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ADVANCES IN PHARMACY PRACTICE

Pharmacist training in suicide prevention

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ABSTRACT

Objective: Suicide in the United States is a major preventable public health problem. Pharmacists need to be educated on suicide prevention strategies so that they can increase their own awareness and identify patients at-risk. A training program for pharmacists was used to provide skills necessary to recognize a crisis and the warning signs of suicide. The program's effect on the participant's general perception, self-efficacy, and attitude towards suicide prevention was examined.

Setting: Various academic, health care, and professional meetings throughout San Diego County.

Practice innovation: First Question, Persuade, and Refer training program targeting pharmacists.

Evaluation: A self-administered presurvey, postsurvey and, Program Outcome Evaluation were given to participants of the suicide training program. Items included demographics, general perception, self-efficacy, and attitude toward suicide prevention. Descriptive statistics were used to describe participants' demographics. *t* tests were used to compare general perception, attitudes, and self-efficacy scores between pretest and post-program evaluation survey responses. Nonparametric Wilcoxon signed rank analyses for matched pairs were used to compare survey responses that asked about attitudes before and after trainings. Regression analyses were conducted to assess factors associated with general perception, self-efficacy, and attitudes.

Results: Participants were more likely to update knowledge after training and reported more confidence to make an intervention for a patient at risk for suicide.

Conclusion: Our findings suggest that a suicide prevention training program helped pharmacist respondents build confidence in several self-efficacy areas relating to detection of suicide signs, response to patients with suicidal thoughts, reassurance for patients, and provision of resources and referrals.

Suicide is a major preventable public health problem[1] and a priority area for the National Institute of Mental Health.[2] The number of suicides in San Diego[3] is similar to that nationwide (13.2 per 100,000 vs. 12.9 per 100,000) but considerably higher than the California average (10.5 per 100,000).[1] Health professionals, including pharmacists, need to be educated on suicide prevention strategies so that they can increase their own awareness and identify and refer at-risk individuals. Pharmacists can help to identify patients through day-to-day interactions with patients and during more formal interactions, such as comprehensive medication management. Pharmacists also have a role in suicide prevention because medications are common methods of suicide.

Pharmacists are among the most trusted professionals and are often the most accessible health professionals.[4] Pharmacists practice in multiple settings, including community pharmacies, hospitals, long-term care facilities, managed care organizations, and government agencies. Even within the busy environment of community pharmacies, pharmacists have demonstrated success in increasing immunization rates and implementing practice recommendations based on educational activities, such as diabetes education, sunscreen application, and melanoma prevention.[5] Recently, Walgreens announced that it will be partnering with Mental Health America to provide increased access to and resources for mental health services.[6] There appears to be a need and demand for training programs in mental health for pharmacists in the community.

As a first in the country, the state of Washington now requires all licensed pharmacists in the state to attend a one-time 3-hour Washington State Department of Health–approved suicide prevention training course before the 2018 license renewal date. Programs and legislation that require suicide prevention training can result in an increased number of pharmacists to be trained.

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Key Points

Background:

- Suicide is a major preventable public health issue in the United States.
- Pharmacists are well positioned to identify patients at risk for suicide.

Findings:

- Training can increase pharmacist respondents' self-efficacy areas relating to detection of suicide signs, response to patients with suicidal thoughts, reassurance for patients, and provision of resources and referrals.
- Training can increase desire to update knowledge of suicide and make appropriate recommendations.
- Other changes in perception of suicide may take multiple interventions.

Setting

Four suicide prevention trainings were conducted between Summer 2013 and Spring 2015. All training sessions were conducted in person by at least 1 trainer from Community Health Improvement Partners (CHIP; described in detail later) and 1 academic trainer. Pharmacists were invited to attend 1 of the live training sessions using listservs from professional organizations, personal contacts, websites, and e-mail announcements to pharmacist preceptors and residents. Sessions were held in various locations, including professional organization continuing education meetings, medical center, and school of pharmacy. The length of each session was 1.5 hours. The training was divided into 3 parts: (1) importance of pharmacists to be trained in suicide prevention, medications as a common method of suicide, and ways for pharmacists to detect those at high risk for suicide; (2) suicide statistics including protective and risk factors; and (3) Question, Persuade, and Refer (QPR) training, including role-play exercises. The academic trainer was responsible for Part 1 and administering the surveys to participants, and the CHIP trainer was responsible for Parts 2 and 3.

Practice innovation

Currently, there is no published educational program that has targeted pharmacists to increase their awareness of suicide prevention strategies for their patients. We used the basis of *Question, Persuade, and Refer (QPR) Gatekeeper Training Program*[7] to prepare training sessions for pharmacists. The QPR is a validated, national, best practice intervention for training individuals using a "train-the-trainer" method created by Paul Quinnett, PhD, and first described in 1995 in a number of presentations and publications by the QPR Institute. More than 9000 Certified QPR Instructors have been trained in the United States and abroad through 2011, and more than 1,000,000 American citizens had been trained as QPR gatekeepers by the end of 2009, at a current rate of approximately 20,000 persons per month. QPR is designed to provide to the public the basic skills necessary to recognize a crisis and the warning signs of suicide to be able to refer someone to help. QPR is described as cardiopulmonary recitation or an emergency mental health intervention for suicidal persons.

QPR training was provided in partnership with CHIP, a community organization contracted with the County of San Diego Health and Human Services Agency to provide a range of programs, including suicide prevention. QPR has been adopted by the county as the preferred method for suicide prevention training. CHIP collaborates with San Diego health care systems, hospitals, community clinics, insurers, physicians, universities, and other community-based organizations. CHIP, via its facilitation of the San Diego County Suicide Prevention Council, has disseminated this suicide prevention training program for the lay community and first-responder health professionals. To successfully disseminate the QPR training within the pharmacy community, CHIP approached the University of California San Diego Skaggs School of Pharmacy and Pharmaceutical Sciences (SSPPS) to partner, design, and deliver enhanced QPR training for pharmacists throughout the county.

Evaluation

Program evaluation

The suicide prevention training program was evaluated using survey methods. The survey instrument was constructed to examine the program's effect on the participant's general perception, self-efficacy, and attitude toward suicide

Table 1
Self-efficacy for suicide prevention (n = 77)

Questions		Not confident, n (%)	Not very confident, n (%)	Neutral, n (%)	Somewhat confident, n (%)	Extremely confident, n (%)
1.	How confident are you in your ability to identify the signs of suicide?	0	2 (2.6)	12 (15.6)	49 (63.6)	14 (18.2)
2.	How confident are you in your ability to listen without judgment?	0	1 (1.3)	5 (6.5)	31 (40.3)	40 (51.9)
3.	How confident are you in responding appropriately to patients who have suicidal thoughts?	0	3 (3.9)	14 (18.2)	45 (58.4)	15 (19.5)
4.	How confident are you in your ability to give reassurance?	0	1 (1.3)	11 (14.3)	44 (57.1)	21 (27.3)
5.	How confident are you in your ability to provide resources for suicide prevention?	0	3 (3.9)	11 (14.3)	28 (36.4)	35 (45.5)
6.	How confident are you in deciding whether medical intervention is necessary?	1 (1.3)	3 (3.9)	19 (24.7)	39 (50.6)	15 (19.5)
7.	How confident are you in your ability to competently refer patients to other agencies?	0	2 (2.6)	9 (11.7)	35 (45.5)	31 (40.3)

prevention. The general perception construct was composed of 10 true-or-false questions based on "Myths and Facts about Suicide" developed by CHIP for the QPR program. The perception questions were related to suicide prevention, child and adolescent suicidal behavior, and gender differences in suicidal behavior (survey available at http://www.sdchip.org/initiatives/suicide-prevention-council/trainings/). The general perception questions were included in the pretest and posttest program evaluation surveys.

The self-efficacy and attitude questions were based partially on the authors' previous development of a train-the-trainer program for pharmacists.[8-10] Participants were asked 7 self-efficacy questions about confidence in identifying and responding to symptoms of suicide; questions and responses are listed in Table 1. Four attitude questions were self-rated likelihood of updating knowledge (1 question about before and 1 question about after suicide prevention training) and making appropriate interventions for patients who might benefit from suicide prevention (1 question about before and 1 question about after suicide prevention training); responses included "not at all likely," "a little likely," "moderately likely," "very likely," and "extremely likely." These 4 attitude questions were assessed using a retrospective pretest and posttest design (both pretest and posttest were assessed with the post-training survey). The decision to use a retrospective design was based on published literature that found this design to be a more sensitive measure of assessing the effects of a training program, allowing control for response-shift bias.[11-15]

In addition to demographics (age, sex, race, practice setting, years in practice), participants were asked 3 questions about bias toward suicide prevention (whether suicide can be prevented, previous training in suicide prevention, personal contact with individual who died by suicide) with response options as "yes" or "no." At the beginning of the training session, participants were asked to complete the pretest survey that included 10 general perception questions. Completed pretest surveys were collected by 1 of the trainers within 5-10 minutes of the start of the session. After the training session, participants were asked to complete the program outcome evaluation survey, which included the same 10 general perception questions and the questions about self-efficacy and attitude toward suicide prevention. CHIP provided guidance for grading questions about perception.

Analysis

Descriptive statistics (percentage, mean, median, standard deviation, range) were used to describe participants' demographics. *t* tests were used to compare general perception, attitudes, and self-efficacy scores between pretest and posttest program evaluation survey responses. Linear regression analyses were conducted to assess factors associated with general perception, self-efficacy, and attitudes; the 7 factors included in the regression analyses were age, sex, ethnicity, years in practice, thinking suicide could be prevented, knowing anyone close who had died by suicide, or ever receiving prior training. Parametric tests were used for *t* tests and linear regression analyses when the outcomes of interests were reported on the summative level, whereas nonparametric tests were used when the comparative outcomes were responses on Likert scales. Nonparametric Wilcoxon signed rank analyses for matched pairs were used to compare survey responses about attitudes before and after trainings (2 sets of questions were assessed on the posttest). Analyses were conducted using SPSS version 23 (Armonk, NY) and STATA Version IC12.1 (College Station, TX).

Results

Over a 2-year period, we conducted 4 training sessions for 103 pharmacists. Response rates for the pretest and posttest surveys were 65% (n = 67) and 76% (n = 77), respectively. Demographics are described from the posttest survey. The mean age of the respondents who completed both the pretest and posttest was 43 ± 16 years (range, 22-74 y), with 48% in the age group between 21 and 40 years, 30% between ages 41 and 55 years, and 22% older than 56 years. Approximately 59% of respondents (n = 41) were female. Respondents were mostly not Spanish, Hispanic, or Latino (96%; n = 65) and were predominantly Asian (40%; n = 27) and white (46%; n = 31) ethnicities. Of those who responded to the question about practice setting (63/77), 30% (n = 19) reported practicing in the community, 11% (n = 7) in outpatient and ambulatory care, 8% (n = 5) in hospital and inpatient care, 2% (n = 1) in a nursing home, 10% (n = 6) in academia, 21% (n = 13) not in clinical practice, and 19% (n = 12) in other settings. The average year in practice as a pharmacist varied greatly among the respondents (20 ±14 y; range, 0-50 y). All (100%) respondents believed that suicide can be prevented; 45% of respondents reported knowing someone close (relative, friend, colleague, trainee) who died by suicide, and only 23% of respondents had ever received previous training in suicide prevention.

In the pretest for general perception, the mean score for correct responses (out of 10 questions total) was 80% ± 16%; 34% of respondents answered at least 90% of the questions correctly. In the posttest, the mean score for correct responses was 82% ± 11%; 37% of respondents answered at least 90% of the questions correctly. There was no statistically significant difference in respondents' general perception before and after the suicide prevention training. No factors were found to be significantly associated with correct responses of general perception at the end of the training.

Regarding self-efficacy of suicide prevention after the training, greater than 75% of respondents felt somewhat confident or extremely confident in identifying signs of suicide, responding appropriately to patients who have suicidal thoughts, giving reassurance to prevent suicide, providing resources for suicide prevention, and referring patients to other agencies (Table 1). More than 90% of respondents were confident in their ability to listen without judgment. Only 70% of respondents felt confident in deciding whether medical intervention is necessary. Several factors were significantly associated with 2 self-efficacy items. For the self-efficacy item "confidence in the ability to identify the signs of suicide," knowing someone close who had ever died by suicide was associated with less confidence ($\beta = -0.487$; $t = -3.11$; $P = 0.003$); similarly, having previous training in suicide prevention was also associated with less confidence ($\beta = -0.640$; $t = -3.11$; $P = 0.003$). For the self-efficacy item "confidence in the ability to give reassurance," older age was associated with less confidence ($\beta = -0.042$; $t = -2.39$; $P = 0.022$); longer years in practice was associated with more confidence

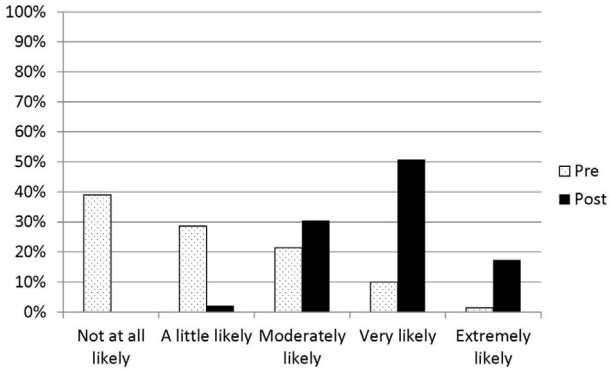

Figure 1. How likely are you to update your knowledge in suicide prevention at frequent intervals? (n = 69). Wilcoxon signed rank test for matched pairs ($P < 0.0001$).

(β = 0.051; $t = 2.67$; $P = 0.011$); and being Hispanic was associated with having more confidence (β = 1.018; $t = 2.07$; $P = 0.045$).

Statistically significant changes in attitudes toward suicide prevention were observed (Figures 1 and 2). The overall mean scores for respondents' likelihood to update their knowledge in suicide prevention before and after training were 2.1 ± 1.1 and 3.8 ± 0.7 ($P < 0.001$), respectively. Their individual responses on a Likert scale of pretraining and posttraining self-ratings for updating knowledge significantly improved ($P < 0.0001$; Figure 1); there was a shift in pretraining versus posttraining response of not at all likely (39% vs. 0%), a little likely (29% vs. 2%), moderately likely (21% vs. 30%), very likely (10% vs. 51%), or extremely likely (1% vs. 17%). The proportion of participants who rated their overall likelihood to update their knowledge as moderately, very, or extremely likely increased from 32% to 98%. Regression analyses showed that having previous training was significantly associated with the respondents' likelihood to update knowledge before suicide prevention training (β = 0.854; $t = 2.34$; $P = 0.024$); however, no factors were found to be significantly associated with their likelihood to update knowledge after training.

The overall mean scores for respondents' likelihood of making appropriate interventions for patients who might benefit from suicide prevention because of personal values and bias before and after training were 2.9 ± 1.0 and 4.1 ± 0.6 ($P < 0.001$), respectively. Their individual responses on a Likert scale of pretraining and posttraining self-ratings for making appropriate interventions significantly improved ($P < 0.0001$; Figure 2); there was a shift in pretraining versus posttraining response of not at all likely (10% vs. 0%), a little likely (17% vs. 0%), moderately likely (48% vs. 13%), very likely (19% vs. 61%), or extremely likely (6% vs. 26%). The proportion of participants who rated their overall likelihood to update their knowledge as moderately, very, or extremely likely increased from 73% to 100%. Regression analyses showed that no factors were significantly associated with respondents' likelihood of making appropriate interventions for patients before suicide prevention training; however, having previous training was associated with their likelihood of making appropriate interventions for patients after training (β = −0.476; $t = -2.26$; $P = 0.029$).

Practice implications

Pharmacists can play a vital role in identifying patients at risk for suicide. However, one of the many barriers facing the community pharmacists is time. Training pharmacists to identify key indicators for suicidal ideation efficiently amid routine patient interactions or comprehensive medication management (CMM) may allow screening of patients who may be at high risk and need additional attention. This training also improves pharmacists' assurance to properly refer to suicide prevention resources in their community.

Discussion

Several suicide prevention training programs for physicians have been implemented and evaluated.[16-24] However, we are aware of only 1 training program for health professionals that includes pharmacists[25] and 2 reports from surveys about Japanese pharmacists' attitudes toward suicide[26] and Canadian pharmacists' perceptions of their ideal and actual involvement in providing suicide prevention.[27]

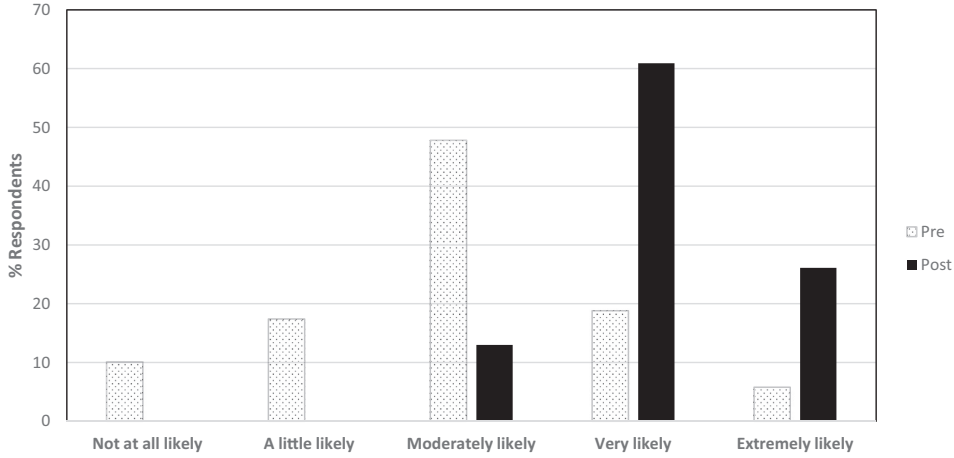

Figure 2. Before and after your suicide prevention training, how likely were you to make appropriate interventions for patients who may benefit from suicide prevention, due to your personal values and biases? (n = 69). Wilcoxon signed rank test for matched pairs ($P < 0.0001$).

In this study, pharmacist respondents who completed the posttest and program evaluation surveys were younger (48% were between ages 21 and 40 y) compared with 28% in the 2014 National Pharmacists Workforce Survey.[28] This could be due, in part, to a group of pharmacy residents who were invited to participate. This could also suggest that younger pharmacists were more interested in learning about suicide prevention. Gender distributions were similar compared to the National Pharmacists Workforce Survey (59% of women in the study vs. 53% from the national workforce report).[28] Hispanic attendees (4%) represented a similar proportion on the national landscape[28]; however, many more Asian pharmacists (40% in the study vs. 8.5% from the national workforce report) participated.[28] This may be due to the higher proportion of Asian pharmacists residing and practicing in California.[29] A higher proportion of the program respondents practiced in a nonpatient care setting (20% vs. 7.5% in the national workforce report)[23]; this may be due to collaborative efforts with pharmacy school faculty and with the California Pharmacists Association. The highest proportion of participants (almost one-third) worked in the community pharmacy setting, similar to the highest proportion (44%) of practice setting in the national workforce report.[28] This might reflect the community pharmacists' interests because of their frequent interactions with the general public. Although relatively young, this group of pharmacist participants had extensive work experience, with an aggregate average of 20 years in practice. Those not currently in practice may be unemployed, retired, working in the industry, or working in indirect patient care areas but have attended a statewide professional society meeting.

All respondents indicated that suicide could be prevented, suggesting that this belief motivated them to attend the training program. Although almost one-half of the respondents had known someone close to them who died by suicide, only one-quarter of them had ever received suicide prevention training. In a survey related to suicide intervention skills and related factors, community professionals including pharmacists reported low self-rated skills in dealing with suicidal patients.[20] This could be due to a lack of accessible training programs for pharmacists. This training was a result of community and academic partnerships between CHIP and SSPPS to expand suicide prevention training to pharmacists. During training, pharmacists learned not only about signs and symptoms of suicide but also about available resources for suicide prevention. It could be helpful if such partnership could be replicated or expanded to reach more pharmacists or student pharmacists from other regions.

In this training program, pharmacists' general perception about suicide showed a slight trend of improvement but did not significantly change. General perceptions about suicide could be affected by cultural beliefs that people develop over time, and a brief training program such as that described here might not easily change a person's general perceptions about suicide. In addition, it appeared that general perceptions could not be easily changed by factors such as age, sex, ethnicity, work experience, personal acquaintance, and previous training. The pretest survey results indicate that the respondents already had high general perceptions about suicide, which could explain the lack of statistically significant change on the posttest. Reports from physician training programs have found that suicide assessment and management knowledge significantly improved between pretests and posttests,[13,30] with effects remaining significant after 3 months. However, a physician study reported by Matthew found suicide prevention to improve only slightly (from 18.4 to 19.4), and the effectiveness was lost after 6 months.[23]

As expected, the suicide prevention training program increased pharmacist respondents' self-efficacy areas relating to detection of suicide signs, response to patients with suicidal thoughts, reassurance for patients, and provision of resources and referrals. Similarly, physician education was associated with increased rates of inquiry about suicide risk and screening patients for suicide prevention.[21,28] In addition, one interprofessional training program that included pharmacists showed that participants improved their ability to distinguish important suicide risk categories and awareness.[31]

We found that respondents' confidence in identifying signs of suicide decreased if they knew someone close to them who had died by suicide. This is understandable, as a personal experience has a far more powerful impact than a brief training program. It is possible that respondents felt inadequate in identifying signs of suicide, especially if they thought they should have recognized the symptoms before someone close to them died by suicide. Of interest is that having previous training in suicide prevention led to less confidence, which can be explained with the Aristotle quote: “The more you know, the more you know you don't know.” Regarding confidence in the ability to give reassurance, a possible explanation for why older age was associated with less confidence could be due to the social taboo of suicide among the older generation.[32] On the contrary, we found that having longer years in practice somehow helped older respondents build more confidence. Another interesting finding was that Hispanic ethnicity was also associated with having more confidence in giving reassurance. A previous report showed that Hispanics or Latinos had increased likelihood of willingness to seek professional help and were less embarrassed about seeking help for mental health care.[33] Perhaps Hispanics or Latinos are more comfortable discussing mental health topics, which instills more confidence. This is also consistent with a report from Mental Health America, which found that Latinos are highly likely to seek guidance from a peer for mental health–related issues.[34]

The training program had significant effects on changing attitudes in updating knowledge and making appropriate interventions among pharmacist respondents. Although the training program did not show a significant difference in general concepts about suicide, the training improved the changing of these attitudes. General concepts can take longer to change and can be affected by cultural factors,[35] but we found that attitudes were changed by the brief 1.5-hour session. Having previous training was significantly associated with both attitudes, showing that pharmacists who had previously received training and remained interested in attending additional training had positive attitudes toward wanting to learn more and to make appropriate interventions. Similarly, Kodaka et al.[26] also found that pharmacist participants who previously received suicide-related education were more likely to have positive attitudes toward suicide prevention.[26]

Limitations

Limitations of the study include having only 1 brief, 1.5-hour training session; it is difficult to assess changes or sustainable

effects from 1 training session. Training sessions also occurred in different settings and venues (e.g., local, statewide, professional society meeting, academic). The participants were self-selected, and this bias could have influenced responses seen in the pretest and posttest surveys. Administration of the surveys was conducted at the beginning and end of the training session; we could not assess sustainable effects from the training program. In addition, we do not have information to validate respondents' actual knowledge or self-efficacy in their practice, although this may be an area of future research.

Conclusion

A suicide prevention training program is helpful in building pharmacist confidence in self-efficacy areas relating to detection of suicide signs, response to patients with suicidal thoughts, reassurance for patients, and provision of resources and referrals. Furthermore, the training program is associated with changing pharmacist attitudes to be more likely to update knowledge and to make appropriate interventions for patients at risk for suicide.

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Question, Persuade, and Refer Suicide Prevention Training for Pharmacists Pretest

Please answer each question to the best of your knowledge.			
1.	No one can stop a suicide; it is inevitable.	⊙1 True	⊙2 False
2.	Confronting a person about suicide will only make him or her angry and increase the risk of suicide.	⊙1 True	⊙2 False
3.	Only experts can prevent suicide.	⊙1 True	⊙2 False
4.	Suicidal people keep their plans to themselves.	⊙1 True	⊙2 False
5.	Adolescents who talk about suicide do not attempt or die by suicide.	⊙1 True	⊙2 False
6.	Parents are often unaware of their child's behavior.	⊙1 True	⊙2 False
7.	Most adolescents who attempt suicide fully intend to die.	⊙1 True	⊙2 False
8.	Once a person decides to die by suicide, there's nothing anyone can do to stop him or her.	⊙1 True	⊙2 False
9.	There is a significant difference between male and female adolescents regarding suicidal behavior.	⊙1 True	⊙2 False
10.	Talking about suicide in the classroom will promote suicidal ideas and suicidal behavior.	⊙1 True	⊙2 False

SUICIDE PREVENTION COUNCIL SUICIDE PREVENTION FOR PHARMACISTS TRAINING

Program Outcome Evaluation

Please answer Questions 1-10.

1.	No one can stop a suicide; it is inevitable.	⊙1 True ⊙2 False
2.	Confronting a person about suicide will only make him or her angry and increase the risk of suicide.	⊙1 True ⊙2 False
3.	Only experts can prevent suicide.	⊙1 True ⊙2 False
4.	Suicidal people keep their plans to themselves.	⊙1 True ⊙2 False
5.	Adolescents who talk about suicide do not attempt or die by suicide.	⊙1 True ⊙2 False
6.	Parents are often unaware of their child's behavior.	⊙1 True ⊙2 False
7.	Most adolescents who attempt suicide fully intend to die.	⊙1 True ⊙2 False
8.	Once a person decides to die by suicide, there's nothing anyone can do to stop him or her.	⊙1 True ⊙2 False
9.	There is a significant difference between male and female adolescents regarding suicidal behavior.	⊙1 True ⊙2 False
10.	Talking about suicide in the classroom will promote suicidal ideas and suicidal behavior.	⊙1 True ⊙2 False

Please rate your confidence for Questions 11-17 from Not Confident to Extremely Confident.

		Not Confident	Not Very Confident	Neutral	Somewhat Confident	Extremely Confident
11.	How confident are you in your ability to identify the signs of suicide?	⊙1	⊙2	⊙3	⊙4	⊙5
12.	How confident are you in your ability to listen without judgment?	⊙1	⊙2	⊙3	⊙4	⊙5
13.	How confident are you in responding appropriately to patients who have suicidal thoughts?	⊙1	⊙2	⊙3	⊙4	⊙5
14.	How confident are you in your ability to give reassurance?	⊙1	⊙2	⊙3	⊙4	⊙5
15.	How confident are you in your ability to provide resources for suicide prevention?	⊙1	⊙2	⊙3	⊙4	⊙5
16.	How confident are you in deciding whether medical intervention is necessary?	⊙1	⊙2	⊙3	⊙4	⊙5
17.	How confident are you in your ability to competently refer patients to other agencies?	⊙1	⊙2	⊙3	⊙4	⊙5

Please rate your overall likelihood of completing the following activities in Questions 18-21 from Not at All Likely to Extremely Likely.

		Not at All Likely	A Little Likely	Moderately Likely	Very Likely	Extremely Likely
18.	Before your suicide prevention training, how likely were you to update your knowledge in suicide prevention at frequent intervals?	⊙1	⊙2	⊙3	⊙4	⊙5
19.	After your suicide prevention training, how likely are you to update your knowledge in suicide prevention at frequent intervals?	⊙1	⊙2	⊙3	⊙4	⊙5
20.	Before your suicide prevention training, how likely were you to make appropriate interventions for patients who may benefit from suicide prevention, due to your personal values and biases?	⊙1	⊙2	⊙3	⊙4	⊙5
21.	After your suicide prevention training, how likely are you to make appropriate interventions for patients who may benefit from suicide prevention, despite your personal values and biases?	⊙1	⊙2	⊙3	⊙4	⊙5

Please answer questions 22-30 as best as you can. There are no right or wrong answers.

22.	Do you think suicide can be prevented?	⊙1 Yes ⊙2 No
23.	Do you know anyone close to you (relative, friend, colleague, trainee) who has ever committed suicide?	⊙1 Yes ⊙2 No
24.	Have you ever had previous training in suicide prevention?	⊙1 Yes ⊙2 No
25.	What is your age?	➲ **ENTER NUMBER OF YEARS.**
26.	What is your gender?	⊙1 Male ⊙2 Female
27.	Please describe your practice setting.	⊙1 Community/Retail ⊙2 Ambulatory Care ⊙3 Hospital/Inpatient ⊙4 Nursing Home/Consultant ⊙5 Academia ⊙6 Other: _____ ⊙7 Not in practice (SKIP TO#29)
28	How many years have you practiced as a pharmacist?	➲ **ENTER NUMBER OF YEARS.**
29.	Are you Spanish, Hispanic, or Latino?	⊙1 Yes ⊙2 No
30.	Which of the following best describes your race?	⊙1 American Indian/Alaskan Native ⊙2 Asian ⊙3 Black/African American ⊙4 Native American/Pacific Islander ⊙5 White ⊙6 Other