). However, participants also had considerable experience with the Risk ID process prior to the start of the pandemic, from which they drew when discussing their perspectives.

CONCLUSIONS

In this study, we found that despite their criticisms, primary care and mental health staff were generally accepting of the VHA's suicide risk screening and evaluation process. Staff expressed appreciation for the importance of VHA's Risk ID initiative and were invested in implementing Risk ID in practice, reflecting a shift in culture over time to supporting population-based screening. Key challenges related to equipping and supporting primary care providers in evaluating level of risk, and improving workflow processes to streamline care

coordination and reduce unnecessary redundancy, remain. Our results also suggested that further modifications of processes are needed for patients already known to have elevated risk of suicide or chronic suicidal ideation.

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Lived Experience Inclusion & Leadership Column Seeks Submissions

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This column aims to publish critical analyses, case studies, and reports on the involvement and leadership of mental health service users (peers and consumers) and caregivers in mental and behavioral health service delivery. Specific topics include novel or innovative peer support and peer-led interventions, case studies of the lived experience leadership roles, participatory research efforts that center meaningful involvement (or leadership), and empirically informed lived-experience perspectives on topics related to the ethics and sociopolitics of interventions and services. We have a strong interest in intersectionality and the perspectives of individuals with multiple historically underrepresented or marginalized identities and encourage all submissions to include lived-experience lead authors or coauthors.

Submissions (via mc.manuscriptcentral.com/appi-ps) are limited to 2,400 total words, inclusive of a 100-word abstract, two or three one-sentence Highlights, and up to 10 references.