



Developmental History of the QPRT Suicide Risk Management Inventory©
(QPRT stands for Question, Persuade, Refer or Treat)

- 1992-1995. Primary author Dr. Paul Quinnett participates as a faculty member in a Depression Awareness, Recognition and Treatment (DA/RT) federal grant funded through the University of Washington School of Medicine and the Washington State Mental Illness, Research and Training Institute. During this three-year provider training experience he learns that healthcare providers have a very difficult time asking role-played patients about suicidal thoughts, feelings and planning. To challenge and teach students to ask about suicide potential, Dr. Quinnett develops a guided interview assessment protocol.
- 1995. At a national convention of the American Association of Suicidology conference in Memphis, Tennessee, and in a seminar on current risk assessment procedures, he suggests 11 key questions in his protocol as a simplified way to detect and assess *current suicide risk*. The concept draws broad interest.
- 1996. Joining forces with co-author Kevin Bratcher M.S., an experienced clinician and Certified Employee Assistance Professional, a draft of the concept and questions are circulated to the leading clinical suicidologists in the United States. Each are asked the following question: “What are the top three questions you always ask of every suicidal patient?”
- 1996. These “most endorsed” questions are then analyzed, compared and synthesized into 15 key questions to be used in a dynamic clinical interview regarding *current suicide risk*. The seven most powerful questions (those which elicit the most useful dynamic, clinical, risk and protective factor data) are included in the QPRT Suicide Risk Management Inventory©.
- 1997. The key questions and protocols are reviewed and improved by malpractice attorneys specializing in mental health law and medical malpractice. The QPRT becomes not only a clinical tool, but a methodology to reduce malpractice exposure. Extensive clinical field trials follow.
- 1997-98. In 1997 Spokane Mental Health, a large mental health center serving over 10,000 persons per year, conducts a formal medical records review for the assessment of suicide risk on a series of 100 adult suicidal outpatients identified as suicidal at intake in the prior two years (1996-97). These data are compared to QPRT protocol findings for 100 suicidal patients admitted in 1998. After a review of the findings and initial data summaries by the Clinical Directors, Medical Director and Quality Improvement Committee, the new database for assessing and managing patient suicide risk is judged so superior no further research is requested.
- 1998. Following a literature review, a training program to teach clinicians how to conduct a suicide risk assessment using the QPRT protocol is written, tested, and evaluated at Spokane Mental Health. With the assistance of the Washington State

Institute for Mental Illness Research and Training, a pre-post 40-item knowledge exam is tested with 200+ clinicians and an item analysis yields a 25-item standardized quiz. The training and protocol is accepted, policy and procedures manuals are written and published, and the training in how to use the protocol is mandated of all clinical providers. The assessment document becomes part of the core clinical record.

- 1998. In response to a national competition for avoiding suicide malpractice, the QPRT Suicide Risk Management Inventory and associated risk reduction practices wins the J.J. Negley Associates, Inc. Presidents Award for Avoiding Suicide Malpractice. This \$15,000 award is given at the National Council for Behavioral Health Care Organizations at their annual convention in Chicago, Illinois.
- 1999. Following acceptance by busy clinicians, and legal approval by counsel, consumer satisfaction studies are conducted to determine how actual suicidal patients experience the QPRT clinical interview. Consumer satisfaction is high. Data are analyzed and reported at the American Association of Suicidology's 1999 Annual Convention.
- 1999. Following the success of the Adult/Older Adult version of the QPRT, the QPRT- Pediatric Version is published with Dr. Louis Sowers, and the QPRT-Hospital Version is published with Dr. Rebecca Cardell. Both lead authors are specialists in suicide risk assessment and management in their fields. A similar process regarding the most important questions to ask children and adolescents is followed, with the nation's leading authorities contributing to the format.
- 1999. The Joint Commission on the Accreditation of Health Care Organizations learns of the QPRT Suicide Risk Management Inventory© and subsequent developments in a systematic, institutional approach to suicide risk reduction (the QPR Institute Suicide Risk Reduction Program), and prominently features this work in three publications, including the monograph *Preventing Patient Suicide*. The QPR Institute Suicide Risk Reduction program is presented as an example of "best practices."
- 1999. The QPR Institute is founded in July and the QPR Institute Suicide Risk Reduction Program, including its standardized risk assessment protocols for all ages in inpatient and outpatient settings, becomes available to the healthcare community. The Devereux Foundation adopts the QPRT and begins using it in all its facilities.
- 2000. James States, M.D., joins the QPR Institute faculty and assists in the refinement and testing of the QPRT training program and assessment protocol for medical providers, including developing PDA applications.
- 2001. Richard Ries, M.D., a leader in addiction medicine joins the QPR Institute faculty and contributes substance abuse and dual disorder specific content for the training of chemical dependency counselors in the use of the QPRT.
- 2002. Dr. Quinnett presents the QPRT as part of a systems approach to suicide risk reduction at the request of the American Psychiatric Association's Special Task Force on Patient Safety.
- 2002-2003. The QPRT is adopted for use by a variety of mental health and substance abuse treatment organizations, while a four-step, competency credentialing process is refined. A national database of pre-post testing outcomes for the QPRT training is established with more than 1,100 professionals.

- 2004. In partnership with Eastern Washington University and its division of Educational Outreach, the QPRT course is offered in a blended online version for continuing education and college credit for all healthcare students and working professionals.
- 2005. The QPRT is highlighted in the U.S. Department of Health and Human Services (SAMHSA) Treatment Improvement Protocol (TIP 42) as an example of best practices in suicide risk assessment.
- 2005. As part of a state-wide suicide risk reduction effort for consumers, and on contract to the University of Georgia via the Division of Mental Health, Addiction Services and Developmental Disabilities for the State of Georgia, the QPRT is taught to providers throughout the state.

Used in more than 60 inpatient and outpatient mental health service provider sites around the United States the QPRT has been used to assess more than 250,000 consumers to date.

QPRT Benefit Summary

- Developed *by* clinicians *for* clinicians
- Routinely detects the presence of suicide risk
- Nests well with other assessment procedures
- Can be “migrated” into existing clinical protocols, and EMRs
- Brief and user friendly
- Standardizes suicide risk data collection
- Nationally peer reviewed
- Heavily field tested
- Versions for adults, children and adolescents
- Inpatient, residential and outpatient versions available
- Fits into any standard medical record
- Improves standard of care while reducing exposure to suicide malpractice
- Accepted by patients (89% report satisfaction with the interview)
- Accepted by clinicians (94% believe it improves standard of care)
- Includes quiz and credentialing steps for competence in assessing suicidal patient
- Available in train-the-trainer, on-site classroom or blended online versions
- CEUs and college credit available