IMPLEMENTATION OF AN EVIDENCE-BASED PROTOCOL TO IMPROVE EARLY SUICIDE RISK IDENTIFICATION IN PSYCHIATRIC PRACTICE

by

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ABSTRACT

Among the top nine leading causes of death for individuals aged 10–64 is suicide, and it's the primary cause of preventable death. Currently, only one-third of healthcare providers routinely screen for suicide risk, even though this screening is recommended by entities such as The Joint Commission. The objectives of this project were to identify ways to increase suicide risk identification in the prevention of suicide through the utilization of a standardized suicide screening using the Ask suicide-screening Questions (ASQ) reflexing to the Brief Suicide Safety Assessment (BSSA), and to mitigate barriers to the implementation of suicide screening protocols in a rural Montana psychiatric practice. This project was accomplished using pre- and post-education surveys and three 2-week PDSA cycles, which evaluated selected aggregate data evaluated against SMART goals. During this project, the facility screened 93% of 86 patients that presented to the practice; 15 patients refused to screen and six were not provided the screening tool. Of the patients screened, 41.3% were positive using the ASQ, with one patient scoring at the threshold for further evaluation with the BSSA. In this sample, none needed further intervention beyond this setting. The project successfully identified the evidence-based tools and processes fitting this practice, provided efficient and convenient implementation steps, gained stakeholder buy-in and support, and facilitated rapid PDSA cycling to identify and mitigate barriers to screening. Per the provider's report, additional secondary assessments improved patient care through standardization and consistency, and provided a conversation structure regarding suicide risk. Limitations, including practice size, rurality, and practice specialty, did not indicate a correlation between suicide screening and early risk identification.

CHAPTER ONE

SUICIDE SCREENING AND PREVENTION LITERATURE REVIEW

Suicide: An International Public Health Concern

Suicide is a tragedy that affects families, communities, societies, and individuals, with long-lasting effects on those left behind. Suicide leaves an immense economic toll on society, attributed to nationally costing $70 billion per year in medical and work-loss costs alone (Centers for Disease Control and Prevention [CDC], 2022a). Suicide is a global phenomenon that occurs throughout the lifespan and, in 2020, was among the top nine leading causes of death of people aged 10–64 (World Health Organization [WHO], 2021; CDC, 2022c). According to the CDC (2020), in the United States, approximately 12.2 million individuals seriously thought about suicide, 3.2 million planned a suicide attempt, and 1.2 million attempted suicide. In the United States, the suicide rate increased by 33% between 1997 and 2017 (Aguinaldo et al., 2021). Globally, there are approximately 800,000 deaths by suicide yearly and 20 suicide attempts for each death (Polihronis et al., 2022).

Eighty-three percent of those who die by suicide and 95% of those who have attempted suicide visited a healthcare provider within months of their death, some within weeks (Inman et al., 2019; Thom et al., 2020; LeCloux et al., 2022). Only 24% of individuals who died by suicide had a mental health diagnosis (Thom et al., 2020). Of the patients who visited a healthcare facility prior to a suicide attempt, many reported somatic complaints, but did not disclose psychiatric symptoms unless explicitly asked (Horowitz et al., 2020). Regrettably, many healthcare providers do not routinely screen for suicide risk, although it is recommended by both

the American Academy of Pediatrics and The Joint Commission (American Academy of Pediatrics [AAP], 2022; The Joint Commission [JCI], 2020).

JCI's current National Patient Safety Goals for suicide prevention 15.01.01 currently includes universal screening for all individuals that present for behavioral health services (JCI, 2019). Despite the benefits of universal screening, only one-third of providers routinely screen in practice (LeCloux et al., 2022). Early identification of patients at risk for suicide is a crucial prevention strategy that often goes unrecognized by healthcare providers (Aguinaldo et al., 2021).

Impact of Suicide in Montana

In Montana, suicide is the number one cause of preventable death (Rosston, 2022). Montana has consistently ranked within the top five states in the nation for suicide for more than 40 years, making suicide one of Montana's highest public health priorities (Center for Children, Families, & Workforce Development [CCFWD], 2019; Koch, 2021). During the last 2 decades, Montana has experienced a 38% increase in suicides (CCFWD, 2019; Koch, 2021). Montana has the third highest rate of suicide in the United States per the National Vital Statistics Report for 2020 with 300 deaths, resulting in a death rate of 26.1 (Curtin, 2020; CDC, 2022b). States such as Montana, which are primarily rural, have higher rates of death by suicide (20 per 100,000) compared to more urban states (11.1 per 100,000) (CCFWD, 2019). Suicide is the sixth leading cause of death for all Montanans (CCFWD, 2019).

In Montana, suicide occurs most frequently between the ages of 25 and 64, which accounts for 62% of suicides (Koch, 2021). Suicide rates in men were significantly higher than

women respectively at 47.0 and 16.9 per 100,000 (Koch, 2021). Suicides occurred more frequently in rural areas (37%) compared to metropolitan areas (34%) and micropolitan areas (29%) (Koch, 2021).

American Indians have the highest rate of suicide at 32 per 100,000 followed by Caucasians at 25.3 per 100,000 (Rosston, 2022). In the youth aged 11 to 17, suicide rate is 11.9 per 100,00; over double the national average (Rosston, 2022). Per the 2021 Youth Risk Behavior Survey, 10.2% of Montana students in grades 9–12 had made a suicide attempt as have 13.5% of grades 7–8 (Rosston, 2022). Of American Indian students, 17.6% had attempted suicide one or more times (Rosston, 2022). Suicide has been the number two cause of death in children aged 10–14 for the last 10 years (Rosston, 2022). Montana has the highest veteran suicide rate in the nation at a rate of 68 per 100,000; overall, 25% of suicide deaths in Montana were veterans (CCFWD, 2019).

Purpose

Given the significance of suicidality in Montana and the devastating impacts of suicide, a literature review was conducted to inform best practices to implement suicide screening in a rural psychiatric practice facility and inform the development of the quality improvement project.

Methods

Articles were collected from the following resources and databases: PsycINFO, ProQuest, PubMed, CDC, National Institute for Mental Health, JCI, and CINAHL Database. Titles and abstracts were searched using the following terms: “suicide,” “suicide prevention,”

"suicide prevention in healthcare," "suicide screening," and "suicide risk assessment." All titles of articles were reviewed and studies were screened against the inclusion criteria. Studies were included if they described suicide prevention through the use of validated screening tools, the psychometric properties of validation of a suicide risk screening tool, use of a validated screening tool, or a quality improvement project implementing a validated screening tool. Dissertations, student quality improvement projects, case reports, studies that did not examine the topic of interest, chart reviews, and abstract-only articles were excluded.

Results

An initial 3,047 articles were yielded from the search terms. After removal of duplications (n=1,451) and excluded articles per criteria (n=1,509), 16 articles were included for full-text review. The types of articles included are as follows: four cross-sectional instrument validation studies, two cohort studies, contextual inquiry, two editorial articles, two quality improvement projects, descriptive study, literature review, systematic review and meta-analysis, psychometric analysis, and summary of screening tools. All of the articles selected evaluated urban or suburban settings or settings were not reported. Of the articles selected, 19% (n=3) evaluated suicide screening implementations in children, 44% (n=7) in adults, 13% (n=2) evaluated both adults and children, 69% (n=11) discussed screening tools, and 88% (n=14) pertained to barriers to screening implementation. During this review, the following themes about suicide prevention and screening emerged: suicide prevention, universal suicide screening, gaps in suicide risk identification, barriers to suicide screening, and evidence-based suicide screening tools.

Discussion

Suicide Prevention

Suicide, like many public health concerns, is preventable (CDC, 2017). Healthcare providers have a unique opportunity to help prevent suicide as many individuals at risk for suicide are seen in the healthcare setting (National Action Alliance for Suicide Prevention [NAASP], 2018). Attention to suicide prevention in healthcare has improved since the inception of the 2012 revised *National Strategy for Suicide Prevention* goal to "Promote suicide prevention as a core component of health care services" (U.S. Department of Health and Human Services Office of the Surgeon General & NAASP, 2012). Per the U.S. Surgeon General's Advisory (2021), clinical treatment is critical to protecting mental health, including risk identification, screening and assessment, indicated interventions, treatment, and recovery. NAASP (2018) recommends utilizing standard care elements of identification and assessment, safety planning, means reduction, and caring contacts in the prevention of suicide in healthcare settings.

The emphasis in care for suicide prevention by healthcare providers is to identify patients at risk for suicide, enhance safety for those with risk, and to provide treatment and support for individuals that have an elevated risk for suicide (NAASP, 2018). The first step in preventative care is identification and assessment of suicide risk using a standardized instrument or scale (NAASP, 2018; AAP, 2022; JCI, 2019; Suicide Prevention Resource Center, n. d.; Montana Department of Public Health and Human Services [DPHHS], n.d.). Asking patients about suicidal ideation or self-harm is a simple and effective way to identify patients at risk for suicide (NAASP, 2018). Provider implementation of suicide screening could detect suicidal individuals and intervene effectively (NAASP, 2018). Through screening and assessment, it is possible to

identify patients with elevated suicide risk, allowing providers to deliver effective supports during times of high risk and reduce the risk of suicide (NAASP, 2018).

Universal Suicide Screening

One means of screening patients presenting to a medical setting is through universal suicide screening. Universal suicide screening requires providers and healthcare facilities to screen every patient for suicide, regardless of reason for seeking care, using a standardized, evidence-based screening tool at every encounter. By screening every patient, providers are more likely to accurately identify individuals that are at risk for suicide and can appropriately intervene to address suicide risk (Mounet & Horowitz, 2021).

JCI's National Patient Safety Goal (NPSG) NPSG 15.01.01 recommends that all accredited hospitals assess suicide risk in patients that are being evaluated or treated for behavioral health conditions (JCI, 2019). This neglects the larger population of nonpsychiatric patients who present to the medical setting, yielding a large risk burden (Roaten et al., 2018). One study of suicidal ideation in patients seeking emergency treatment for nonpsychiatric reasons reported that 20.1% acknowledged suicidal ideation, 1.9% acknowledged a suicide plan, and four returned to the emergency department after a suicide attempt within the following 45 days (Roaten et al., 2018). Another study implemented a universal suicide screening program in a hospital system that identified positive screening results found in various nonbehavioral health units as follows: 6.3% in the ED, 1.6% in inpatient units, and 2.1% in outpatient clinics (Roaten et al., 2018). The implementation of universal screening in this study demonstrates the necessity and value of screening all patients for suicide risk, especially those that do not present with mental health concerns.

Gaps in Practice

Currently, only one-third of providers routinely screen for suicide in practice and, when completed, it is not done via a standardized protocol (LeCloux et al., 2022). Of those that do not implement a suicide screening tool, only 47% of mental health practitioners are reported to ask about suicide-related behaviors (Polihronis et al., 2022). Mental health and psychiatric providers have substantial opportunities to identify individuals at risk for suicide. While there has been a recent rise in patient safety research, including suicide prevention, research conducted in mental health services remains meager and outdated when compared to the amount of research conducted in general healthcare settings (Quinlivan et al., 2020).

Although suicide prevention should be a priority in patient safety research, few studies have addressed suicide prevention in patients accessing mental health services (Quinlivan et al., 2020). One of these studies by Davis et al. (2020) assessed suicide screening techniques used by mental health providers and found practitioners reported variability in screening methods with some using standardized measures and some integrating questions about suicidality into other safety topics. Other clinicians integrate safety planning into interventions aimed towards promoting coping and crisis management (Davis et al., 2020). This variability in suicide assessment can readily lead to gaps in identification of individuals at risk for suicide.

Barriers to Identification

In addition to gaps in identification of patients at risk for suicide, there is also the consideration of barriers to suicide screening implementation. Barriers to routine suicide screening reported by non-mental healthcare providers include concerns for appropriate follow-up for patients that screen positive, fear of iatrogenic risk, lack of time, discomfort asking about

suicide, limited provider confidence and efficacy, and insufficient knowledge or training regarding suicide risk (LeCloux et al., 2022; Polihronis et al., 2022; Horowitz et al., 2022; Heyland et al., 2018; Davis et al., 2020). Lack of screening guidelines, input from patients and or parents/guardians, and screening education may result in providers being hesitant to provide routine suicide screening (LeCloux et al., 2022; Polihronis et al., 2022; Horowitz et al., 2022; Heyland et al., 2018).

Barriers reported by mental healthcare providers to implementing routine suicide screenings include (a) uncertainty and anxiety about what to do if the patient is determined to be at risk and reliance on clinical judgment, (b) uncertainty whether patients would implement the provider's safety plan, (c) lack of clarity regarding protocols, (d) which providers were responsible for the suicide screening, and (e) the frequency in which screening should be conducted (Davis et al., 2021). In response to these identified barriers, clinicians recommended that clarifying policies regarding suicide screening implementation, delineation of screening frequency, improved protocols for follow-up on positive screenings, additional training, and workflow improvements in the electronic medical record could facilitate screening and mitigate barriers (Davis et al., 2021). The resounding theme between medical providers to facilitating suicide screening and overcoming barriers includes standardized screening protocols, an evidence-based screening tool, and provider education (LeCloux et al., 2022; Polihronis et al., 2022; Horowitz et al., 2022; Heyland et al., 2018; Davis et al., 2021).

Evidence-Based Screening Tools

There are many screening instruments that can be used to detect suicide risk (e.g. Columbia-Suicide Severity Rating Scale, Suicide Behavior Questionnaire-Revised, Beck Scale

for Suicide Ideation) (JCI, 2019). The ASQ is a 20-second, four- to five-item, evidence-based suicide screening tool developed to rapidly assess suicidal ideation and behaviors (Mournet & Horowitz, 2021; Aguinaldo et al., 2020; Horowitz et al., 2020; LeCloux et al., 2022). The ASQ was designed for patients of all ages in multiple settings including Emergency Departments, Medical/Surgical units, outpatient primary care, and specialty clinics (JCI, 2019). The ASQ showed strong psychometric properties as follows: a sensitivity of 96.9% to 100%, a specificity of 87.6% to 89%, and a negative predictive value of 96.9% to 100% (Horowitz et al., 2012; Horowitz et al., 2020). A 2019 study reported the ASQ may improve clinicians' ability to foresee future suicide-related behaviors and identified the ASQ as a valid screening tool in emergency rooms, outpatient settings, and specialty care clinics (Aguinaldo et al., 2021).

The ASQ and the Brief Suicide Safety Assessment (BSSA) are intended for concurrent use as part of a three-level, standardized suicide risk and assessment protocol (LeCloux et al., 2022). The BSSA is a follow-up, secondary risk-assessment tool used to determine an appropriate disposition plan for patients that screen positive in the ASQ (LeCloux et al., 2022). It is a two-page guide that instructs mental health providers in the completion of a more detailed suicide risk assessment including suicidal ideation, suicide plan, past behavior, current symptoms, social supports, and safety (LeCloux et al., 2022).

Although more cumbersome than the ASQ, the Columbia Suicide Severity Rating Scale (C-SSRS) is another validated suicide screening tool. The C-SSRS is approved for use in all age groups and populations in different settings (JCI, 2019). The C-SSRS was developed in 2007 by a group comprised of members from Columbia University, the University of Pennsylvania, and the University of Pittsburgh to create a tool that would assess the severity of and track changes in

suicidal ideation and behavior (Thom et al., 2020; Syndergaard et al., 2022). The C-SSRS is made up of eight questions with an additional four questions to assess suicidal intent, plan, and intensity of ideation (Thom et al., 2020). In studies, the C-SSRS demonstrated good convergent and divergent validity for suicidal ideation and behavior scales and a high sensitivity (94% to 100%) and specificity (99% to 99.4%) for suicidal behavior classifications (Posner et al., 2011; Thom et al., 2020). Although the C-SSRS Full Version is a validated tool, if not used with the risk assessment, it is not sufficient to qualify as an evidence-based suicide risk assessment (JCI, 2019).

More burdensome than either of the previously mentioned tools, are the Beck Scale for Suicide Ideation (BSI) and the Suicide Behavior Questionnaire-Revised (SBQ-R). The BSI is a 21-item self-report instrument used to detect the current intensity of the patients' attitudes, behaviors, and plans for suicide within the past week (JCI, 2019). While the BSI is a valid and reliable tool, it is not appropriate for universal screening as it is approved for ages 17 and older (Beck & Steer, 1991). The SBQ-R is a four-item self-report questionnaire that assesses future anticipation, as well as past and present suicidal thoughts or behaviors, and includes one question regarding lifetime suicidal ideation, plans to complete suicide, and actual suicide attempts (JCI, 2019). Although the SBQ-R is a well-validated and reliable tool, it is not appropriate for universal screening as it is only approved for patients aged 13–18 (JCI, 2019).

Conclusion

Based on the literature review, suicide is a preventable public health concern. By utilizing standardized screening tools and screening every patient at every visit, more at-risk individuals

may be detected. While there are many standardized screening tools available, there exist barriers to implementation and ease of adoption dependent upon setting. The ASQ was selected due to its brevity, ease of administration and scoring, inclusion of evidence-based protocols for positive screenings, and inclusion of the BSSA secondary screening tool. For this quality improvement project, the ASQ and BSSA will be implemented at a rural Montana psychiatric clinic.

CHAPTER TWO

SUICIDE SCREENING PROPOSAL

Introduction

Suicide is a global, national, and state health priority. Suicide rates have seen an exponential increase in recent years. At present, only one-third of providers routinely screen for suicide risk in practice and only 47% of mental health practitioners ask about suicide-related behaviors (LeCloux et al., 2022; Polhironis et al., 2022). Lack of screening has been attributed to concerns for appropriate follow-up for patients that screen positive, fear of iatrogenic risk, lack of time, discomfort asking about suicide, limited provider confidence and efficacy, and insufficient knowledge or training regarding suicide risk (LeCloux et al., 2022; Polihronis et al., 2022; Horowitz et al., 2022; Heyland et al., 2018; Davis et al., 2020). With appropriate training, use of an evidence-based screening tool, and screening protocols, routine suicide screening is feasible in practice. Through the implementation of routine suicide screening using an evidence-based tool, providers can identify patients at risk for suicide and intervene to provide appropriate medical care.

Problem Statement

Suicide prevention is a public health priority in the state of Montana due to current and rising suicide rates and rurality (CCFWD, 2019; Koch, 2021). There is no current information regarding suicide prevention screening rates in Montana-based mental healthcare. To prioritize suicide prevention in Montana, this quality improvement project will implement a suicide

screening protocol to follow national suicide prevention goals. These goals include increased identification of patients at risk for suicide and provision of appropriate mental health services to those identified as at-risk at a private rural psychiatric practice.

Organizational Microsystem Assessment

Organizational microsystem assessment was completed at an independent rural psychiatric practice in Montana. This practice currently operates only a few days a week, seeing between 16 and 20 patients per week for mental health concerns. The patients currently being seen at this practice represent a diverse population of both rural and urban residents throughout the lifespan from throughout the state. A variety of mental health concerns are addressed at this practice, including but not limited to anxiety, depression, Alzheimer's disease, attention-deficit hyperactivity disorder, bipolar, and schizophrenia. Of those being seen for depression, roughly two patients per week report having suicidal thoughts without a plan of action or intention to complete suicide.

Utilizing the 5 Ps microsystem assessment tool to evaluate this practice, it was noted that the practice had a process deficit regarding suicide screening. As all patients presenting to this practice are being seen for mental health concerns, it is imperative to screen for possible suicidal thoughts or behaviors for early detection. Current practices include administration of the PHQ-9 (Patient Health Questionnaire-9) to assess patients' current depression scores and questions are asked about suicidality during patient interviews. Although the PHQ-9 does address depression, thoughts of self-harm, and thoughts that the individual is better off dead, it does not ask direct questions regarding suicidality (American Psychological Association, 2020; The Joint

Commission [JCI], 2019). While asking patients about suicidal thoughts and behaviors is appropriate, it may not supply the depth of information that using an evidence-based tool could provide. There is opportunity at this rural psychiatric practice to implement a suicide screening tool to address shortfalls of the PHQ-9 related to direct questions pertaining to suicidality.

Theoretical Framework

The Plan-Do-Study-Act (PDSA) framework was chosen for this quality improvement project. The PDSA is a systematic model that promotes continual learning and improvement through the implementation of small changes in the PDSA cycle until the desired goal is met (Mournet & Horowitz, 2021; Knudsen et al., 2019). The PDSA method consists of four steps—plan, do, study, and act—that guide the process by breaking down tasks into steps which can then be used to evaluate outcomes, improve upon the project, and go back through the cycle to test again (Agency for Healthcare Research and Quality [AHRQ], 2020). After each cycle of the PDSA, information will be collected to help guide changes in subsequent cycles to improve project outcomes, account for possible challenges, and integrate changes to workflows (Mournet & Horowitz, 2021).

The rapid and cyclical nature of the PDSA is beneficial to this project due to the short, 6-week implementation time available. By implementing 2-week cycles, data can be continuously collected, and testing can be conducted on a small scale as this project is being conducted by one nurse and one PMHNP-BC as facilitators of the change process. During the 2-week cycles, the DNP student will evaluate the findings of the previous cycle and provide weekly updates to improve processes and incorporate stakeholder feedback from the previous week’s data

collection cycle (Agency for Healthcare Research Quality, 2020). Through process improvements in each cycle of the PDSA, the QI project could successfully reach the desired goals.

Specific Aim

The DNP quality improvement project aims to implement a standardized suicide screening tool and protocol at an independent, rural Montana psychiatric facility to enhance early detection of patients at risk for suicide. The desired goal of this quality improvement project is to offer education to stakeholders regarding the importance of suicide screening and suicide screening implementation and provide 100% suicide screening of all patients that present to the clinic by April 2023. This DNP project's timeline and goals are outlined in the logic model (Appendix A).

Context

This quality improvement project will be conducted at an independent rural psychiatric practice in Montana. The stakeholders involved in this project include one PMHNP-BCand one RN. This practice was selected due to its rural location, patient diversity, lack of current utilization of a suicide screening tool, and acceptance of a student-led project within the facility.

Intervention and Implementation

Plan

In this DNP project, the "plan" phase is the pre-implementation phase, which includes (a) stakeholder collaboration, (b) student-led education planning (Appendices B, C, and E), (c) obtaining the Ask Suicide-Screening Questions (ASQ) screening tool (Appendix D) and scoring process, (d) Brief Suicide Safety Assessment (BSSA) secondary screening tool for ASQ positive screenings (Appendices F, G, H, and I), (e) PMHNP-BC verbal assessment protocol materials, and (f) creating student data-collection materials. Student-led education planning will include education for the RN and PMHNP-BC to support the importance of suicide screening in suicide prevention, the role of the RN and PMHNP-BC in screening implementation, and PMHNP-BC screening protocol execution. The "plan" phase will be initiated once IRB (Institutional Review Board) approval is obtained and will continue until the implementation of the project in January 2023.

Do

The second phase, "do," includes conducting a 1-hour, student-led, in-person educational session of the stakeholders at the psychiatric facility (Appendix B), implementation of the suicide screening tool, protocols for positive suicide screenings, and inputting of the suicide screening data into the her for longitudinal suicidality trend tracking by the provider. A report will be run weekly giving aggregate information on the ASQ and BSSA scoring in patient charts and observation of the cycle's success with weekly examination of the cycle's processes, implementation, screening reports, and possible need for modification. The "do" phase will be

implemented in January 2023, at which time all patients presenting to the facility will receive a suicide screening tool at registration. The PMHNP-BC will evaluate the screening tools and follow the protocol for positive screens.

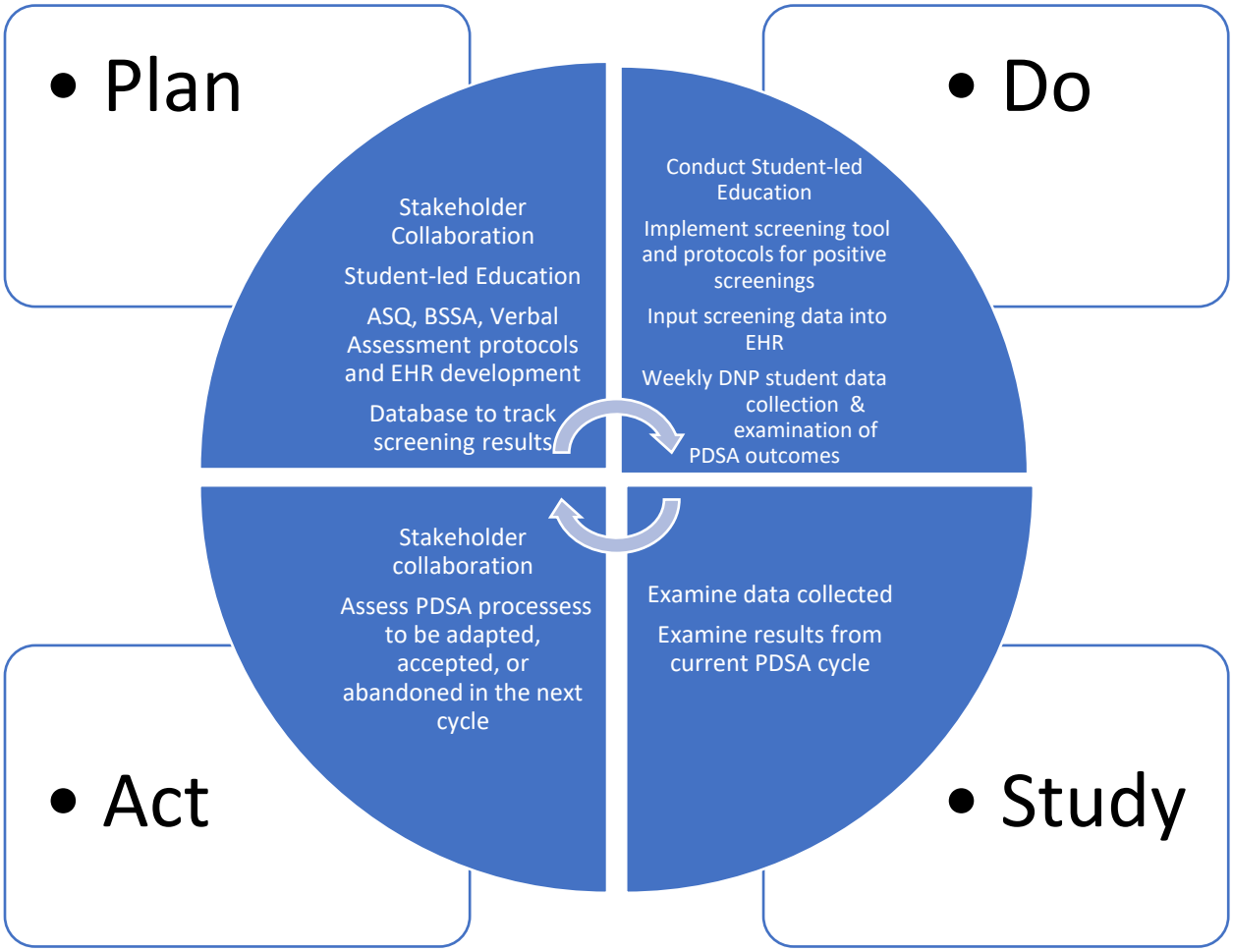
Study

The third phase, “study,” will require an examination of the data collected and results from the cycle conducted, including stakeholder feedback, lessons learned, and if the cycle met the intended goals. During this phase the DNP student will assess all aggregate data presented through the screening tools and feedback and insights from the stakeholders regarding problems, possible improvements, and workflow analysis. All data will be recorded in an Excel spreadsheet for analysis to determine if the previous week’s implementation met the goals and aims of the project.

Act

The final phase, “act,” will include collaboration with stakeholders to identify what was concluded through the cycle conducted and assess processes that should be adapted, accepted, or abandoned in the next cycle. This cycle will be evaluated using SMART goals.

Figure 1. PDSA Cycle



Timeline and Budget Considerations

The timeline of this DNP project will be conducted from IRB approval to April 2023 as follows: (1) Pre-implementation planning IRB approval January 2023, (2) PDSA cycle-1 January 27, 2023, to February 9, 2023, (3) PDSA cycle-2 February 13, 2023, to March 24, 2023, and (4) PDSA cycle-3 March 27, 2023, to April 6, 2023. After conclusion of PDSA cycle-3, all data will be assessed and reported. The current budget for this project is $50, to be supplied by the DNP

student to mitigate the costs of office supplies necessary to the project. This budget is anticipated to be adequate to cover the expense of the project, but can be reevaluated and supplemented by the DNP student if necessary. Confidentiality will be maintained throughout the DNP project as data will not include patient names or other identifiers, and the DNP student will have no contact with the patients participating in the project.

Facilitators

Facilitators to this DNP project include support from the participating psychiatric facility. The PMHNP-BC and RN have expressed a desire to implement best suicide prevention practices and are willing to facilitate the education and implementation of a new suicide screening protocol to provide the best level of patient care. This mitigates a common barrier providers expressed in confidence, hesitancy to provide screening, and insufficient knowledge or training in suicide screening (LeCloux et al., 2022; Polihronis et al., 2022; Horowitz et al., 2022; Heyland et al., 2018; Davis et al., 2020).

The ASQ and BSSA are free to use and are easily accessible through the National Institute of Mental Health (n.d.), *Ask Suicide-Screening Questions (ASQ) Toolkit*. The cost of copies for screening tools is $0.15 per page, making this a cost-effective means to screen for suicide risk. Other cost-saving measures include free creation of the ASQ into the current electronic health record (EHR). The current EHR system does not require additional payment for the creation of screening tools.

Barriers

The most prominent barrier to implementation of suicide screening is incorporation into the current facility workflow and the amount of time it takes to implement the BSSA secondary screening tool after a positive screening result on the ASQ. As this is an established psychiatric practice, the current workflow has been perfected for current practices. With the implementation of a new screening practice the current workflow will have to be revised, which may cause disruption to current processes.

While the ASQ was selected due to its brevity, it will still take time for patients to complete. The largest consumer of time is the implementation of the secondary protocols, which include utilization of the BSSA and verbal assessment of the patient. Current appointment lengths are between 30 minutes and 1 hour, and the utilization of this tool could consume 10 to 15 minutes, if not more, of that time (Le Cloux et al., 2022). This could become a barrier to implementation of the secondary protocols for patients with a positive initial screening.

Evaluation

Evaluation of this DNP project was conducted using quantitative statistics to measure aggregate data collected throughout the PDSA cycles. Descriptive statistics were used to evaluate the number of patients who completed the screening tool, number of patients that refused to complete the screening tool, number of patients that screened positive, number of patients that screened negative, and number of patients assessed using the BSSA and verbal assessment after a positive ASQ screening.

To ensure completeness and accuracy of the data, the student collected data from the psychiatric facility weekly to include: (1) number of patients presenting to the facility, (2) patients screened, (3) patients refusing screening, (4) positive ASQ screening, (5) negative ASQ screening, (6) BSSA secondary screening, and (7) verbal assessment. All data collected was assessed against the number of patients presenting to the facility each day to confirm each patient is accounted for. During data collection, the student compiled all data into an Excel spreadsheet database.

Each cycle of the PSDA process and final evaluation of the DNP project was assessed against the desired short-term, intermediate, and long-term SMART goals set forth in the logic model. These goals are seen in Tables 1–3.

Table 1. SMART Goal #1

SMART Goal #1: One education session on the use of the suicide screening tool and screening tool implementation with clinical staff will be completed by January 2023. Education will include a 1-hour presentation given by the student to all staff. This goal is set at one educational session as it is understood that, at minimum, one educational session will be necessary prior to implementation of the suicide screening tool and secondary protocols.
Description of strategies to be utilized to accomplish goal including any needed resources. • See Appendix B for Student-led Educational Plan. • Student will confer with stakeholders to set a time and date for the student to provide an educational session appropriate for all parties. • Student will provide copies of all educational materials to stakeholders to ensure learning and knowledge retention. • Funding for paper and printing for educational handouts is in the current operational budget. No additional funds are necessary.

Table 1. SMART Goal #1 Continued

Data to be collected	Method of Collection and who is responsible	Planned data analysis
• Number of facility staff members present at the educational session.	• Sign-in sheet will be used to assess staff members present at the educational session.	• Descriptive Statistics of the number of staff members that complete the education.

Table 2. SMART Goal #2

SMART Goal #2: Clinic staff will increase suicide screening of all patients to 50% by February 9, 2023. This goal will be achieved through provision of the screening tool to each patient presenting to the clinic. This goal is set at 50% screening of all patients to account for potential barriers to implementation, problems in development in PDSA processes that may hinder screening, and acclimatization time to increase suicide screening practices.

Description of strategies to be utilized to accomplish goal including any needed resources.
 	
• RN will provide ASQ screening tool to all patients presenting to the facility upon arrival.
  ○ DNP student will provide copies of the ASQ screening tool for facility use.
  ○ Funding for paper and printer services for screening tool is in the current operational budget. No additional funds are necessary.
• PMHNP will note the number of patients being seen that day and number of patients that decline to complete the ASQ screening tool.
• PMHNP will assess and score all ASQ screening tools after patient completion.
• PMHNP will input screening data into EHR for ASQ screening tool.
• PMHNP will mark DNP student-provided chart to denote positive and negative results for data collection.

Table 2. SMART Goal #2 Continued

Data to be collected	Method of Collection and who is responsible	Planned data analysis
Number of patients seen at the facility each day. Number of patients that decline screening. Number of patients that screened ++, +, or -.	RN will provide screening tool to patients. PMHNP-BC will document results on DNP student-provided chart. DNP student will enter deidentified data into Excel spreadsheet capturing number of patients screened, declined, and positive and negative screening results.	Frequency data including the average, mean, median, and percentages will be calculated to analyze percentage of patients screened, refused screening, positive results, and negative results.

Table 3. SMART Goal #3

SMART Goal #3: Protocols for positive screenings will be executed in 50% of screened positive patients by February 9, 2023. This goal will be accomplished using a secondary screening and verbal assessment on any patient that screens positive on the primary screening tool. This goal is set at 50% execution to implementation of positive screening protocols to account for potential barriers to implementation, problems in development in PDSA processes that may hinder screening, and acclimatization time to increase secondary protocol practices.

Table 3. SMART Goal #3 Continued

<table>
<tr><td colspan="3">Description of strategies to be utilized to accomplish goal including any needed resources.

• PMHNP will assess and score all ASQ screening tools after patient completion.

• PMHNP will use clinical pathway to determine course of action for secondary protocols dependent upon patient scoring on ASQ screening tool.

o Copies of clinical pathway will be provided by the DNP student.

o Funding for paper and printer services for secondary protocol tools is in the current operational budget. No additional funds are necessary.

• PMHNP will follow secondary protocols if patient scores ++ or + by utilizing the BSSA for youths or adults based on the patient's age and verbal assessment.

o Copies of the BSSA youth and adult assessment and worksheets will be provided by the DNP student.

o Funding for paper and printer services for secondary protocol tools is in the current operational budget. No additional funds are necessary.

• PMHNP will mark DNP student-provided chart to reflect the method of collection listed below.</td></tr>
<tr><td>Data to be collected</td><td>Method of Collection and who is responsible</td><td>Planned data analysis</td></tr>
<tr><td>Number of patients screened with the BSSA.

Number of patients verbally assessed for suicidality.</td><td>PMHNP-BC will document results on DNP student-provided chart.

DNP student will enter deidentified data into Excel spreadsheet capturing number of patients screened, declined, and positive and negative screening results.</td><td>Descriptive statistics will be used to determine the percentage of total number of patients per day screened with BSSA and verbally assessed for suicidality.</td></tr>
</table>

SMART goals 1, 2, & 3 represent the first PDSA cycle. SMART goals 4, 5, & 6 represent the second PDSA cycle. These goals will follow the same format while increasing screening of all patients from 50% to 80% by March 10, 2023. SMART goal 7 reflects 100% screening by the end of the third PDSA cycle.

CHAPTER THREE

IMPLEMENTATION OF A SUICIDE SCREENING PROTOCOL AT A RURAL MONTANA PSYCHIATRIC PRACTICE

Suicide: An International Public Health Concern

Suicide affects individuals, families, and communities with long-lasting effects. Suicide takes an economic toll costing $70 billion annually in medical and work loss (Centers for Disease Control and Prevention [CDC], 2022a). A global phenomenon, suicide occurs throughout the lifespan and, in 2020, was among the top nine leading causes of death of people aged 10–64 (World Health Organization [WHO], 2021; CDC, 2022a). According to the CDC (2022c), approximately 12.2 million individuals seriously thought about suicide, 3.2 million planned a suicide attempt, and 1.2 million attempted suicide in the US in 2020. Additionally, the suicide rate increased by 33% between 1997 and 2017 (Aguinaldo et al., 2021). Worldwide, approximately 800,000 deaths occur by suicide yearly with an additional 20 attempts per death (Polihronis et al., 2022).

Eighty-three percent of those who die by suicide and 95% of those who have attempted suicide visited a healthcare provider within months and sometimes weeks of their death or attempt (Inman et al., 2019; Thom et al., 2020; LeCloux et al., 2022). However, only 24% of individuals who died by suicide had a mental health diagnosis (Thom et al., 2020). Many patients who visit healthcare facilities prior to a suicide attempt did not report psychiatric symptoms unless they were directly asked (Horowitz et al., 2020). Unfortunately, numerous providers do not screen for suicide risk routinely even though it has been recommended by The Joint

Commission and the American Academy of Pediatrics (American Academy of Pediatrics [AAP], 2022; The Joint Commission [JCI], 2020).

JCI's current National Patient Safety Goals for Suicide Prevention (NPSGSP) (2019) recommend universal screening for all individuals that present for behavioral health services. Only one-third of providers routinely screen in practice, despite reported benefits (LeCloux et al., 2022). Suicide screening is a crucial prevention strategy that often goes unrecognized by healthcare providers (Aguinaldo et al., 2021).

Impact of Suicide in Montana

In Montana, suicide is the number one cause of preventable death and the sixth leading cause of death (Rosston, 2022; Center for Children, Families, & Workforce Development [CCFWD], 2019). For the last 40 years, Montana has ranked within the top five in the US for suicide and it is one of the highest public health priorities (CCFWD, 2019; Koch, 2021). During the last 2 decades, there has been a 38% increase in suicides, making Montana the third highest-ranking state of suicide in the US for 2020 (CCFWD, 2019; Koch, 2021; Curtin, 2020; CDC, 2022b). Rural states, such as Montana, have higher rates of death by suicide (20 per 100,000) compared to urban states (11.1 per 100,000) (CCFWD, 2019).

Suicide occurs most frequently in individuals between the ages of 25 and 64, accounting for 62% of suicides with rates being significantly higher in men than women respectively at 47.0 and 16.9 per 100,000 (Koch, 2021). Within Montana, suicides occurred more frequently in rural areas (37%) compared to metropolitan areas (34%) and micropolitan areas (29%) (Koch, 2021).

Literature Review

Methods

A literature review was completed utilizing PsycINFO, ProQuest, PubMed, CDC, National Institute for Mental Health, JCI, and CINAHL Database. The following terms were used to search: “suicide,” “suicide prevention,” “suicide prevention in healthcare,” “suicide screening,” and “suicide risk assessment.” Inclusion criteria were suicide prevention through the use of validated screening tools, psychometric properties of validation of a suicide risk screening tool, use of a validated screening tool, or a quality improvement project implementing a validated screening tool. Dissertations, student QI projects, case reports, and studies that didn’t examine these topics were excluded.

Results

During the search, 3,047 articles were yielded. Sixteen articles were included for review after exclusion per criteria (n=1,509) and duplicates were removed (n=1,451); 88% (n=14) discussed barriers to suicide screening implementation, 69% (n=11) evaluated screening tools, 44% (n=7) highlight screening implementation in adult populations, 19% (n=3) in children, and 13% (n=2) assessed both adults and children. The following themes emerged: prevention, universal screening, gaps in risk identification, barriers to screening, and evidence-based screening tools.

Suicide Prevention

Suicide is a preventable health concern (CDC, 2022a). There is a unique opportunity afforded to healthcare providers to prevent suicide in the healthcare setting (National Action

Alliance for Suicide Prevention [NAASP], 2018). Utilization of standard care elements in suicide prevention in healthcare settings include identification, assessment, safety planning, means reduction, and caring contacts (NAASP, 2018). The use of a standardized screening instrument or scale is the gateway to preventative care (NAASP, 2018; AAP, 2022; JCI, 2019; Suicide Prevention Resource Center [SPRC], n. d.; Montana Department of Public Health and Human Services [DPHHS], n.d.).

Universal Suicide Screening

One means of screening patients presenting to a medical setting is through universal suicide screening, requiring providers and healthcare facilities to screen every patient, regardless of the reason for seeking care, using a standardized, evidence-based screening tool at every encounter. By screening every patient, providers are more likely to accurately identify individuals at risk for suicide and appropriately intervene (Mournet & Horowitz, 2021). Although JCI NPSGSP (2019) recommends assessing suicide risk in patients being evaluated or treated for behavioral health conditions, this recommendation neglects the larger population of nonpsychiatric patients in a medical setting (Roaten et al., 2018). Studies have found that many patients seeking nonpsychiatric care have been identified as at-risk when universal suicide screening programs have been implemented, demonstrating the necessity and value of screening all patients for suicide risk (Roaten et al., 2018).

Gaps in Practice

Only one-third of all providers routinely perform suicide screening in practice, and it is often not completed via a standardized protocol (LeCloux et al., 2022). Additionally, only 47%

of mental health providers report asking about suicide-related behaviors (Polihronis et al., 2022). Psychiatric mental health providers have a unique opportunity to recognize individuals at risk. Although the research has recently increased, including suicide prevention, mental health services research remains outdated and paltry compared to research in general healthcare settings (Quinlivan et al., 2020).

Assessment of suicide screening techniques utilized by mental health providers reported variable screening methods including some using standardized measures, some integrating suicide questions into other safety topics, and some placing suicide questions into safety planning interventions that promote coping and crisis management (Davis et al., 2020). Variability in suicide assessment can readily lead to gaps in identifying at-risk individuals.

Barriers to Identification

Barriers reported by non-mental health providers to suicide screening implementation include concerns for appropriate follow-up for positive screenings, fear of iatrogenic risk, lack of time, discomfort discussing suicide, provider confidence and efficacy, and insufficient knowledge or training (LeCloux et al., 2022; Polihronis et al., 2022; Horowitz et al., 2022; Heyland et al., 2018; Davis et al., 2020). Providers may be hesitant to screen routinely due to a lack of screening guidelines and education (LeCloux et al., 2022; Polihronis et al., 2022; Horowitz et al., 2022; Heyland et al., 2018).

In contrast, barriers reported by mental health care providers include uncertainty and anxiety about actions that should be taken if a patient is determined to be at risk, provider reliance on clinical judgment, uncertainty if patients would follow the provider's safety plan,

lack of clarity regarding protocols, which providers are responsible for suicide screening, and the frequency in which screening should be conducted (Davis et al., 2021).

Evidence-based Screening Tools

Many screening instruments, such as the Ask Suicide-Screening Questions (ASQ) and concurrent Brief Suicide Safety Assessment (BSSA), Columbia-Suicide Severity Rating Scale (CSSRS), Suicide Behavior Questionnaire-Revised (SBQ-R), and Beck Scale for Suicide Ideation (BSSI), can detect suicide risk (JCI, 2019). The ASQ is a 20-second, four- to five-item, evidence-based suicide screening tool developed to assess suicidal ideation and behaviors rapidly, and them follow-up with the BSSA helps determine an appropriate disposition plan for patients that screen positive in the ASQ (Mournet & Horowitz, 2021; Aguinaldo et al., 2020; Horowitz et al., 2020; LeCloux et al., 2022). The ASQ/BSSA was designed for patients of all ages in multiple settings and showed strong psychometric properties: a sensitivity of 96.9% to 100%, a specificity of 87.6% to 89%, and a negative predictive value of 96.9% to 100% ((JCI, 2019; Horowitz et al., 2020).

The Columbia Suicide Severity Rating Scale (C-SSRS) is another validated screening tool. The C-SSRS can be utilized in all age groups and different population settings (JCI, 2019). The C-SSRS was developed to assess the severity of and track changes in suicidal ideation and behavior and demonstrated good convergent and divergent validity and a high sensitivity (94% to 100%) and specificity (99% to 99.4%) (Posner et al., 2011; Thom et al., 2020).

The Beck Scale for Suicide Ideation (BSI) and the Suicide Behavior Questionnaire-Revised (SBQ-R) are the most cumbersome and age-restricted screening tools. While the BSI is a valid and reliable tool, it is not appropriate for universal screening as it is only approved for

ages 17 and older (Beck & Steer, 1991). However, the SBQ-R is a well-validated and reliable tool, but is only approved for patients aged 13–18 (JCI, 2019).

Rationale

Suicide is a preventable health concern based on the literature review. More at-risk individuals may be detected using standardized screening tools and screening every patient at every visit. Despite screening, availability barriers exist to implementation and ease of adoption dependent upon the setting. The ASQ was selected due to brevity, ease of administration and scoring, the inclusion of evidence-based protocols for positive screenings, and the BSSA secondary screening tool. The ASQ and BSSA will be implemented at a rural Montana psychiatric facility during this quality improvement project.

Specific Aim

This project aims to enhance the early detection of patients at risk for suicide by implementing a standardized screening tool and protocol at an independent rural Montana psychiatric facility. The desired goal is to provide suicide risk screening to 100% of patients that present to the clinic by April 2023.

Context

The project was completed at an independent rural psychiatric practice in Montana. Stakeholder involvement in the project included one PMHNP-BC and one RN. This facility was

selected due to rural location, patient diversity, lack of current utilization of a suicide screening tool, and acceptance of a student-led project within the facility.

Intervention and Implementation

The framework selected for this quality improvement project was the Plan-Do-Study-ACT (PDSA). The PDSA is a systematic model that consists of four steps, plan, do, study, and act, which guide the process by breaking down tasks into steps, promoting continual learning and improvement by implementing small changes in the PDSA cycle until the desired goal is met (Mournet & Horowitz, 2021). The PDSA was selected for this project due to its rapid and cyclical nature, benefiting the short 6-week implementation time available. Implementation of 2-week cycles allow for continuous data collection and small-scale testing, which can be conducted by one nurse and one provider as change process facilitators.

Plan

The “plan” phase was the pre-implementation phase, including student-led education planning, stakeholder collaboration, verbal assessment protocols, provision of the ASQ and BSSA, and creation of student data-collection sheets.

Do

In the “do” phase, implemented in January 2023, the student conducted a 1-hour, student-led, in-person educational session with the psychiatric facility stakeholders, including introducing screening tools, defining staff roles, implementation process, and screening

protocols. This phase also included project implementation, screening reports, weekly observation of each 2-week cycle's success, and recognizing the possible need for modification.

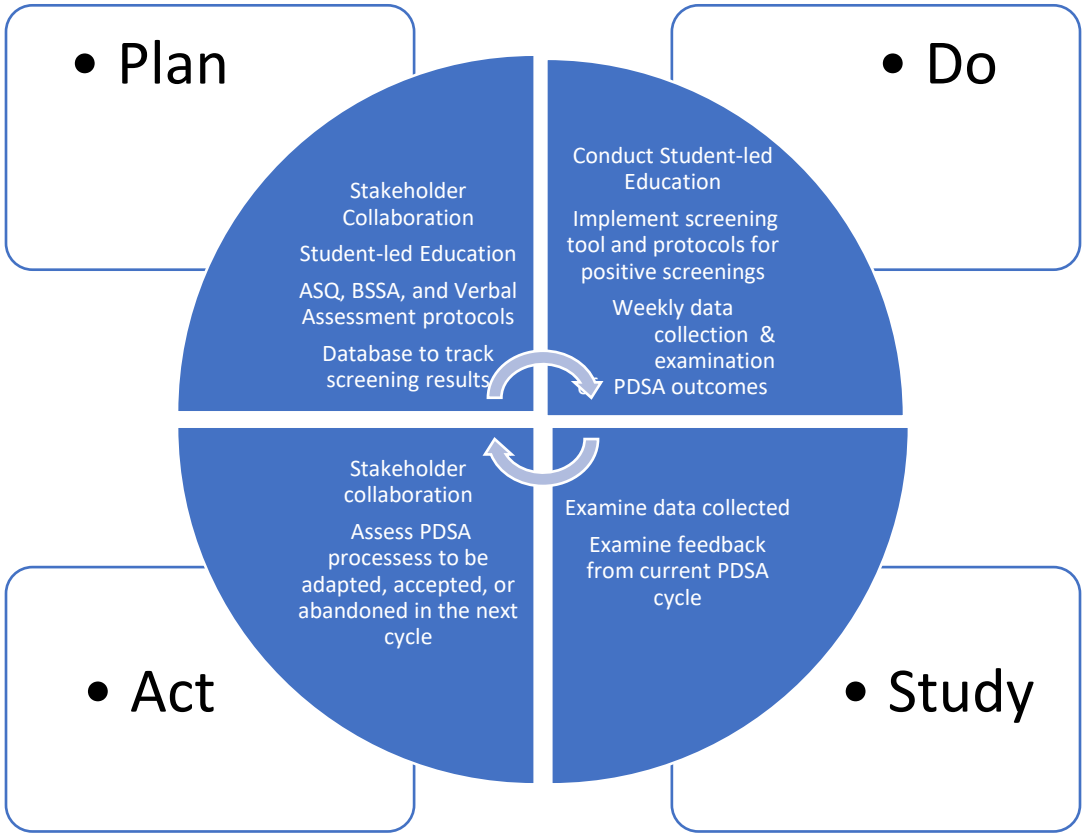
Study

In the "study" phase, the student assessed aggregate data obtained through the screening tools and considered stakeholder feedback and insights regarding problems, possible improvements, and workflow analysis.

Act

The "act" phase included collaboration with stakeholders to identify and assess processes that should be adapted, accepted, or abandoned in the next cycle, dependent upon SMART goal evaluation. SMART goals were to screen 50%, 80%, and 100% of patients by the end of the PDSA cycles 1, 2, and 3 respectively.

Figure 2. PDSA Cycle



Evaluation

This DNP project was evaluated using quantitative statistics to measure aggregate data collected throughout the PDSA cycles. Descriptive statistics were used to evaluate the number of patients who completed the screening tool, refused to complete the screening tool, screened positive, screened negative, and the number of patients assessed using the BSSA and verbal assessment after positive ASQ screening.

All data collected was cross-referenced with the number of patients presenting to the facility to confirm that each patient was counted. The student compiled all data into an Excel

spreadsheet database during data collection. Each PSDA process cycle and the DNP project's final evaluation were assessed against desired short-term, intermediate, and long-term goals.

Ethical Considerations

All aggregate, deidentified data were collected via student data sheets with forms completed by the patient or provider being kept in the patient chart and not disclosed to the student. Data collected from the student data sheets were deleted after data collection and analysis were completed. The probability and magnitude of harm or discomfort anticipated in the research were not greater in and of themselves than those ordinarily encountered in daily life or during routine physical or psychological examinations or tests. Pre- and post-education surveys involved minimal risk, which was not greater than those encountered in daily life. Completion of the ASQ and BSSA were done at a psychiatric nurse practitioner's office in conjunction with a scheduled appointment.

Results

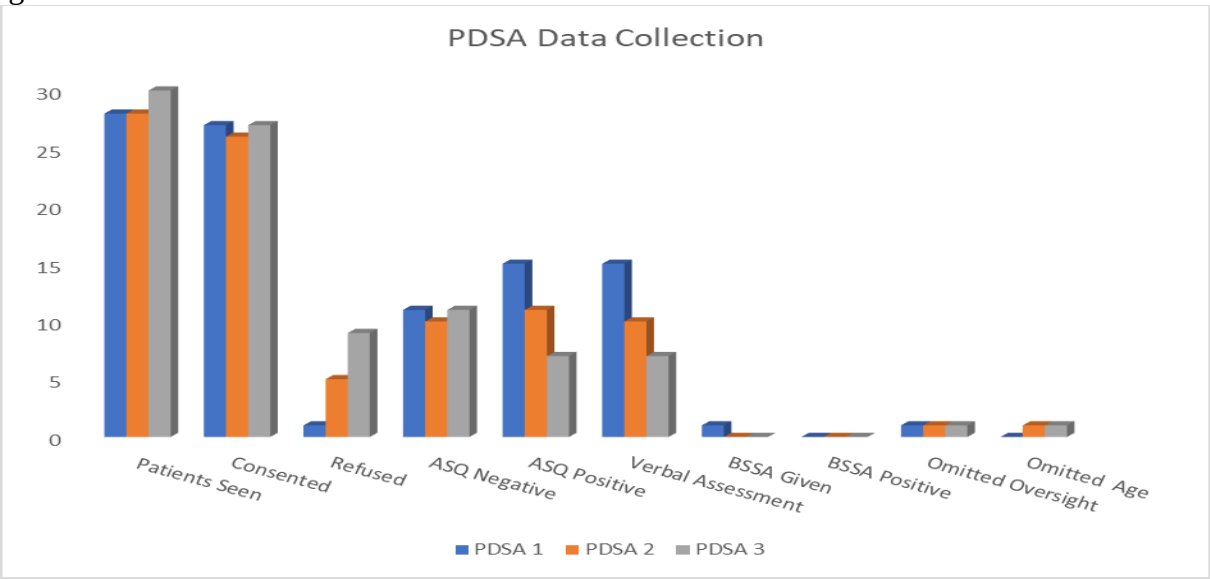
Pre- and Post-education Surveys

A total of two stakeholders were screened using a five-question pre- and post-educational survey to determine the impact of the student-led educational session. There were no significant differences between pre- and post-testing as both individuals scored 5/5 on the pre- and post-surveys.

Screening

Figure 3 depicts the screening results of the three PDSA cycles completed during this QI project.

Figure 3. PDSA Data Collection



Facility Feedback

After each PDSA cycle, the facility staff was queried for feedback regarding difficulty providing screening, following the screening protocol, interpreting results, increased stress, feelings of burden due to screening, or if there were patient complaints regarding the new screening process. Facility staff reported that they did not find the new process burdensome, difficult, or stressful. They reported no patient complaints. The provider reported that the additional verbal assessment and BSSA were time-consuming, but improved patient care.

Discussion

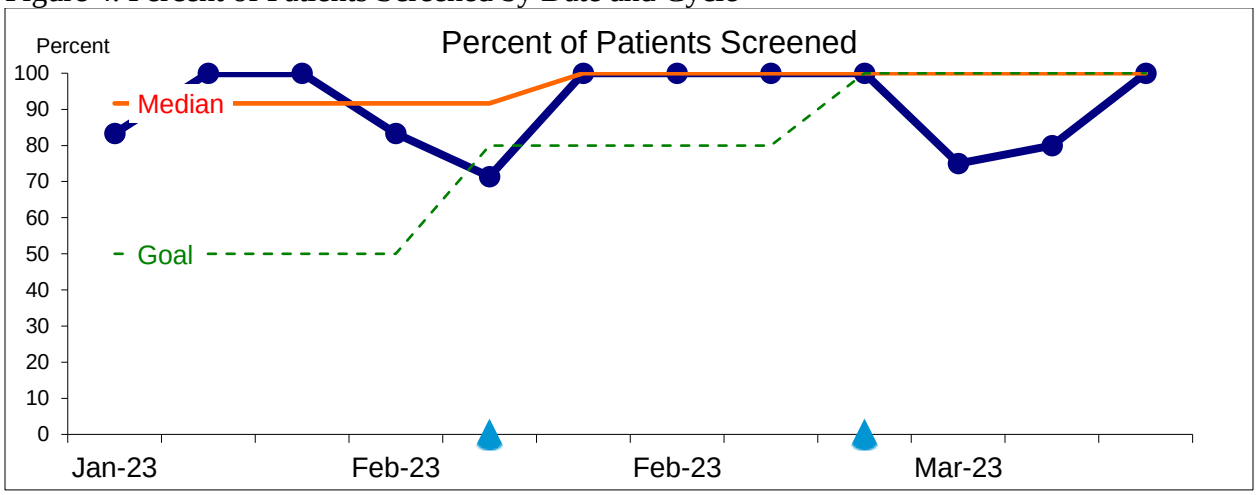
This project aimed to implement a suicide screening tool at a psychiatric practice to improve suicide screening rates and early detection of suicide risk and identify barriers to implementation in specialty practice. Eighty-six patients were seen during the study period, six were not given the screening tool, 80 consented to participate, and 65 completed the screening protocol. Age, race/ethnicity, sex, diagnosis, or presenting concern were not considered in the screening process. Of those screened, 32 screened negative, 33 screened positive, 32 were verbally assessed after a positive screen, one was administered the BSSA, and zero were BSSA positive. Patients screened positive on the ASQ often stated during the verbal assessment that, while they did have suicidal thoughts, they had no plans or thoughts of acting upon them, or have always had suicidal thoughts.

During this project, the facility screened 93% (80/86) of 86 patients that presented to the practice; 15 patients refused to screen and, for six, screening was omitted. Of patients screened, 41.3% (33/80) were positive using the ASQ, with one patient scoring at the threshold for further evaluation with the BSSA. In this sample, none needed further intervention beyond this setting. Although patients were not considered high-risk after the screening, the screening did allow the provider to assess any patients that had reported suicidal ideation or had tried to complete suicide in the past, which may not have been reported before the implementation of the screening tool. During the verbal assessment and BSSA, it was found that, of the patients that reported having suicidal thoughts, none had plans to act upon them, or they reported having chronic suicidal thoughts.

Throughout the project, the student contacted the facility to assess any barriers to implementation, as reported by other providers in the literature review. Surprisingly, the only reported difficulty in this project was screening oversight during telehealth appointments and the omission of one screening due to patient age. In traditional appointments, the admitting RN gave the screening tool to patients whereas telehealth appointments were conducted entirely by the provider and required verbal administration of the screening tool. This made remembering to implement the screening more difficult as it was not part of the provider's previous routine. To mitigate this, the provider placed a note on her computer to remind her to screen any patients seen via telehealth. The facility was also reminded to screen all patients regardless of age.

Comparison of the Three Cycles

Figure 4. Percent of Patients Screened by Date and Cycle



- SMART goals for cycle 1 were surpassed with an ASQ screening rate of 96.4% (27/28) and the provision of secondary protocols for positive screenings at 100% (15/15) on February 9, 2023.

- SMART goals for cycle 2 were surpassed, with an ASQ screening rate of 92.9% (26/28) and the provision of secondary protocols for positive screenings at 90.9% (10/11) on February 22, 2023.
- SMART goals for cycle 3 were not met, with an ASQ screening rate of 90% (27/30) and the provision of secondary protocols for positive screenings at 100% (7/7) on March 10, 2023.

Analysis

A psychiatric practice is a viable medical setting for implementing suicide screening. As can be seen through the project results, many individuals were identified as having suicidal thoughts (n=33), but none needed further intervention beyond this setting. The initial and additional screening allowed the provider to assess risk, and identified that the individuals that screened positive had no plans or thoughts of acting upon these thoughts or had chronic suicidal thoughts.

While this project was implemented for early detection and prevention, the results are inconclusive in meeting the goals of early detection. Patients screened positive primarily consisted of established patients previously known to report suicidal ideation (n=32). New patients screened at the facility (n=7) were notably negative in screening (n=6), preventing any correlations toward early detection of suicide risk.

One barrier to the implementation found consistently in the literature review was a need for more education for providers before employing a screening tool. This was considered during this project and the student conducted a pre-implementation educational session to address any

provider concerns. Due to this educational session, this barrier may have been mitigated. Still, this finding is inconclusive as the pre- and post-educational surveys identified no differences in staff educational levels before and after the educational session. All questions were answered correctly in both survey administrations.

The success of this project is, in part, due to stakeholder buy-in. Facility stakeholders were invested and engaged in the QI project and desired to improve practice through suicide intervention. Stakeholder buy-in allowed for a more collaborative and cooperative implementation experience.

The use of the ASQ and BSSA protocol made this project easier as it provided a clear and easy-to-use process that leads the provider through screening, assessing, and decision-making based on the results. This clear delineation of tasks and outcomes removes bias due to clinical judgment, discomfort, uncertainty, anxiety, and stress associated with new screening protocols. Additionally, the screening tools can be acquired at no cost to the facility, thus decreasing the financial burden that may accompany other screening tool options. Other financial considerations include printing or systems purchased to electronically screen patients, which would be comparable for all screening implementation processes.

Consideration must also be given to the type of facility this project was conducted in. This project was implemented in a psychiatric practice where suicidal thoughts were previously assessed during patient appointments. This may affect implementation as the provider was already comfortable addressing suicide risk before screening protocols were employed. This may not be true for another specialty, emergency, or primary health facility.

Limitations

Limitations identified during the project include the absence of potentially significant patient data, lack of electronic health record (EHR) involvement, time constraints, small facility size, and small sample size. Potentially significant patient data not included in the project would be age, race/ethnicity, diagnoses, history of suicide attempts, plans, or thoughts, and PHQ-9 results. This data may be significant in making correlations between suicide risk factors and results found during screening.

EHR involvement was not implemented during this project. The use of screening tools and reminders to screen could have been built into the EHR to improve the screening process for telehealth visits, track longitudinal data, and allow the provider to compare results from previous visits to assess symptoms and adjust patient treatment plans. The lack of EHR involvement in this project was considered an impactful limitation.

Time constraints were the most significant problem during this project. This project was conducted over 6 weeks, limiting the number of PDSA cycles that could be completed and the amount of data collected. The results of this project should be assessed based on the limited amount of time in which the project was conducted and, if reimplemented, would need to assess for unforeseen factors which may impact future projects.

Conducting this project at a small rural psychiatric practice that is only open 2 days a week was also a limitation of the project. Due to the practice's small size and limited operation days, the staff and patient samples are small. Correlations should be made, with care, to a larger facility with larger patient sizes based on the success of this project.

Future Implications

More studies are needed on implementing suicide screening protocols in psychiatric and other settings such as family practice, pediatrics, and emergency facilities. Each of these areas of practice are in a strong position to implement suicide screening protocols. Suicide screening in clinical practice provides an opportunity to assess suicidal ideation, plans, and previous attempts, which may have otherwise not been reported. Screening for suicide and referral of at-risk patients create a patient-centered environment, reduce suicide risk, and allow for preventive efforts from healthcare providers.

Incorporating suicide screening into technology is feasible and would provide more consistent screening by providers. Future projects should include EHR inclusion, post-project provider evaluation, and inclusions of additional data collection to include age, race/ethnicity, diagnoses, history of suicide attempts, plans, or thoughts, and PHQ-9 results. Long-term quality-improvement projects should assess correlations using the additional data and track longitudinal changes to screening results after multiple patient visits.

Conclusion

The project successfully identified the evidence-based tools and processes fitting this practice, provided efficient and convenient implementation steps, gained stakeholder buy-in and support, and facilitated rapid PDSA cycling to identify and mitigate barriers to screening. Per the provider's report, additional secondary assessments improved patient care through standardization and consistency, and provided a conversation structure regarding suicide risk.

Limitations, including practice size, rurality, and practice specialty, did not indicate a correlation between suicide screening and early risk identification.

CHAPTER FOUR

DNP ESSENTIALS REFLECTION

DNP Essentials

Throughout my education journey at Montana State University, I have been able to meet the Essentials of Doctoral Education for Advanced Nursing Practice defined by the American Association of Colleges of Nursing (AACN) (2006). The AACN (2006) outlines competencies and quality indicators mastered by DNP students before graduation. This sense of mastery delineates students capable of practicing independently in the clinical setting at a doctoral level (AANC, 2006).

Essential I: Scientific Underpinnings for Practice

DNP Essential I, Scientific Underpinnings for Practice, prepares graduate students to apply scientific knowledge through evidence-based practices to clinical decision-making to improve nursing practice and patient outcomes (AANC, 2006). This essential was met while completing the DNP quality improvement (QI) project and completing projects in evidence-based practice courses. While completing these projects, I assessed and evaluated the current scientific knowledge and evidence-based practices associated with suicide prevention to implement a quality improvement protocol that promotes positive patient outcomes and advanced patient care practices in psychiatry.

During the DNP QI project, I conducted an in-depth literature search to support evidence-based suicide screening implementation, created after I identified a lack of standardized

screening processes in outpatient psychiatric practice. The literature was then reviewed, screened, and examined based on content and relevance to guide the QI project. I used the Plan-Do-Study-Act framework to turn the evidence-based practices found in the literature into an interventional plan to implement a suicide screening protocol and address or mitigate barriers to screening.

In previous evidence-based practice courses, I researched smoking cessation and intra-articular knee injections to determine best practices based on the current evidence-based literature. Through this process, I developed the necessary skills in researching, synthesizing, and applying scientific evidence to clinical practice to improve patient outcomes and advance patient care, which will benefit me in my future Advance Practice Nurse Practitioner (APRN) role.

Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking

DNP Essential II, Organizational and Systems Leadership for Quality Improvement and Systems Thinking, highlights the student's ability to examine current health systems to identify processes that could be improved to promote patient safety and clinical practice (AACN, 2006). These competencies were met in the QI project and during a clinical rotation in my Advanced Clinic IV class. During this clinical rotation, I identified a process and workflow barrier in utilizing the electronic health record (HER) in the psychiatric department of the clinical facility. The facility had not previously adapted the EHR system to allow the psychiatric department to chart patient visits efficiently and effectively. Due to this oversight, the providers had to create individual charting systems, leading to inconsistencies, inefficiencies, and potential safety issues.

During this clinical rotation, I accepted a leadership role to improve and adapt the facility's EHR system to prevent provider barriers and improve charting efficacy. I collaborated with the psychiatric department, management, information technology department, and education department to design, create, and implement a new psychiatric EHR template. This new template allows for efficient, effective, consistent, and safe patient charting and care department-wide.

This competency was also met through projects completed during my Health Care Designs course. Projects included process mapping to assess and improve processes at the facility I work at. During this project I evaluated the current organizational and distributive functions for the supply chain at the facility as well as processes involved in patient care from patient admission to discharge. Through these experiences, I was able to understand better how organizational systems operate, identify facilitators and barriers that affect interfacility change, participate in team building and networking, and act in an inter-collaborative leadership role. This experience and the ensuing understanding are essential to my future role as an APRN.

Essential III: Clinical Scholarship and Analytical Methods for Evidence-based Practice

DNP Essential III, Clinical Scholarship and Analytical Methods for Evidence-based Practice, examines the student's ability to examine existing literature to identify high-quality, applicable evidence to influence clinical practice and decision-making (AACN, 2006). During this educational program, I have had many opportunities to research and understand the significance of high-quality evidence and the application of analytical methods in the Statistical Analysis course and during the implementation of my scholarly project. The student met significant areas of understanding in the course and research, including reliability, validity,

statistical significance, clinical significance, and generalizability. These concepts were learned during the course and applied during the QI project when researching suicide prevention methods, standardized screening tools and subsequent protocols, and barriers to screening implementation, and during the QI project results and outcomes analysis. During this project, I analyzed the evidence and quality of these methods, tools, reported barriers, results, and outcomes to inform clinical practice decisions. This is imperative to quality, effective, and safe patient care as a future APRN.

Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care

DNP Essential IV, Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care, examines the student's ability to utilize systems or technology and provide leadership to improve patient care (AACN, 2006). During the Advanced Clinical IV course, I worked inter-collaboratively with a team of professionals at the facility I was assigned to improve the current use of EHR technology to enhance the overall care delivery system in the psychiatric department. I accepted a leadership role in which I headed and designed the project. However, much of the creation of the upgrades to the system was completed by others, including many members of the IT department, the educational director, and EHR system professionals. Through this project, the facility and I created a template in the current version of the EHR to improve psychiatric charting and patient care. We were additionally able to ask for and incorporate changes to be implemented with the next update to the EHR system in August 2023, which will continue to support the efficiency and consistency of charting to improve provider experiences and patient safety.

This essential was also met during the Healthcare Informatics course. During this course, I completed a project assessing current technological advances in GPS tracking devices and how using these technologies in the care of Alzheimer's patients could benefit current patient care. Through these experiences, I gained insight and skill in designing, using, and evaluating integrative health-information systems and interprofessional collaborative networking to improve processes and systems, providing a solid foundation for my future role as an APRN.

Essential V: Health Care Policy for Advocacy in Health Care

DNP Essential V, Health Care Policy for Advocacy in Health Care, highlights the DNP graduate student's role in developing and engaging in health policy in healthcare and government (AACN, 2006). In the course Ethics, Law, and Policy for Advocacy in Healthcare, the students were asked to analyze and research current healthcare problems. Post analysis and research, the student was to write a letter to the appropriate association, professional organization, or other entity to advocate for policy changes. During this class, I analyzed and researched the current guidelines and findings regarding screening for autism spectrum disorder (ASD), gaps in screening practices, and reasons for screening failures. After this research, I wrote a letter to the American Academy of Pediatrics advocating for additional screenings to be added to the current guidelines to improve early detection and intervention practices. This educational opportunity increased my comfort and confidence regarding patient advocacy, an essential skill for the APRN.

Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes

DNP Essential VI, Interprofessional Collaboration for Improving Patient and Population Health Outcomes, describes the DNP graduate's role in providing multidisciplinary comprehensive patient care (AACN, 2006). I was placed at a Patient Aligned Care Team (PACT) facility during my Advanced Clinical IV class for clinical hours. This experience taught me the importance and significance of inter-collaborative wrap-around patient care at this facility. At this facility, group members, including care managers, prescribers, social workers, and therapists, come together to provide complete patient care. This care often includes nutrition, housing, medication management, psychiatric treatment, group and individual therapy, legal assistance, employment assistance, and transportation. This requires weekly collaborative communication between team members to provide seamless care and improve patient outcomes. My participation in this inter-collaborative team has shown me that patient care should be a shared endeavor between professionals to meet the patient's needs, which is essential to the APRN role.

Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health

DNP Essential VII, Clinical Prevention and Population Health for Improving the Nation's Health, summarizes the DNP graduate's responsibility as a leader in clinical preventative care and population health activities (AACN, 2006). The DNP QI project allowed me to identify a preventable global healthcare problem that could be targeted within the psychiatric setting through prevention-themed interventions to improve outcomes of individuals at risk for suicide. Through the literature review, I recognized that early identification of risk and intervention

improved health outcomes for patients with suicidal ideation. This could be accomplished by implementing standardized screening protocols for every patient presenting to the facility for care. I created and then implemented a population-health process improvement plan intending to identify patients at risk for suicide and subsequently improve health outcomes.

Preventative healthcare was also addressed in the course Vulnerability and Health Care in Diverse Communities. During this course, I was required to complete a project to identify and address the concerns facing a vulnerable population in Montana. These projects helped me to understand the importance of preventative health care, which will be applied to my future APRN role.

Essential VIII: Advanced Nursing Practice

DNP Essential VIII, Advanced Nursing Practice, defines the DNP graduate's role in treating patients using advanced practice techniques, including assessment, diagnosis, treatment planning, and care evaluation (AACN, 2006). This essential was primarily met through my clinical courses where I worked with other APRNs in outpatient settings treating adults and children with diverse mental health needs. I completed psychiatric evaluations, planned and managed treatment, provided psychotherapy, and evaluated responses to treatments over subsequent appointments. Courses through the program that contributed to mastery of this essential include pathophysiology, psychopharmacology, evidence-based practice courses, and advanced clinical courses. These courses provided the foundation for clinical decision-making in the healthcare setting. These experiences have shaped the APRN I am and will continue to become after completing this program.

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APPENDICES

APPENDIX A

LOGIC MODEL

Appendix A: Logic Model



APPENDIX B

STUDENT-LED EDUCATION PLAN

Appendix B: Student-Led Education Plan

Student-led Educational Plan

PMHNP and RN

- Provide and discuss educational handouts created by the student
- Watch videos:
    - Physicians: The Importance of Screening https://youtu.be/QaPeu6s__YM
    - Mayo Clinic: What to Say and What Not to Say https://www.youtube.com/watch?v=3BByqa7bhto&feature=youtu.be
- Discuss timeline and implementation
- Questions, comments, concerns

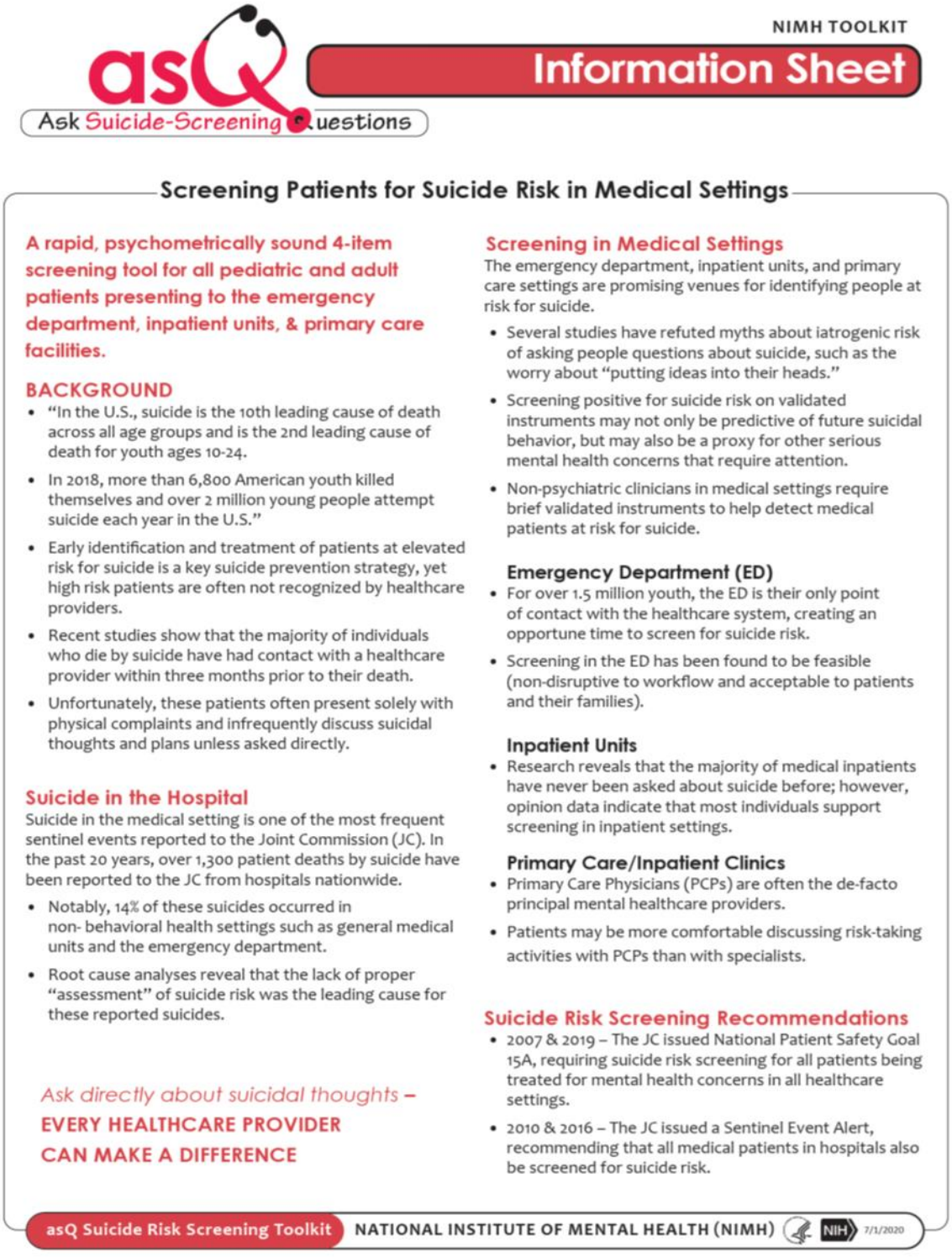
PMHNP

- Education on the screening tool, scoring, and secondary assessment tool
- Questions, comments, concerns

APPENDIX C

SCREENING TOOL INFORMATION SHEET

Appendix C: Screening Tool Information Sheet



asQ
Ask Suicide-Screening Questions

NIMH TOOLKIT

Information Sheet

Screening Patients for Suicide Risk in Medical Settings

A rapid, psychometrically sound 4-item screening tool for all pediatric and adult patients presenting to the emergency department, inpatient units, & primary care facilities.

BACKGROUND

- "In the U.S., suicide is the 10th leading cause of death across all age groups and is the 2nd leading cause of death for youth ages 10-24.
- In 2018, more than 6,800 American youth killed themselves and over 2 million young people attempt suicide each year in the U.S."
- Early identification and treatment of patients at elevated risk for suicide is a key suicide prevention strategy, yet high risk patients are often not recognized by healthcare providers.
- Recent studies show that the majority of individuals who die by suicide have had contact with a healthcare provider within three months prior to their death.
- Unfortunately, these patients often present solely with physical complaints and infrequently discuss suicidal thoughts and plans unless asked directly.

Suicide in the Hospital

Suicide in the medical setting is one of the most frequent sentinel events reported to the Joint Commission (JC). In the past 20 years, over 1,300 patient deaths by suicide have been reported to the JC from hospitals nationwide.

- Notably, 14% of these suicides occurred in non- behavioral health settings such as general medical units and the emergency department.
- Root cause analyses reveal that the lack of proper "assessment" of suicide risk was the leading cause for these reported suicides.

Ask directly about suicidal thoughts –
EVERY HEALTHCARE PROVIDER CAN MAKE A DIFFERENCE

Screening in Medical Settings

The emergency department, inpatient units, and primary care settings are promising venues for identifying people at risk for suicide.

- Several studies have refuted myths about iatrogenic risk of asking people questions about suicide, such as the worry about "putting ideas into their heads."
- Screening positive for suicide risk on validated instruments may not only be predictive of future suicidal behavior, but may also be a proxy for other serious mental health concerns that require attention.
- Non-psychiatric clinicians in medical settings require brief validated instruments to help detect medical patients at risk for suicide.

Emergency Department (ED)

- For over 1.5 million youth, the ED is their only point of contact with the healthcare system, creating an opportune time to screen for suicide risk.
- Screening in the ED has been found to be feasible (non-disruptive to workflow and acceptable to patients and their families).

Inpatient Units

- Research reveals that the majority of medical inpatients have never been asked about suicide before; however, opinion data indicate that most individuals support screening in inpatient settings.

Primary Care/Inpatient Clinics

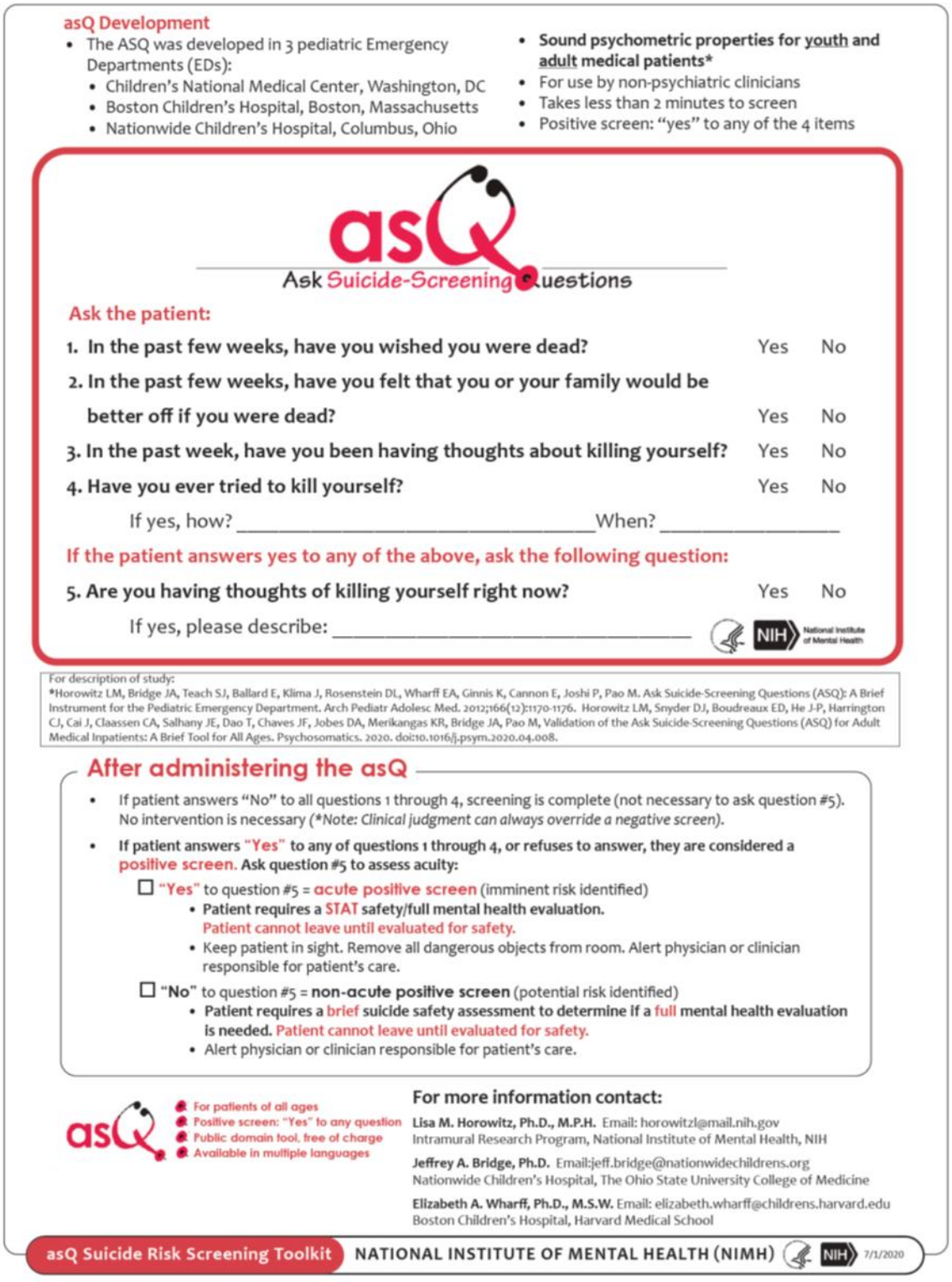
- Primary Care Physicians (PCPs) are often the de-facto principal mental healthcare providers.
- Patients may be more comfortable discussing risk-taking activities with PCPs than with specialists.

Suicide Risk Screening Recommendations

- 2007 & 2019 – The JC issued National Patient Safety Goal 15A, requiring suicide risk screening for all patients being treated for mental health concerns in all healthcare settings.
- 2010 & 2016 – The JC issued a Sentinel Event Alert, recommending that all medical patients in hospitals also be screened for suicide risk.

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/1/2020

(National Institute of Mental Health, n.d.)



asQ Development

- The ASQ was developed in 3 pediatric Emergency Departments (EDs):
  - Children's National Medical Center, Washington, DC
  - Boston Children's Hospital, Boston, Massachusetts
  - Nationwide Children's Hospital, Columbus, Ohio
- **Sound psychometric properties for youth and adult medical patients***
- For use by non-psychiatric clinicians
- Takes less than 2 minutes to screen
- Positive screen: "yes" to any of the 4 items

asQ

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** Yes No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** Yes No
3. **In the past week, have you been having thoughts about killing yourself?** Yes No
4. **Have you ever tried to kill yourself?** Yes No

   If yes, how? _____ When? _____

If the patient answers yes to any of the above, ask the following question:

5. **Are you having thoughts of killing yourself right now?** Yes No

   If yes, please describe: _____

NIH National Institute of Mental Health

For description of study:
*Horowitz LM, Bridge JA, Teach SJ, Ballard E, Klima J, Rosenstein DL, Wharff EA, Ginnis K, Cannon E, Joshi P, Pao M. Ask Suicide-Screening Questions (ASQ): A Brief Instrument for the Pediatric Emergency Department. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176. Horowitz LM, Snyder DJ, Boudreaux ED, He J-P, Harrington CJ, Cai J, Claassen CA, Salhany JE, Dao T, Chaves JF, Jobes DA, Merikangas KR, Bridge JA, Pao M, Validation of the Ask Suicide-Screening Questions (ASQ) for Adult Medical Inpatients: A Brief Tool for All Ages. Psychosomatics. 2020. doi:10.1016/j.psym.2020.04.008.

After administering the asQ

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary *(*Note: Clinical judgment can always override a negative screen).*
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

asQ

- For patients of all ages
- Positive screen: "Yes" to any question
- Public domain tool, free of charge
- Available in multiple languages

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Boston Children's Hospital, Harvard Medical School

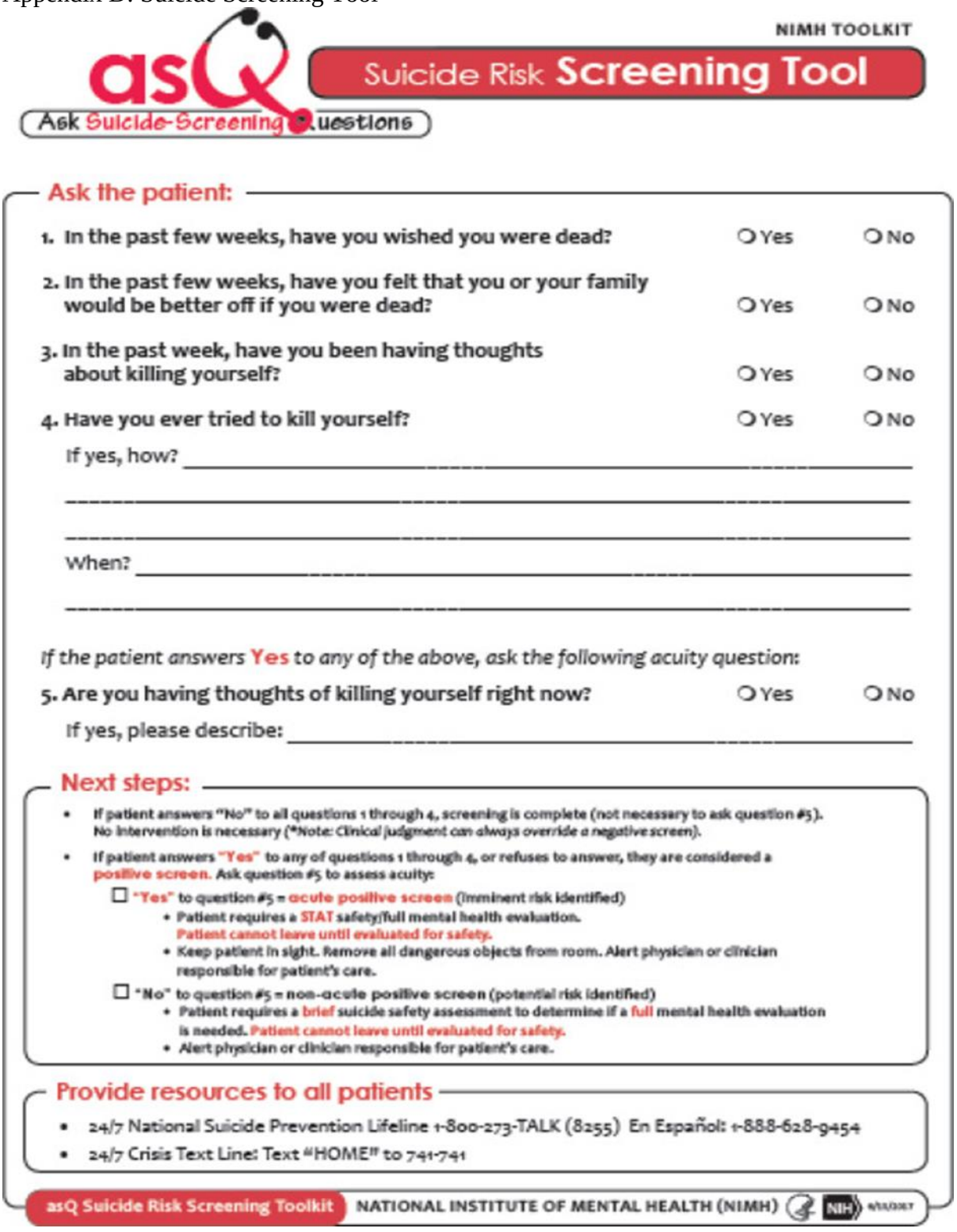
asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) NIH 7/1/2020

(National Institute of Mental Health, n.d.)

APPENDIX D

SUICIDE SCREENING TOOL

Appendix D: Suicide Screening Tool

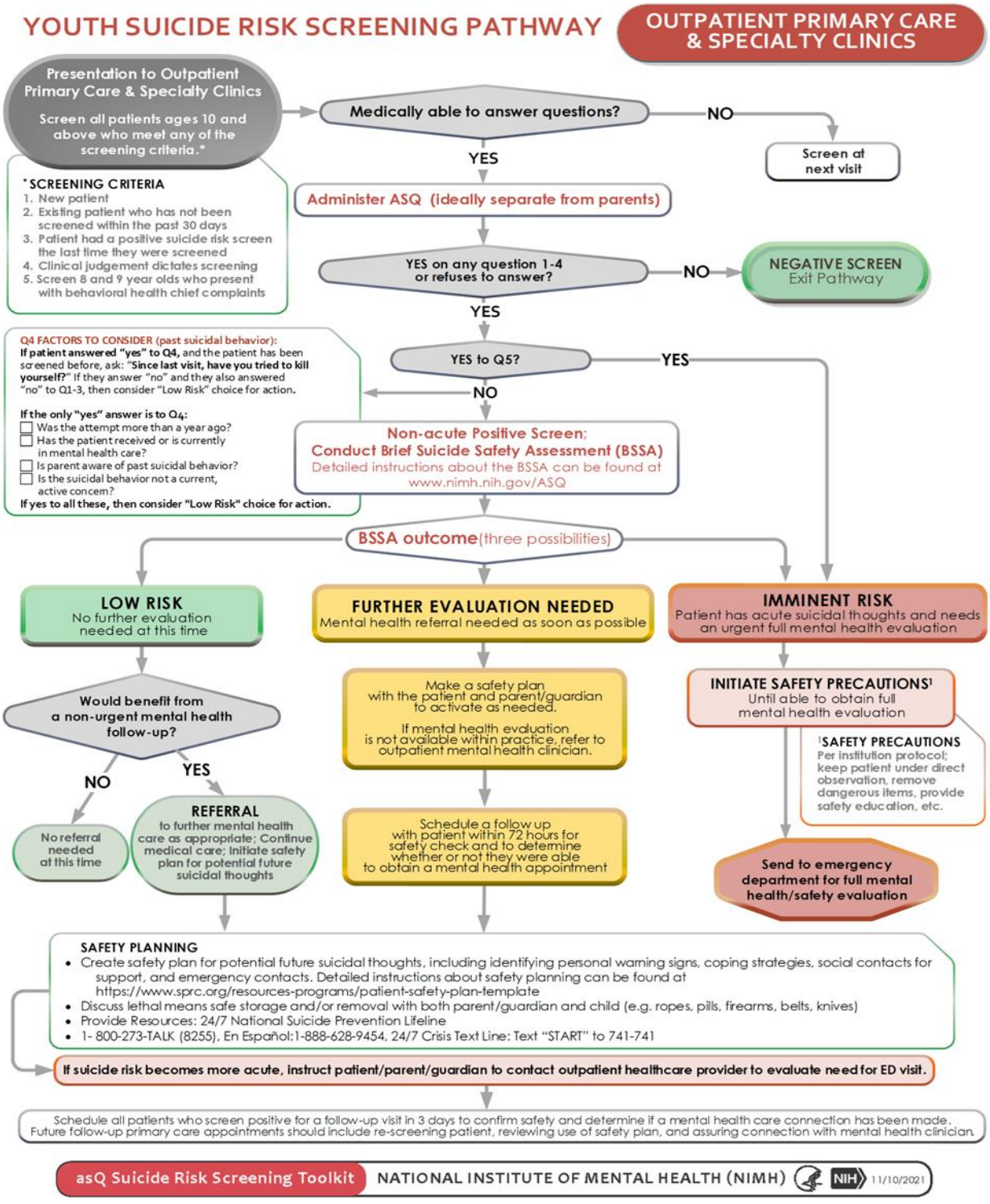


(National Institute of Mental Health, n.d.)

APPENDIX E

SUICIDE RISK SCREENING PATHWAY

Appendix E: Suicide Risk Screening Pathway

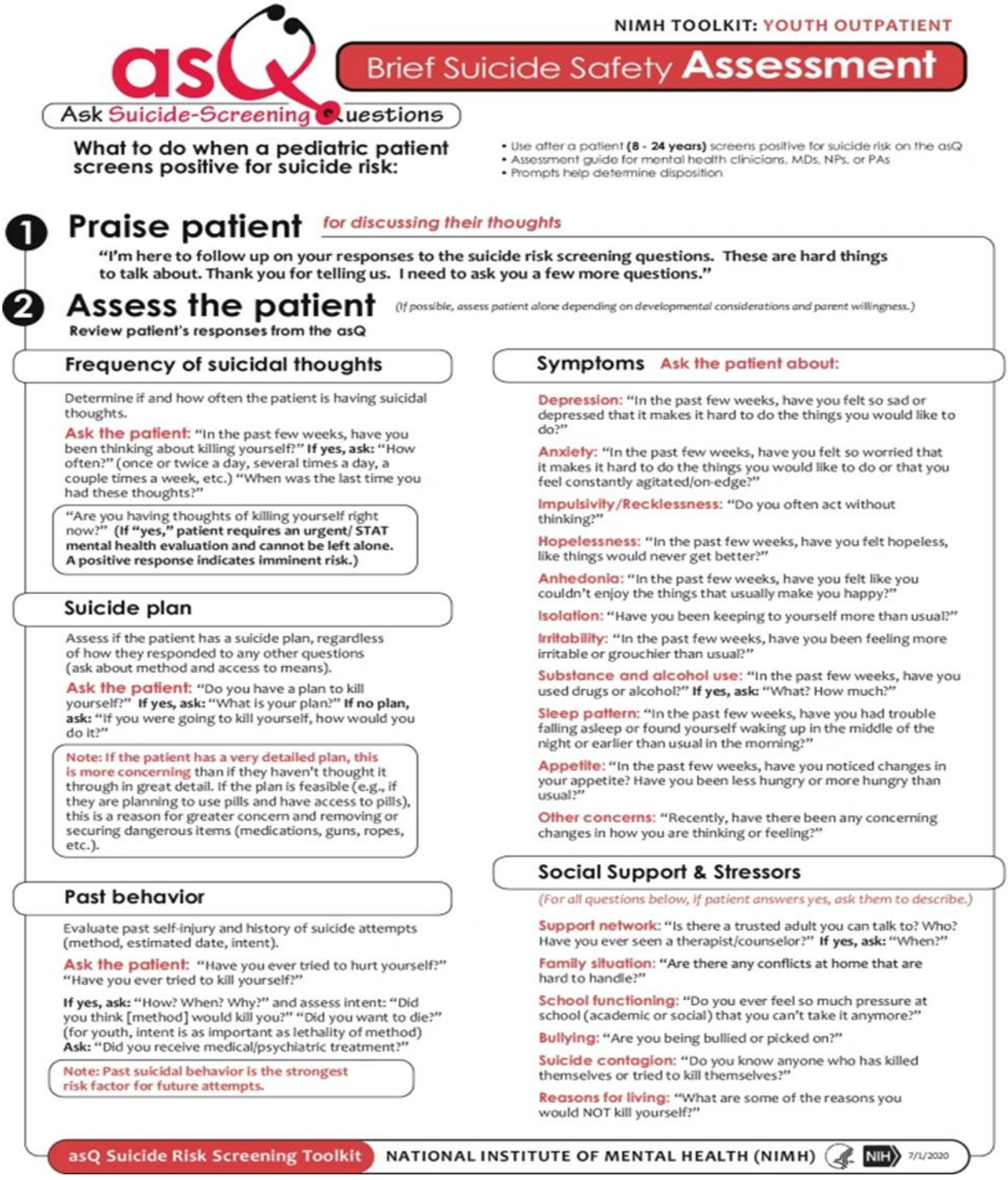


(National Institute of Mental Health, n.d.)

APPENDIX F

BRIEF SUICIDE SAFETY ASSESSMENT TOOL FOR YOUTH

Appendix F: Brief Suicide Safety Assessment Tool for Youth

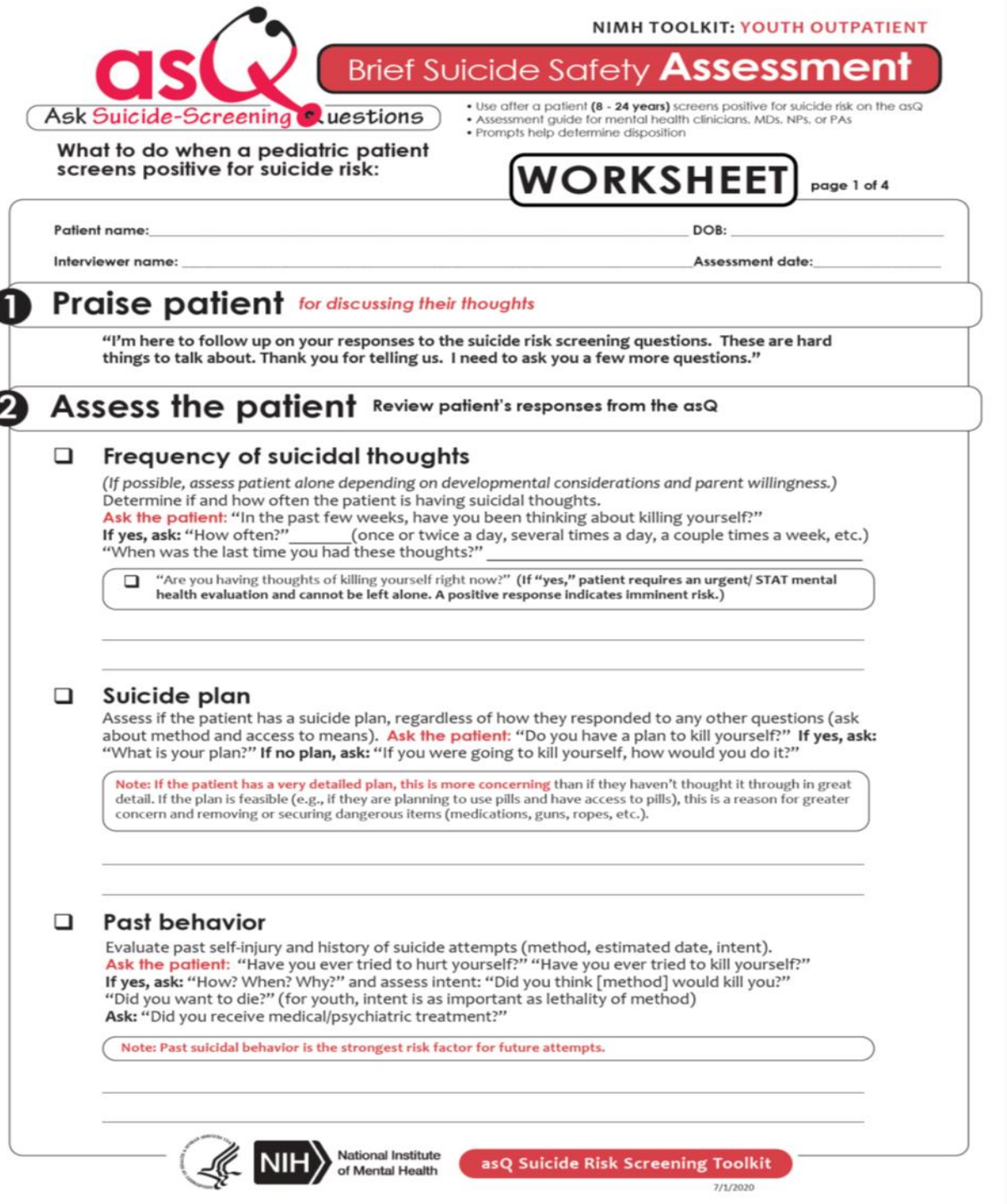


(National Institute of Mental Health, n.d.)

APPENDIX G

BRIEF SUICIDE SAFETY ASSESSMENT WORKSHEET FOR YOUTH

Appendix G: Brief Suicide Safety Assessment Worksheet for Youth



NIMH TOOLKIT: YOUTH OUTPATIENT

asQ Ask Suicide-Screening Questions

Brief Suicide Safety Assessment

- Use after a patient **(8 - 24 years)** screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

What to do when a pediatric patient screens positive for suicide risk:

WORKSHEET page 1 of 4

Patient name:_____ DOB: _____

Interviewer name: _____ Assessment date:_____

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient Review patient's responses from the asQ

❑ Frequency of suicidal thoughts

(If possible, assess patient alone depending on developmental considerations and parent willingness.)
Determine if and how often the patient is having suicidal thoughts.
Ask the patient: "In the past few weeks, have you been thinking about killing yourself?"
If yes, ask: "How often?"_____(once or twice a day, several times a day, a couple times a week, etc.)
"When was the last time you had these thoughts?" _____

❑ "Are you having thoughts of killing yourself right now?" **(If "yes," patient requires an urgent/ STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)**

❑ Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means). **Ask the patient:** "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

❑ Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).
Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"
If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?"
"Did you want to die?" (for youth, intent is as important as lethality of method)
Ask: "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

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asQ Suicide Risk Screening Toolkit

7/1/2020

(National Institute of Mental Health, n.d.)



NIMH TOOLKIT: YOUTH OUTPATIENT

asQ Ask Suicide-Screening Questions

Brief Suicide Safety Assessment

WORKSHEET page 2 of 4

2 Assess the patient Review patient's responses from the asQ

❑ Symptoms Ask the patient about:

- ❑ **Depression:** "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"
- ❑ **Anxiety:** "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"
- ❑ **Impulsivity/Recklessness:** "Do you often act without thinking?"
- ❑ **Hopelessness:** "In the past few weeks, have you felt hopeless, like things would never get better?"
- ❑ **Anhedonia:** "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"
- ❑ **Isolation:** "Have you been keeping to yourself more than usual?"
- ❑ **Irritability:** "In the past few weeks, have you been feeling more irritable or grouchier than usual?"
- ❑ **Substance and alcohol use:** "In the past few weeks, have you used drugs or alcohol?" **If yes, ask:** "What? How much?"
- ❑ **Sleep pattern:** "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"
- ❑ **Appetite:** "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"
- ❑ **Other concerns:** "Recently, have there been any concerning changes in how you are thinking or feeling?"

❑ Social Support & Stressors *(For all questions below, if patient answers yes, ask them to describe.)*

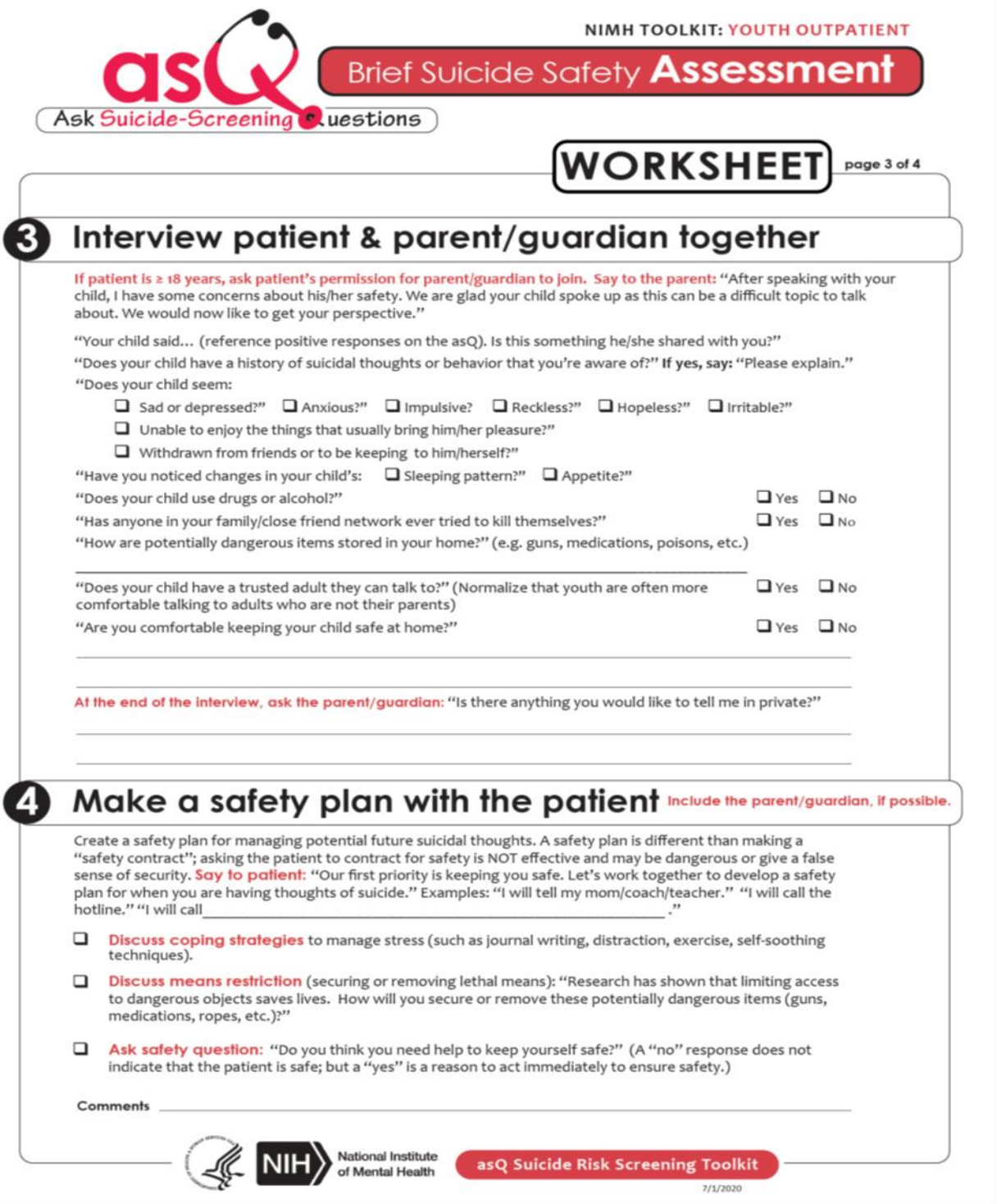
- ❑ **Support network:** "Is there a trusted adult you can talk to? Who? Have you ever seen a therapist/ counselor?" **If yes, ask:** "When?"
- ❑ **Family situation:** "Are there any conflicts at home that are hard to handle?"
- ❑ **School functioning:** "Do you ever feel so much pressure at school (academic or social) that you can't take it anymore?"
- ❑ **Bullying:** "Are you being bullied or picked on?"
- ❑ **Suicide contagion:** "Do you know anyone who has killed themselves or tried to kill themselves?"
- ❑ **Reasons for living:** "What are some of the reasons you would NOT kill yourself?"

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asQ Ask Suicide-Screening Questions

Brief Suicide Safety **Assessment**

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3 Interview patient & parent/guardian together

If patient is ≥ 18 years, ask patient's permission for parent/guardian to join. Say to the parent: "After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective."

"Your child said... (reference positive responses on the asQ). Is this something he/she shared with you?"

"Does your child have a history of suicidal thoughts or behavior that you're aware of?" **If yes, say:** "Please explain."

"Does your child seem:

- ❑ Sad or depressed?" ❑ Anxious?" ❑ Impulsive? ❑ Reckless?" ❑ Hopeless?" ❑ Irritable?"
- ❑ Unable to enjoy the things that usually bring him/her pleasure?"
- ❑ Withdrawn from friends or to be keeping to him/herself?"

"Have you noticed changes in your child's: ❑ Sleeping pattern?" ❑ Appetite?"

"Does your child use drugs or alcohol?" ❑ Yes ❑ No

"Has anyone in your family/close friend network ever tried to kill themselves?" ❑ Yes ❑ No

"How are potentially dangerous items stored in your home?" (e.g. guns, medications, poisons, etc.)

_____

"Does your child have a trusted adult they can talk to?" (Normalize that youth are often more comfortable talking to adults who are not their parents) ❑ Yes ❑ No

"Are you comfortable keeping your child safe at home?" ❑ Yes ❑ No

_____

_____

At the end of the interview, ask the parent/guardian: "Is there anything you would like to tell me in private?"

_____

_____

4 Make a safety plan with the patient Include the parent/guardian, if possible.

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than making a "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or give a false sense of security. Say to patient: "Our first priority is keeping you safe. Let's work together to develop a safety plan for when you are having thoughts of suicide." Examples: "I will tell my mom/coach/teacher." "I will call the hotline." "I will call_____."

- ❑ Discuss coping strategies to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).
- ❑ Discuss means restriction (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"
- ❑ Ask safety question: "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

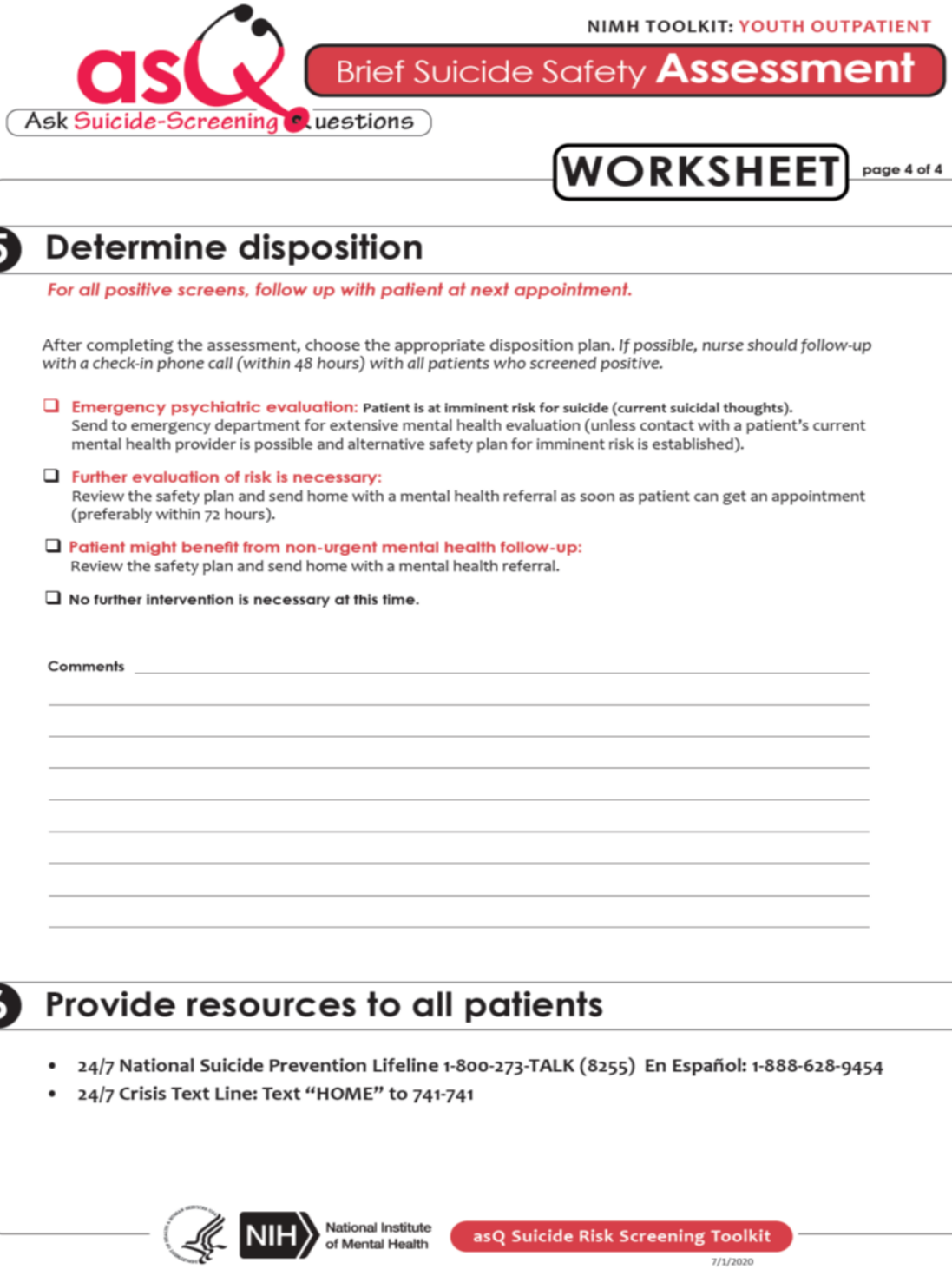
Comments _____

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Brief Suicide Safety Assessment

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5 Determine disposition

For all positive screens, follow up with patient at next appointment.

After completing the assessment, choose the appropriate disposition plan. *If possible, nurse should follow-up with a check-in phone call (within 48 hours) with all patients who screened positive.*

- ❑ **Emergency psychiatric evaluation:** **Patient is at imminent risk for suicide (current suicidal thoughts).** Send to emergency department for extensive mental health evaluation (unless contact with a patient's current mental health provider is possible and alternative safety plan for imminent risk is established).
- ❑ **Further evaluation of risk is necessary:** Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (preferably within 72 hours).
- ❑ **Patient might benefit from non-urgent mental health follow-up:** Review the safety plan and send home with a mental health referral.
- ❑ **No further intervention is necessary at this time.**

Comments _____

6 Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

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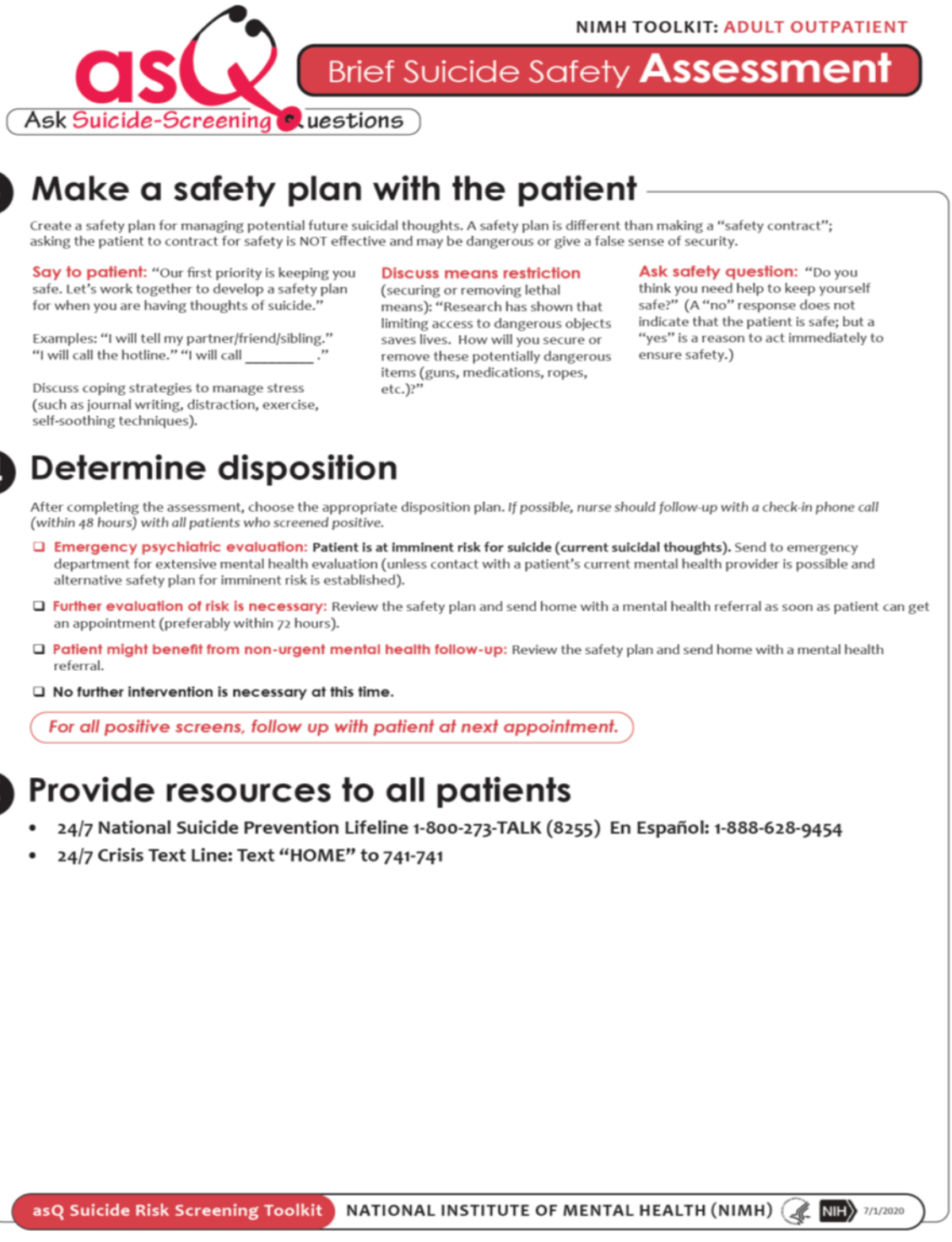
APPENDIX H

BRIEF SUICIDE SAFETY ASSESSMENT FOR ADULTS

Appendix H: Brief Suicide Safety Assessment for Adults



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NIMH TOOLKIT: ADULT OUTPATIENT

asQ Ask Suicide-Screening Questions

Brief Suicide Safety Assessment

3 Make a safety plan with the patient

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than making a "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or give a false sense of security.

Say to patient: "Our first priority is keeping you safe. Let's work together to develop a safety plan for when you are having thoughts of suicide."

Examples: "I will tell my partner/friend/sibling." "I will call the hotline." "I will call _____."

Discuss coping strategies to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).

Discuss means restriction (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"

Ask safety question: "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

4 Determine disposition

After completing the assessment, choose the appropriate disposition plan. *If possible, nurse should follow-up with a check-in phone call (within 48 hours) with all patients who screened positive.*

- ❑ **Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts).** Send to emergency department for extensive mental health evaluation (unless contact with a patient's current mental health provider is possible and alternative safety plan for imminent risk is established).
- ❑ **Further evaluation of risk is necessary:** Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (preferably within 72 hours).
- ❑ **Patient might benefit from non-urgent mental health follow-up:** Review the safety plan and send home with a mental health referral.
- ❑ **No further intervention is necessary at this time.**

For all positive screens, follow up with patient at next appointment.

5 Provide resources to all patients

- **24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454**
- **24/7 Crisis Text Line: Text "HOME" to 741-741**

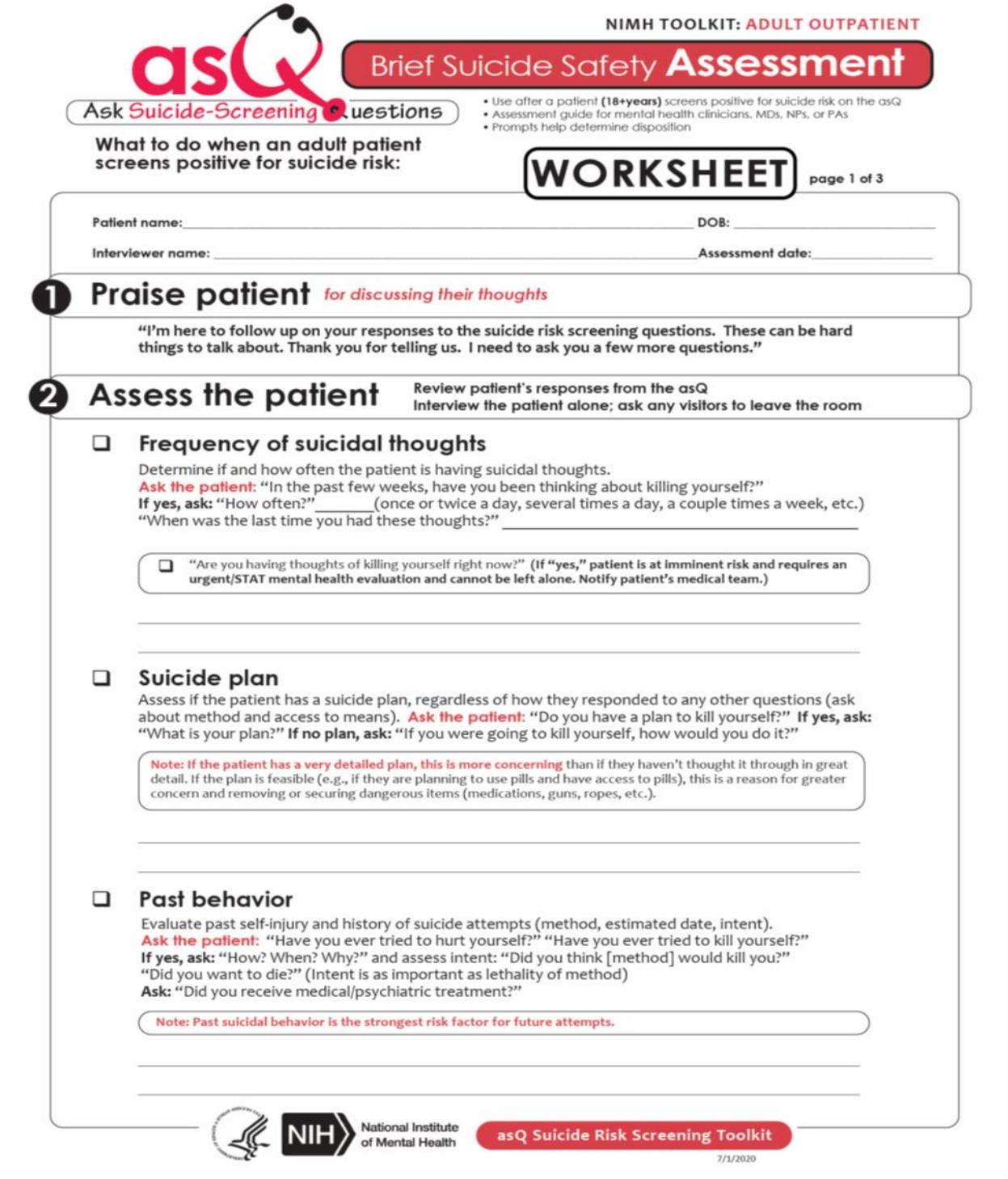
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APPENDIX I

BRIEF SUICIDE SAFETY ASSESSMENT WORKSHEET FOR ADULTS

Appendix I: Brief Suicide Safety Assessment Worksheet for Adults



NIMH TOOLKIT: ADULT OUTPATIENT

asQ Ask Suicide-Screening Questions

Brief Suicide Safety Assessment

- Use after a patient **(18+years)** screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

What to do when an adult patient screens positive for suicide risk:

WORKSHEET page 1 of 3

Patient name:_____ DOB: _____

Interviewer name: _____ Assessment date:_____

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These can be hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient

Review patient's responses from the asQ
Interview the patient alone; ask any visitors to leave the room

❑ Frequency of suicidal thoughts

Determine if and how often the patient is having suicidal thoughts.
Ask the patient: "In the past few weeks, have you been thinking about killing yourself?"
If yes, ask: "How often?"_____(once or twice a day, several times a day, a couple times a week, etc.)
"When was the last time you had these thoughts?" _____

❑ "Are you having thoughts of killing yourself right now?" **(If "yes," patient is at imminent risk and requires an urgent/STAT mental health evaluation and cannot be left alone. Notify patient's medical team.)**

❑ Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means). **Ask the patient:** "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

❑ Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).
Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"
If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?"
"Did you want to die?" (Intent is as important as lethality of method)
Ask: "Did you receive medical/psychiatric treatment?"

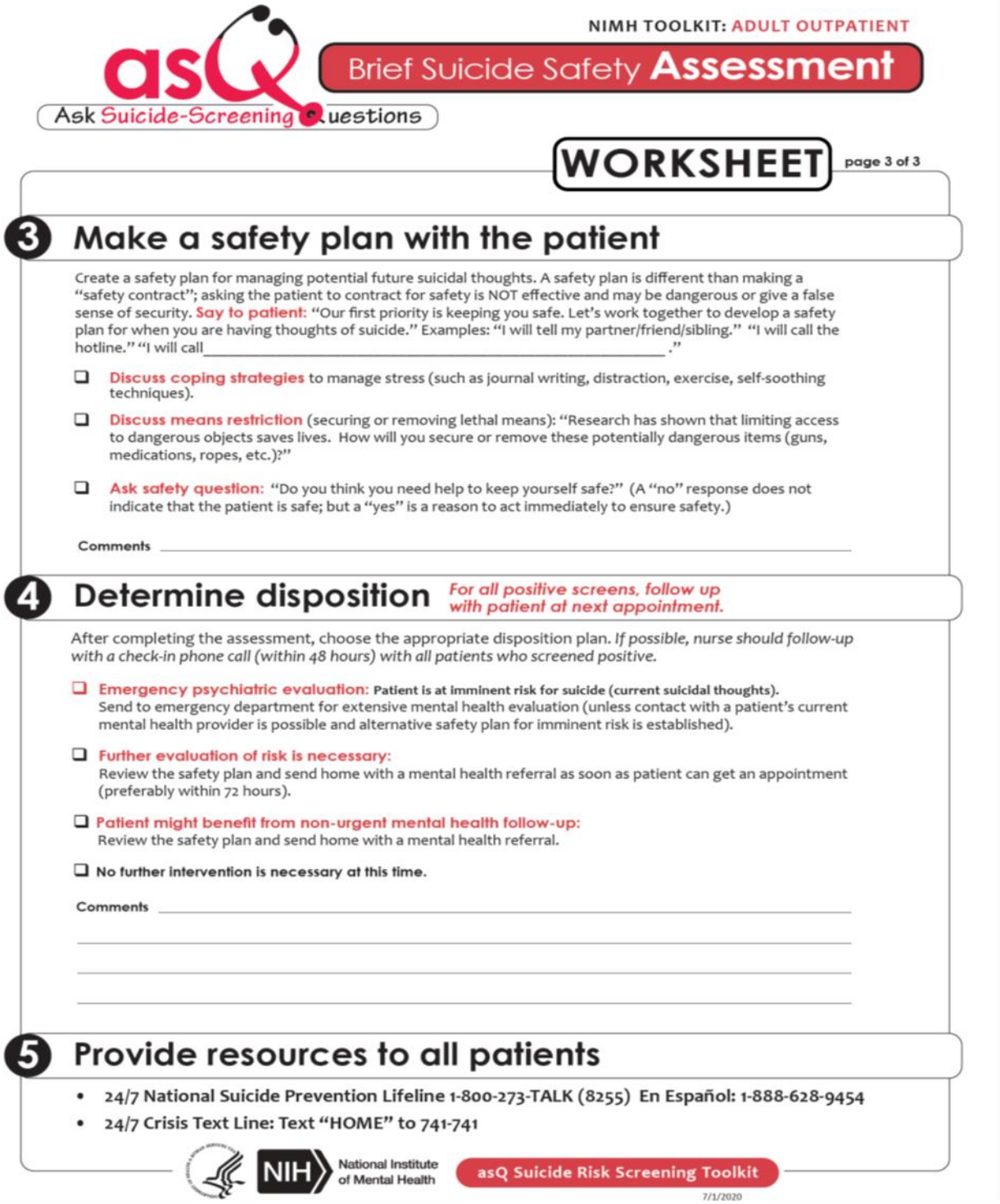
Note: Past suicidal behavior is the strongest risk factor for future attempts.

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