



HHS Public Access

Author manuscript

J Acquir Immune Defic Syndr. Author manuscript; available in PMC 2024 August 15.

Published in final edited form as:

J Acquir Immune Defic Syndr. 2023 August 15; 93(5): 374–378. doi:10.1097/QAI.0000000000003217.

Task-shifting ‘gold standard’ clinical assessment and safety planning for suicide risk among people living with HIV: A feasibility and fidelity evaluation in Tanzania

Brandon A. Knettel^{1,2}, Ismail Amiri^{2,3}, Linda Minja³, Alyssa J. Martinez², Elizabeth T. Knippler^{1,4}, Kim Madundo^{5,6}, Catherine Staton^{2,7}, Joao Ricardo N. Vissoci^{2,7}, Judith Mwobobia², Blandina T. Mmbaga^{2,3,5,6}, Sylvia Kaaya⁸, Michael V. Relf^{1,2}, David B. Goldston⁹

¹Duke University School of Nursing, Durham, NC, USA

²Duke Global Health Institute, Durham, NC, USA

³Kilimanjaro Clinical Research Institute, Moshi, Tanzania

⁴Duke Center for AIDS Research, Durham, NC, USA

⁵Kilimanjaro Christian Medical Centre, Moshi, Tanzania

⁶Kilimanjaro Christian Medical University, Moshi, Tanzania

⁷Duke Department of Emergency Medicine, Durham, NC, USA

⁸Department of Psychiatry and Mental Health, Muhimbili University of Health and Allied Sciences, Dar es Salaam, Tanzania

⁹Department of Psychiatry & Behavioral Sciences, Duke University, Durham, NC, USA

Abstract

Background: Suicide is a leading cause of death among people living with HIV (PLWH) worldwide, with suicide deaths occurring twice as frequently among PLWH than among the general public. In Tanzania, resources for mental health care are sorely lacking, with 55 psychiatrists and psychologists providing treatment for 60 million people. In light of this shortage, non-specialists play a crucial role. The objective of this study was to assess feasibility of implementing task-shifted screening, assessment, and safety planning for suicide risk among PLWH.

Setting: Two adult HIV clinics in Kilimanjaro, Tanzania.

Methods: Registered professional nurses in the HIV clinics were trained to administer brief screening of suicidal ideation in the past month. Patients experiencing suicidal ideation were

Corresponding author: Brandon A. Knettel, Ph.D., Duke University School of Nursing, 307 Trent Drive, Room 3080, Durham, NC 27710. Phone: 919-660-1218. brandon.knettel@duke.edu.

Disclosure statement: The authors report there are no competing interests to declare in relation to this research. An earlier version of this work was presented at the 2022 Association of Nurses in AIDS Care annual conference.

referred to Bachelor's-level counselors for further assessment and safety planning, supervised by specialist providers who reviewed audio recordings for quality assurance.

Results: During 180 days of implementation, nurses screened patients attending 2745 HIV appointments. Sixty-one (2.2%) endorsed suicidal ideation and were linked to further assessment and safety planning. We cross-checked screening with clinic attendance logs on seven random days and found high fidelity to screening (206/228 screened, 90%). Quality assurance ratings demonstrated key assessment pieces were consistently completed (mean=9.3/10 possible), with “Good” to “Excellent” counseling skills (mean=23.7/28), and “Good” to “Excellent” quality (mean=17.1/20), including appropriate referral for higher levels of care.

Conclusions: Brief screening can be implemented and paired with task-shifted counseling to facilitate high-quality assessment of suicide risk. This model shows excellent potential to extend mental health services for PLWH in low-resource settings.

Keywords

Counseling; HIV; Mental health; Referral and consultation; Suicide prevention; Task-shifting

Background

Suicide is a leading cause of death among people living with HIV (PLWH) worldwide, and PLWH are twice as likely to die by suicide compared to the general public.¹⁻³ Globally, more than 700,000 people die by suicide each year, and more than 75% of these deaths occur in low- and middle-income countries (LMICs).⁴ The true burden of suicide may be even higher, as reporting challenges, stigma, and criminalization of suicidal behavior often contribute to under-reporting or misclassification of suicide as a cause of death in many LMIC settings.^{5,6}

The elevated burden of suicide in LMICs is due to multiple factors, including socioeconomic challenges and other social determinants of health and well-being.⁷ Additionally, in many LMICs, resources for the assessment and treatment of suicide risk are sorely lacking.^{8,9} In Tanzania, only 55 psychiatrists and psychologists provide mental health treatment for more than 60 million people.^{10,11} In light of this remarkable shortage of formal treatment, nurses and non-specialists play a crucial role in identifying serious mental health challenges such as suicide risk among PLWH in Tanzania.^{8,12} However, task-sharing approaches must be utilized with caution to avoid the perception of “task-dumping,” or assigning new responsibilities to healthcare workers who may already be overtaxed and under-resourced in their existing roles.^{13,14}

Beyond assessment, very few strategies for suicide prevention have been developed for or adapted to African settings.¹⁵ We conducted a scoping review of counseling interventions for suicide prevention in Africa and identified only thirteen studies, including only five clinical trials.¹⁶ Findings from several studies showed reductions in suicidality among intervention participants; however, the mechanisms of change for suicide prevention were poorly articulated, presenting serious challenges for replicability.¹⁶

In high-resource medical settings, the ‘gold standard’ for assessing suicide risk involves universal screening of patients at elevated risk for death by suicide, such as PLWH; individuals who screen positive are then referred for a clinical interview with a mental health professional, guided by an evidence-based assessment tool.¹⁷ Patients identified as having considerable risk (i.e., a plan and/or intent to die by suicide) are guided to develop a safety plan, which involves identifying and documenting personal, social, and professional resources to avert suicide.^{18,19} Accompanying brief counseling is focused on identifying strengths, reasons for living, and eliciting hope and agency.^{20,21} Throughout the assessment and counseling process, the clinician assesses the need for higher levels of care including inpatient hospitalization.¹⁷

Given the disproportionate burden of suicide in LMICs and extreme shortages of mental health specialists, there is a critical need for brief yet effective interventions for suicide prevention. At the outset of this study, we were unable to identify any suicide interventions adapted to the Tanzanian setting. To address this need, we developed a suite of task-shifted services for brief screening, assessment, and safety planning for suicide risk among PLWH. The objective of this research was to assess the feasibility of implementing these resources in two adult HIV clinics in Kilimanjaro, Tanzania.

Methods

In Tanzania, HIV care is provided by Care and Treatment Centers (CTCs), most often embedded in hospitals or clinics. This research was conducted at two adult CTCs in the Kilimanjaro region of Tanzania. The first clinic is located within a large referral hospital and the second is located within a small community hospital, both in urban areas. Together, the clinics see approximately 4000 PLWH for regular HIV care, with a local adult HIV prevalence of approximately 4.8%.

Procedures

We trained registered professional nurses in the HIV clinics to administer a single screening item assessing suicidal ideation to all adult PLWH attending appointments at both study CTCs. Patients who screened positive for suicidal ideation were referred by the HIV nurses to meet with a Bachelor’s-level counselor for further assessment and safety planning. One of these counselors had completed a Bachelor’s of Psychiatry degree, which is the entry-level counselor credential in Tanzania, and the other was a non-specialist with extensive prior training and experience in providing brief counseling in research settings.

Nurses briefly explained the study and participants who indicated interest were accompanied to a private research office near the clinic to meet with the counselor. Participants who screened positive but were not interested in the study were to receive a referral for standard of care psychiatric services; however, in the current study, all participants who screened positive for suicidal ideation agreed to meet with the study counselor and all were enrolled in the study.

Patients were eligible to participate in this study if they were 18 years of age or older and able to speak Swahili or English. All participants provided written informed consent after

screening, prior to engaging in further assessment and counseling. During the screening and enrollment process, clinic nurses and study staff assessed whether patients were medically and cognitively capable of providing informed consent and completing the study procedures. Patients who screened positive for suicidal ideation but were not physically or cognitively capable of participating in the research were referred to a hospital-based psychiatry service.

Upon enrollment, the Bachelor's-level counselors conducted a clinical assessment using the Columbia-Suicide Severity Rating Scale (C-SSRS) Full Version²² and a structured safety planning intervention for all enrolled participants.²³ The C-SSRS assessment was audio recorded for later review and quality assurance, then translated and transcribed by a skilled bilingual interpreter. The safety planning intervention was not recorded due to confidentiality concerns, given its focus on naming and providing contact information for people who can provide support. Participants received 10,000 Tanzanian shillings (approximately \$4.50 U.S.) for time and transportation costs. At the conclusion of their participation, all participants received referral information for standard of care psychiatric services.

Prior to the start of the study, counselors received two weeks of daily training provided by two Tanzanian psychiatrists and a U.S.-based counseling psychologist. Training focused on general counseling skills, the study assessment and intervention, and suicide risk management. As part of training, counselors completed several mock assessment and safety planning sessions. Counselors were required to demonstrate acceptable fidelity and quality of care in mock sessions prior to engaging with patients, assessed by the Quality Assurance procedures described under "Measures" below.

After study enrollment began, counselors participated in one hour per week of ongoing clinical supervision with the supervising psychiatrists and psychologist, who reviewed audio recordings of assessments each week for quality assurance and provided verbal feedback to the counselors.

All intervention and assessment materials were translated to Swahili, back-translated to English, and revised by the research team in collaboration with partners at the HIV clinics to maximize linguistic and cultural equivalence. The study received ethical approval from the institutional review boards of the Tanzanian National Institute for Medical Research, Kilimanjaro Christian Medical Centre, and the Duke University Health System.

Measures

Suicidal Ideation.—HIV nurses assessed suicidal ideation using one yes/no item derived from the C-SSRS Screen Version²², "In the last month, have you had any actual thoughts of killing yourself?" Upon enrollment, Bachelor's-level counselors completed a full clinical assessment of suicide risk for all enrolled participants using the C-SSRS Full Version.²²

Quality Assurance.—For each weekly supervision session, one audio recorded C-SSRS assessment was selected, reviewed, and rated by the supervisors for quality assurance. In total, 14 recordings were assessed for quality assurance during this study period. Quality assurance was assessed using an adapted Enhancing Assessment of Common Therapeutic

Factors (ENACT) rating scale²⁴, which includes ratings of fidelity (completion of core assessment components), quality, and counseling skills (e.g., eliciting hope, active listening). Five fidelity items were rated as 0 – “Not Done”, 1 – “Partial”, or 2 – “Completed” for a total score of 0 to 10. Five quality and seven counseling skills items were rated on a scale of 0 – “Not Done” to 4 – “Excellent” for total scores of 0 to 20 (quality) and 0 to 28 (counseling skills).

Statistical Analysis

We assessed the proportion of patients screening positive for suicidal ideation during the 180-day (26-week) study period. To assess nurse fidelity to screening, we compared paper screening forms to clinic attendance records on seven random days, reported as a simple proportion. When patients were not screened, we followed up verbally with the nurses to record the reason. For the quality assurance forms, we calculated item and subscale descriptive statistics for fidelity/completion, quality, and counseling skills. For fidelity, we identified a pre-established threshold of 1.8 or greater (out of 2 possible, indicating 90% completion of core assessment components). For quality and counseling skills items, we identified a pre-established threshold of 3 or greater (out of 4 possible, representing “Good” to “Excellent” quality or skills) as acceptable. We also conducted Pearson correlations to assess changes in assessment fidelity/completion, quality, and counseling skills over the 26 weeks of data collections.

Results

During 180 days of implementation, nurses screened patients attending 2745 HIV appointments. Of these, 61 (2.2%) endorsed suicidal thoughts, all of whom were referred for assessment and safety planning and enrolled in the study. On seven random days, we found high fidelity to screening (206/228 patients screened, 90%). Among the 22 patients not screened on these days, 11 were due to nurses forgetting or neglecting to ask the screening question, 9 were due to competing nurse obligations, 1 was due to a patient’s acute emotional distress, and 1 was due to acute medical instability. The patient with acute emotional distress was referred directly to the psychiatry service at the hospital. The patient with acute medical instability was referred directly to an inpatient medical unit. To our knowledge, no study participants attempted suicide or died by suicide during the study period.

Three mental health professionals rated quality assurance for audio recordings of fourteen C-SSRS assessments. Ratings demonstrated that counselors consistently completed key assessment pieces (mean=1.88/2.00 possible, SD=0.19), with “Good” to “Excellent” quality (mean=3.43/4.00, SD=0.46), and “Good” to “Excellent” counseling skills (mean=3.46/4.00, SD=0.42).

Fidelity/completion item scores were consistently high, all met the pre-established threshold for fidelity, and no items were identified as specifically strong or challenging in the assessment. For quality, ratings were slightly lower for initial risk identification (mean=3.30) and assessment of intensity of ideation (mean=3.33), with supervisor feedback commonly focusing on the need for more clarity on the timing of onset of suicidal ideation,

plan, and intent. Quality was higher for assessing potential lethality (mean=3.61). For counseling skills, scores were slightly below the mean for eliciting hope (mean=3.09) and acknowledging the patient's experience (mean=3.20), and slightly above the mean for allowing expression of difficult emotion (mean=3.62) and avoiding giving advice (mean=3.61). Overall means for all items exceeded the pre-established threshold of 3.00 for acceptable assessment quality and skills. See Table 1 for additional detail.

Pearson correlations showed no significant changes over time (i.e., which week they were enrolled in the study) for fidelity/completion ($r=-.041$, $p=.891$) nor for assessment quality ($r=.268$, $p=.354$), both of which were consistently high across the study period. Counseling skills were high at baseline and significantly improved over the course of the study ($r=.544$, $p=.044$). See Figure 1 for additional detail.

Discussion

We developed a suite of task-shifted services for brief screening, assessment, and safety planning for suicide risk among PLWH. The objective of this research was to assess the feasibility of implementing these resources in two adult HIV clinics in Kilimanjaro, Tanzania. We observed high fidelity to suicide screening and referral among registered professional nurses in the HIV clinics. Upon referral, Bachelor's-level counselors consistently completed key assessment pieces with high fidelity, quality, and counseling skills.

Strong protocols exist for the exploration of suicide risk in sub-Saharan Africa, yet interventions are sorely lacking.^{15,25} This may be due to concerns about working with a high-risk population, particularly in settings where mental health resources are limited.¹⁵ With this demonstration that task-shifting can be effectively implemented to improve early screening, assessment, and access to safety planning, it is plausible for mental health specialists to redirect effort to the training and supervision of non-specialists and the treatment of select, higher-risk cases. This type of redistribution of tasks to improve reach and efficiency of care is a historical hallmark of task-shifting approaches.²⁶

HIV care in Tanzania has been successfully decentralized from larger tertiary hospitals to smaller hospitals and clinics throughout the country.^{27,28} These efforts have been extremely effective at improving access to HIV care; however, smaller clinics rarely have specialists available, including mental health providers. To maximize the benefits of task-shifting, governments should universally integrate suicide screening and prevention efforts in HIV care.²⁹

Future studies should first assess the adequacy of safety planning for suicide prevention and the additional human resource capacity needed to effectively reduce suicide attempts and deaths by suicide. For higher acuity cases, including patients at immediate risk for suicide, it may be necessary to integrate other innovative strategies for implementation. This may include telehealth links to remote counselors, the establishment of national mental health crisis hotlines, and improving emergency transportation options to assist patients in reaching hospitals where psychiatric services exist.^{30,31} Similar efforts are also needed to integrate

task-shifted assessment and intervention for suicide risk among people experiencing other serious health conditions, such as cancer and traumatic injury.^{32,33}

A limitation of this study is that we did not assess the quality of safety planning due to confidentiality concerns related to recording these sessions. However, we believe ratings of suicide risk assessment and associated counseling provided a reasonable picture of the quality of all services provided. Finally, these data were focused on feasibility and did not assess patient acceptability of these resources, which will be a crucial area for future research.

Conclusions

Suicide is a leading cause of death among PLWH, yet few resources have been implemented in low- and middle-income countries to assess and intervene for suicidal ideation. In contexts where few mental health providers are available, task-shifting is an essential approach for improving capacity. In this study, we demonstrated that brief screening can be implemented by HIV clinic nurses and that the historical ‘gold standard’ clinical interview by a psychiatrist or psychologist can be effectively task-shifted to non-specialist counselors. This model shows excellent potential to extend mental health services for PLWH in low-resource settings.

Funding details:

Dr. Knettel is supported by a Career Development Award from the NIH National Institute of Mental Health (K08 MH124459). We also acknowledge support from the grant, “Sociobehavioral Sciences Research to Improve Care for HIV Infection in Tanzania” (D43 TW009595) and the Duke Center for AIDS Research (P30 AI064518), an NIH-funded program.

References

1. Croxford S, Kitching A, Desai S, et al. Mortality and causes of death in people diagnosed with HIV in the era of highly active antiretroviral therapy compared with the general population: an analysis of a national observational cohort. *Lancet Public Health*. 2017;2(1):e35–e46. doi:10.1016/S2468-2667(16)30020-2 [PubMed: 29249478]
2. Smith CJ, Ryom L, Weber R, et al. Trends in underlying causes of death in people with HIV from 1999 to 2011 (D:A:D): a multicohort collaboration. *Lancet Lond Engl*. 2014;384(9939):241–248. doi:10.1016/S0140-6736(14)60604-8
3. Tsai YT, Padmalatha S, Ku HC, et al. Suicidality among people living with HIV during 2010–2021: a systematic review and a meta-regression. *Psychosom Med*. 2022; Publish Ahead of Print. doi:10.1097/PSY.0000000000001127
4. World Health Organization. Suicide. World Health Organization; 2021. Accessed April 13, 2022. <https://www.who.int/news-room/fact-sheets/detail/suicide>
5. Aggarwal S, Borschmann R, Patton GC. Tackling stigma in self-harm and suicide in the young. *Lancet Public Health*. 2021;6(1):e6–e7. doi:10.1016/S2468-2667(20)30259-0 [PubMed: 33417848]
6. Uddin R, Burton NW, Maple M, Khan SR, Khan A. Suicidal ideation, suicide planning, and suicide attempts among adolescents in 59 low-income and middle-income countries: a population-based study. *Lancet Child Adolesc Health*. 2019;3(4):223–233. doi:10.1016/S2352-4642(18)30403-6 [PubMed: 30878117]
7. Lemmi V, Bantjes J, Coast E, et al. Suicide and poverty in low-income and middle-income countries: a systematic review. *Lancet Psychiatry*. 2016;3(8):774–783. doi:10.1016/S2215-0366(16)30066-9 [PubMed: 27475770]

8. Fleischmann A, Arensman E, Berman A, et al. Overview evidence on interventions for population suicide with an eye to identifying best-supported strategies for LMICs. *Glob Ment Health*. 2016;3:e5. doi:10.1017/gmh.2015.27
9. World Health Organization. Preventing Suicide: A Global Imperative. World Health Organization; 2014. Accessed April 13, 2022. <https://www.who.int/publications-detail-redirect/9789241564779>
10. Knettel BA, Rugira J, Tesha F. “They will start believing in counseling”: Provider perceptions of the presentation and treatment of mental illness in northern Tanzania. *Int Perspect Psychol Res Pract Consult*. 2018;7(1):4–18. doi:10.1037/ipp0000078
11. WHO. Mental Health Atlas 2017. World Health Organization; 2018. http://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/
12. Knettel BA, Wanda L, Amiri I, et al. Assessing the Influence of Community Health Worker Support on Early Antiretroviral Therapy Adherence, Anticipated Stigma, and Mental Health Among People Living with HIV in Tanzania. *AIDS Patient Care STDs*. 2021;35(8):308–317. doi:10.1089/apc.2021.0028 [PubMed: 34375138]
13. Dambisya YM, Matinhure S. Policy and programmatic implications of task shifting in Uganda: a case study. *BMC Health Serv Res*. 2012;12(1):61. doi:10.1186/1472-6963-12-61 [PubMed: 22409869]
14. Jacobs Y, Myers B, van der Westhuizen C, Brooke-Sumner C, Sorsdahl K. Task Sharing or Task Dumping: Counsellors Experiences of Delivering a Psychosocial Intervention for Mental Health Problems in South Africa. *Community Ment Health J*. 2021;57(6):1082–1093. doi:10.1007/s10597-020-00734-0 [PubMed: 33161458]
15. Venturo-Conerly KE, Wasil AR, Osborn TL, Puffer ES, Weisz JR, Wasanga CM. Designing Culturally and Contextually Sensitive Protocols for Suicide Risk in Global Mental Health: Lessons From Research With Adolescents in Kenya. *J Am Acad Child Adolesc Psychiatry*. Published online February 22, 2022. doi:10.1016/j.jaac.2022.02.005
16. Knettel BA, Knippler E, Martinez A, et al. A scoping review of counseling interventions for suicide prevention in Africa: Few studies address this life-saving aspect of mental health treatment. *J Affect Disord*. 2023;328:183–190. doi:10.1016/j.jad.2023.02.038 [PubMed: 36806597]
17. Ryan EP, Oquendo MA. Suicide Risk Assessment and Prevention: Challenges and Opportunities. *FOCUS*. 2020;18(2):88–99. doi:10.1176/appi.focus.20200011 [PubMed: 33162846]
18. Ferguson M, Rhodes K, Loughhead M, McIntyre H, Procter N. The Effectiveness of the Safety Planning Intervention for Adults Experiencing Suicide-Related Distress: A Systematic Review. *Arch Suicide Res Off J Int Acad Suicide Res*. Published online April 29, 2021:1–24. doi:10.1080/13811118.2021.1915217
19. Stanley B, Brown GK, Brenner LA, et al. Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department. *JAMA Psychiatry*. 2018;75(9):894–900. doi:10.1001/jamapsychiatry.2018.1776 [PubMed: 29998307]
20. Finlayson BT, Jones E, Pickens JC. Solution Focused Brief Therapy Telemental Health Suicide Intervention. *Contemp Fam Ther*. Published online August 10, 2021. doi:10.1007/s10591-021-09599-1
21. Govender RD, Schlebusch L, Esterhuizen T. Brief suicide preventive intervention in newly diagnosed HIV-positive persons. *Afr J Psychiatry J Afr Psychiatr*. 2014;17:543–547. doi:10.4172/1994-8220.1000112
22. Posner K, Brown GK, Stanley B, et al. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. *Am J Psychiatry*. 2011;168(12):1266–1277. doi:10.1176/appi.ajp.2011.10111704 [PubMed: 22193671]
23. Stanley B, Brown GK. Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. *Cogn Behav Pract*. 2012;19(2):256–264. doi:10.1016/j.cbpra.2011.01.001
24. Kohrt BA, Jordans MJD, Rai S, et al. Therapist competence in global mental health: Development of the ENhancing Assessment of Common Therapeutic factors (ENACT) rating scale. *Behav Res Ther*. 2015;69:11–21. doi:10.1016/j.brat.2015.03.009 [PubMed: 25847276]
25. Merrill KG, Mwansa JK, Miti S, et al. Experiences with a violence and mental health safety protocol for a randomized controlled trial to support youth living with HIV. *Glob Health Res Policy*. 2021;6(1):40. doi:10.1186/s41256-021-00224-0 [PubMed: 34654487]

26. Bolton P. 1 - Global mental health and psychotherapy: Importance of task-shifting and a systematic approach to adaptation. In: Stein DJ, Bass JK, Hofmann SG, eds. *Global Mental Health and Psychotherapy. Global Mental Health in Practice*. Academic Press; 2019:11–24. doi:10.1016/B978-0-12-814932-4.00001-X
27. Fonner VA, Geurkink D, Chiwanga F, Amiri I, Likindikoki S. Long-Distance Travel for HIV-Related Care—Burden or Choice?: A Mixed Methods Study in Tanzania. *AIDS Behav*. 2021;25(7):2071–2083. doi:10.1007/s10461-020-03136-1 [PubMed: 33415657]
28. Tanzania Ministry of Health. Decentralized and Integrated HIV and AIDS Care, Treatment and Support Services – National AIDS Control Programme. Published 2022. Accessed October 21, 2022. <https://nacp.go.tz/decentralized-and-integrated-hiv-and-aids-care-treatment-and-support-services/>
29. Bantjes J, Kagee A. Suicide Prevention in HIV Treatment Centres: Population Attributable Risk Analysis of Treating Common Mental Disorders. *AIDS Behav*. 2021;25(6):1864–1872. doi:10.1007/s10461-020-03116-5 [PubMed: 33387136]
30. Ngcobo-Sithole MB, Mabusela TE. Chapter Nine - Challenges and opportunities in the provision of mental health care services during the COVID-19 pandemic and beyond. In: Kaklauskas A, Abraham A, Okoye K, Guggari S, eds. *Lessons from COVID-19*. Academic Press; 2022:241–262. doi:10.1016/B978-0-323-99878-9.00008-X
31. Wright S, Thompson N, Yadrich D, et al. Using telehealth to assess depression and suicide ideation and provide mental health interventions to groups of chronically ill adolescents and young adults. *Res Nurs Health*. 2021;44(1):129–137. doi:10.1002/nur.22089 [PubMed: 33305830]
32. Qin P, Syeda S, Canetto SS, et al. Midlife suicide: A systematic review and meta-analysis of socioeconomic, psychiatric and physical health risk factors. *J Psychiatr Res*. 2022;154:233–241. doi:10.1016/j.jpsychires.2022.07.037 [PubMed: 35961179]
33. Saab MM, Murphy M, Meehan E, et al. Suicide and Self-Harm Risk Assessment: A Systematic Review of Prospective Research. *Arch Suicide Res*. 2021;0(0):1–21. doi:10.1080/13811118.2021.1938321

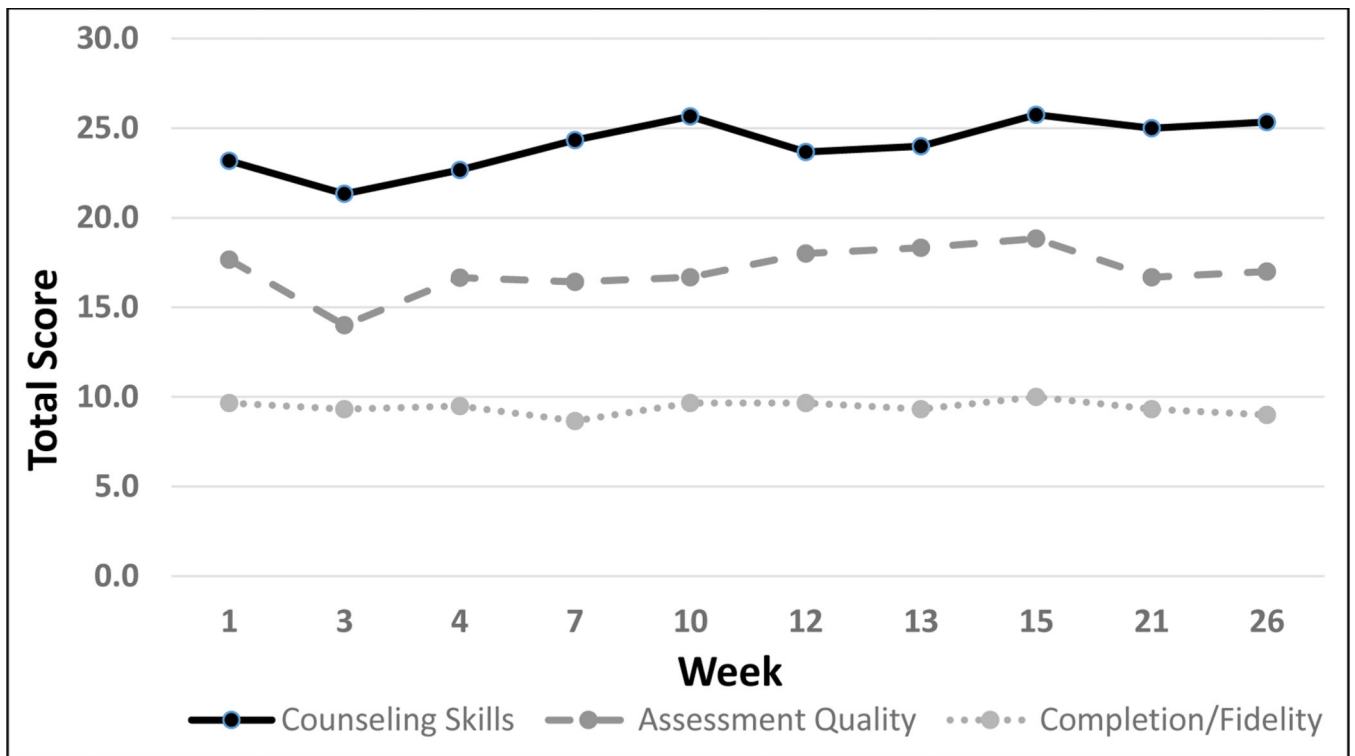


Figure 1.
Ratings of C-SSRS Completion/Fidelity, Quality, and Counseling Skills Over Time
Note: Total Score is the sum of the item scores for each section of the ENACT rating scale

Table 1.

Mean Item Ratings for C-SSRS Assessment Fidelity, Quality, and Counseling Skills

Fidelity/Completion (out of 2.00 possible)						
Item	Risk Identification	Intensity of Ideation	Past Attempt	Suicidal Behavior	Lethality	Total
Mean Score	1.86	1.86	1.91	1.89	1.88	1.88

Assessment Quality (out of 4.00 possible)						
Item	Risk Identification	Intensity of Ideation	Past Attempt	Suicidal Behavior	Lethality	Total
Mean Score	3.30	3.33	3.44	3.38	3.61	3.43

Counseling Skills (out of 4.00 possible)								
Item	Non-Judgmental	Elicits Hope	Expresses Warmth	Acknowledges Experience	Active Listening	Allows Emotion	Avoids Advice	Total
Mean Score	3.43	3.09	3.30	3.20	3.48	3.62	3.61	3.46