

**Universal Screening for Youth Suicide Risk in a School-Based Health Clinic: A Quality
Improvement Project**

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Abstract

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Rates of youth death by suicide have been consistently rising in the United States since the beginning of the 21st century. In light of this alarming trend, new guidelines support the need for universal screening for suicide risk on an annual basis for patients 12 and older. This quality improvement (QI) project addressed the implementation of universal, annual suicide screening for youth in a school-based health clinic (SBHC) newly established by a Federally Qualified Health Center (FQHC) in Gresham, Oregon. This QI project was a collaboration between a Doctor of Nursing Practice (DNP) student and the FQHC's SBHC team: a Family Nurse Practitioner (FNP), a medical assistant (MA), a behavioral health provider (BHP), and the Data and Quality Team. With the goal of administering the Ask-suicide Screening Questions (ASQ) tool to 75% of all new 12- to 18-year-old clinic visits, data was collected for two different Plan-Do-Study-Act (PDSA) cycles between October and December 2023. The Data and Quality Team compiled two data sets through Electronic Health Record (EHR) chart scrubbing for metrics such as age, gender, ASQ tool completion, and acute vs. non-acute scores; information was organized by patient MRN to ensure confidentiality. The data was then displayed in run charts to help demonstrate trends, shifts, astronomical data points, and directions of goodness. Recommendations and possible future steps were presented to the FQHC that included further increasing ASQ screening at the SBHC, expanding to other SBHCs, identifying community resources available to patients, and cementing clear management policies for follow up post risk identification.

Introduction

Problem Description

Between 2007 and 2021 alone, the suicide rate tripled for youth aged 10-14 years in the United States (Curtin & Garnett, 2023). Two subsets stand out nationally amid the rising rates of youth death by suicide: Black youth and female youth. Rates of suicide in Black youth aged 10-24 years increased by 36.6% over the span of three years in 2018 to 2021 (Stone, Mack, & Qualters, 2023). In Black children younger than 13, the suicide rate is double that of White children (Bridge et al., 2017). Similarly, the sex ratio gap between male and female youth suicide rates has been steadily decreasing since 2007 and is especially notable in younger females between the ages of 10 to 14 years (Ruch et al., 2019). The COVID-19 pandemic saw an increase in Emergency Department (ED) visits for suspected suicide attempts in female youth, with a 50.6% higher rate during the winter of 2021 when compared with 2019 (Yard et al., 2021).

Oregon is ranked among the top states for youth suicide, with suicide as the second leading cause of death among youth under the age of 25 (Oregon Health Authority, 2021). In Oregon, male youth are three times more likely to die of suicide than female youth (Oregon Health Authority, 2021). Lesbian, Gay, Transgender, Bisexual and Queer (LGBTBQ+) youth are also at increased risk: from 2015 to 2019 this population represented 2.7% of all deaths in Oregon by suicide, which is most likely an undercount (Oregon Health Authority, 2021). The OHA reported that in 2020, Multnomah County accounted for 16.5% of suicide-related hospitalizations and 17% of suicide deaths across the state, demonstrating an outsized risk for suicide within this specific geographic area (OHA, 2021). These trends demonstrate a need for early identification and prevention of youth death by suicide

Historically, guidelines for mental health screening in youth have only recommended screening for depression during well-child visits; these tools do not always include assessment for suicide and not all adolescents who are suicidal have depression (Zuckerbrot et al., 2018). In 2022 the American

Academy of Pediatrics (AAP) updated screening guidelines to include universal, annual screening for suicide risk in ages 12 and older as well as screening for ages 8 to 11 when clinically indicated (Green, Gottschlich, & Burr, 2023). Almost half of adolescents who died by suicide visited their primary care provider (PCP) within one month of their suicide (Diamond et al., 2017), placing primary care clinics in a unique position to address youth death by suicide through screening. However, Green, Gottschlich, & Burr (2023) found that while 8/10 pediatricians reported having a patient attempt or die of suicide, only 9% of the 377 respondents universally screened for suicidal ideation (SI) using a standardized suicide-specific screening tool (Green, Gottschlich, & Burr, 2023).

This project implemented universal suicide screening for youth in the setting of a new school-based health clinic (SBHC) undertaken by a Federally Qualified Health Center (FQHC) at a Multnomah County high school in Gresham, Oregon. This QI project aligns with the Oregon Health Authority (OHA) Youth Suicide and Annual Prevention Report's goal of universal suicide screening for youth; primary care providers fall under the Treatment and Support Services strategic pillar of the plan (OHA, 2021).

Available Knowledge

Search Strategy. For youth suicide risk screening in primary care, the CINAHL, PubMed, and Scopus databases were searched for English-language articles published globally between 2010 and 2023. Keywords and PubMed MeSH terms included *suicide*, *mass screening*, *preventive health services* or *primary health care*, and *adolescent* or *child 0-18 years* or *youth*. Studies that were identified as consistent with the project's theme were then cross-referenced in Scopus to ensure peer review and high evidence quality. In total, 12 articles were appraised with the following themes: screening tools, delivery methods, and setting.

Screening Tool. While there are numerous suicide screening tools available for inpatient and outpatient use, many have been shown to be time or technology intensive and/or unvalidated (Aguinaldo et al., 2021). Thabrew et al. (2019) assessed the benefit of pairing a shorter, electronic tool

(YouthCHAT) with the longer face-to-face Home, Education, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety (HEEADSSS) assessment conducted with a provider. In this randomized control trial, YouthCHAT was found to take on average 9 minutes while the HEEADSSS assessment took on average 16 minutes, making this a timely process for a well-child visit. The tool identified psychosocial risk factors for suicide indirectly; rather than isolating any one factor, this tool examines the psychosocial context in which suicidal ideation can grow (Thabrew et al., 2019).

The Youth Suicide Ideation Screen-3 Item (YSIS-3) tool, originally adapted from the Beck Scale for Suicidal Ideation (BSSI) for adults, is designed to screen for suicidal ideation in youth ages 12-25. A study by Hetrick et al. (2021) investigated the validity of the YSIS-3, concluding that the YSIS-3 is effective in assessing suicide risk and is sensitive enough to be used for monitoring suicide risk over time in a clinical setting. While this study used a large sample size (n=1107), 76.7% of the participants had already received formal depression and/or anxiety diagnoses.

Another tool with validated utility for screening suicide risk in youth is the Columbia-Suicide Severity Rating Scale (C-SSRS). The most widely cited study in the literature used to support the use of the C-SSRS in clinical and research settings was conducted by Posner et al. (2011); in this analysis of three multi-site studies, two studies focused on adolescents. The adolescent populations were small sample sizes, n=124 and n= 312 respectively, and only studied the tool's efficacy in adolescent "re-attempters" with prior suicide attempts and adolescents with a prior MDD diagnosis (Posner et al., 2011). The study of "re-attempters" found the C-SSRS to have a sensitivity of 100% and a specificity of 96% when identifying actual and interrupted suicide attempts (Posner et al., 2011).

The Ask-suicide Screening Questions (ASQ) is a brief, four-question screening tool that was initially developed for pediatric emergency departments (Aguinaldo et al., 2021). A study by Aguinaldo et al. (2021) evaluated the content validity of the ASQ in outpatient and primary care settings. The authors found a positive response to at least one question in the ASQ successfully identified 100% of the youth at

risk of suicide, recognized by the validated Suicide Ideation Questionnaire (SIQ/SIQ Jr). The ASQ was found to have a notably high sensitivity (100%) and specificity (87.9%) in primary care while also being brief and concise, which are crucial qualities in interventions that are standard in primary care. It is a publicly available tool that has been specifically validated in primary care settings

Bellairs-Walsh et al. (2021) found that screening and assessment tools can help primary care providers manage uncertainty and discomfort when identifying and supporting youth at risk for death by suicide. PCPs in the United States identified such barriers to suicide screening as fear of leading the patient to consider suicide, lack of comfort with counseling and lack of training, and unavailability of screening instruments in the EHR (Green, Gottschlich, & Burr, 2023).

Delivery Method. There is insufficient evidence in the literature to support a specific delivery method when screening youth for suicide risk. Of note, Aguinaldo et al. (2021) validated the ASQ in primary care settings with high tool sensitivity and specificity when verbally administered, potentially demonstrating a benefit to provider-administered vs. self-administered suicide screening. However, Horowitz et al. (2022) found in a quality improvement project at a pediatric primary care clinic that almost half of all participants (n=271) would have preferred a written version of the ASQ instead of verbally answering the questions.

Evidence with other tools in other sub-populations has supported the superiority of verbally administered screening. The PHQ-9, which screens for depression, has performed better when administered by a nurse in general, geriatric, and perinatal populations (Ransing et al., 2020). Indu et al. (2018) found that specific to primary care, the PHQ-9 had a higher positive likelihood ratio (LR) of 8.7 when conducted by health workers when compared to a positive LR of 7.1 from another study with a self-administered PHQ-9.

Regardless of delivery, evidence has shown that directly assessing suicide risk garners higher specificity than indirectly assessing suicide risk. Hatkevich (2022) found in a multi-site study of 5909

youth aged 12-17, 94% of participants responded consistently to both indirectly and directly phrased suicide attempt questions. In a qualitative study, Richards et al. (2019) found that the PHQ-9 wording of suicidal ideation falsely overlooked certain at-risk patients who only felt suicidal intermittently or in a different time-frame than the two weeks proffered. The authors suggest that “use of a validated suicide severity risk assessment that asks directly about suicidal thoughts and plans may aid identification of patients at high risk of suicide” (Richards et al., 2019).

Setting. Crandal et al. (2022) found that when primary care providers neglect to screen for depression and suicidal ideation at non-psychiatric medical concern visits, a small but significant percentage of youth at risk for death by suicide are missed. In a retrospective observational study conducted by Crandal et al. (2022), patients were screened for risk at each encounter regardless of the chief concern. Of the 95,613 youth aged 12-17 screened at various healthcare settings including primary care, targeted screening of youth presenting only with a primary psychiatric concern would have missed 45.9% of the total youth endorsing suicide risk (Crandal et al, 2022). Additionally, Kemper et al. (2021) found that of 803 adolescents aged 12 and older, targeted screening identified 8.3% additional cases of youth at risk for suicide without also screening positive for Major Depressive Disorder (MDD).

Rationale

Increasing suicide screening for youth aged 12-18 at the SBHC in Gresham was guided by the Model for Improvement (MFI), a dynamic quality improvement process used by the Institute for Healthcare Improvement (IHI). The MFI follows a four-step framework: setting an aim, selecting measures, developing ideas for change, and testing changes (IHI, 2020a). The final step of testing changes is an iterative process composed of Plan-Do-Study-Act (PDSA) cycles, which encourages testing on a small scale (IHI, 2020a).

Specific Aims

This QI project aimed to administer the ASQ at all new 12–18-year-old clinic visits between October 10th, 2023 and December 14th, 2023, with the goal of reaching 75% of the target population by the end of the second PDSA cycle.

Methods

Context

The FQHC in Gresham, OR provides free and low-cost healthcare to both insured and uninsured patients. It follows a medical home model, including both medical and dental services as well as behavioral health, psychiatric support, care coordination, and other community services. The city of Gresham has a population 113,106, with a median household income of \$66,129 and 14% of the community living below the federal poverty line (Census Reporter, 2019). Of the 15.4% foreign-born minority of the population, 47% were born in Latin America (Census Reporter, 2019).

While the FQHC serves the Gresham community at multiple sites, the school-based health initiative is a novel undertaking: it is a mobile SBHC serving students at a local high school. The clinic opened to the public May 1, 2023 and seeks to provide an array of free services including routine physicals and sports exams, immunizations, reproductive health services, acute complaints, and identification and management of chronic illnesses. The healthcare team is made up of a Family Nurse Practitioner (FNP), a medical assistant (MA), and a behavioral health provider (BHP), all of whom work at the FQHC. The team partners with the school's healthcare team, consisting of a school nurse and health aide, and the attendance office to ensure coordinated, confidential care.

The healthcare team is based at the SBHC on Tuesdays and Thursdays from 8:30 AM to 2:30 PM every other week during the school year. Baseline data collected during the SBHC's soft opening from May 7, 2023 to June 10th, 2023 found that of the 16 patients seen, zero were screened for suicide risk. The school serves 1,532 students in grades 9th through 12th within the larger Multnomah County. Over

half of the student body qualifies for free or reduced lunch, with 58% minority enrollment; the highest percentage of minority students identify as Hispanic/ Latinx (Public School Review, 2023).

Interventions

After a broad search of the literature, the ASQ screening tool was identified as a validated, brief, and publicly available tool for screening youth aged 12-18 years in a primary care type setting (Aguinaldo et al., 2021). Baseline data was collected during the clinic's soft opening from May 7, 2023 to June 10th, 2023 to provide a comparison of before and after the intervention. The results of the QI project as well as future recommendations were presented to the clinic staff and the organizational Data and Quality Team February 27, 2024.

Administering the ASQ entailed two parts: the medical assistant provided a printed form to the patient and then the provider reviewed the answers with the patient. The 'plan' and 'do' phases of the PDSA cycles focused on creating a clear process to correctly identify patients who qualified for suicide screening (Appendix A). As this was a newly implemented health initiative at a high school, all new patients and any established patients not previously screened within the ages of 12-18 needed to be screened. A programmed Electronic Health Record (EHR) alert, configured as a Best Practice Advisory (BPA), helped to ensure correct identification of patients and signaled when over a year had passed between screenings.

Once a patient was correctly identified, an easily accessible, printed and laminated version of the ASQ and a dry erase marker was given to the patient by the MA while they waited for the provider. To ensure this step, it was essential that there were four laminated copies of the ASQ: two in English and two in Spanish that were kept in an easily accessible location with other standardized forms (Appendices B and C).

When the provider entered the exam room to complete the visit with the student, they reviewed the student's answers before the end of the visit. If the student's screening was positive, an algorithm to advise next steps was employed to provide adequate resources to the student and ensure close follow-up to best promote safety and support. This algorithm was modeled upon the FQHC's existing behavioral health protocol which utilizes a warm handoff to the BHP. The Multnomah County Suicide Prevention Plan Process, in place at several established school-based health initiatives in Portland, provided a follow-up model appropriate for ages 12-18 as well as a comprehensive list of national and local community resources available to patients (Appendix D). The OHA Mobile Response and Stabilization Services (MRSS) was identified as an additional resource to be utilized by BH (Appendix E).

Finally, the results of the ASQ were uploaded to the patient's chart by the MA, who directly inputted the data into the ASQ tool accessible under "flowsheets" in the EHR. Epic was the EHR system utilized by the FQHC at the clinic through the nonprofit health care organization Oregon Community Health Information Network (OCHIN).

Study of the Interventions

Utilizing the MFI framework, a standardized protocol that reflected the recent update and change to AAP guidelines by implementing universal, annual suicide risk screening with the ASQ tool for patients age 12-18 was implemented at the Gresham high school-based initiative.

Measures

There are three different kinds of measures identified by the MFI: outcome, process, and balance measures (IHI, 2020a). The outcome measure, or the measure ultimately wished to improve, was the percentage of patients that were screened for suicide risk with the ASQ tool. One process measure illuminated whether the steps in the system were being performed as planned: the MA marked on a daily checklist whether the four laminated screening forms were located in their designated area. Balancing measures, which assess whether the changes designed to improve one part of the system are

introducing problems elsewhere, were evaluated with periodic informal check-ins via email and text message to assess the impact on clinic staff time, productivity, and burnout.

Analysis

The FQHC Data and Quality team collected the specific data requested for this project through chart scrubbing. The team then compiled the data in two different sets using patient MRNs to ensure confidentiality. Additionally, the FQHC and school clinic have been de-identified in this paper. Data was collected bi-weekly and stored in an excel spreadsheet.

A run chart was used to display data for the outcome measure demonstrating the percentage of eligible patients screened using the ASQ tool. Following the MFI framework, four rules were applied to reveal evidence of real change: a shift (≥ 6 consecutive data points above the median), a trend (≥ 5 consequential data points in the same direction), the number of runs (≥ 1 consecutive data point on the same side of the median), and an astronomical data point positioned very far away from the others (Institute for Healthcare Improvement, n.d. a). The presence of any one of these patterns, such as a trend or shift in the “direction of goodness”, signified either a successful PDSA run or indicated the need to adjust proposed interventions or measures (Institute for Healthcare Improvement, 2020b).

To display data from the process measure, a grouped bar chart tracked whether “yes”, the checklist was marked, or “no”, the checklist was not marked. A graphical trend line indicated possible success of the measure, especially supported by its steepness in one direction (IHI, n.d. b).

Ethical Considerations

As this is a QI project undertaken at a school, the age range of the patients and associated classification as minors presented some additional ethical considerations. Under Oregon law, anyone under the age of 18 is considered a minor unless they have been formally emancipated (OHA, 2016). However, minors of 15 years of age and older can consent to medical and dental procedures as well as outpatient mental health, drug, or alcohol treatment without parental consent (OHA, 2016). When a

patient over the age of 15 screens positive for suicide risk, they can access help from a psychiatrist or psychologist or mental health therapy from a provider or social worker (OHA, 2016).

When assessing suicide risk in youth, the provider's designation as a mandatory reporter also further complicates medical decision-making, consent, and confidentiality. Mandatory reporting circumstances include reportable infectious and communicable diseases, suspicion of abuse or neglect in vulnerable individuals, entering a drug or alcohol detoxification program, and if an individual is deemed a health or safety risk to themselves or others (OHA, 2016). Thus, if a patient is deemed a safety risk to themselves through suicidal ideation acuity, there may be circumstances in which the provider is obligated to break confidentiality.

Results

The first PDSA cycle, from Tuesday October 10th to Thursday October 26th, 2023, was displayed as a run chart with a median of 0% (Appendix G); of note, one of the four data points was recorded on a day that the clinic was unexpectedly closed. Unfortunately, there were not enough data points to demonstrate a trend or a shift. Three of the four data points reside on the median line of 0%. Day 3, however, marks a point in the direction of goodness; though the median was 20%, far below the goal of 75%, two patients were screened for suicide risk using the CSSR-S tool, bringing the median up to 60% for suicide screening that day.

The second PDSA cycle, from Tuesday November 7th to December 14th, 2023, demonstrated an increase in the percentage of patients screened using the ASQ with a median of 25%. The run chart for this PDSA cycle (Appendix H) demonstrated an astronomical data point, with 100% of the two eligible patients screened on Day 3. A total of 14 patients were seen for scheduled sports physicals on Day 3, which marked a distinct increase in quantity from other clinic days, with 50% of eligible patients screened with the ASQ tool. As with the first PDSA cycle, the first of the four data points fell on a day that the school was unexpectedly closed. Additionally, only one patient was seen on Day 4 with a complaint

of “mental health concerns” related to side effects from an antidepressant; while a lack of suicidal ideation was noted in the chart, there was no completed ASQ.

The data for the process measure, ensuring that the four laminated ASQ screening forms were located in their designated area, was meant to be displayed in a grouped bar chart; however, the daily checklist was not filled out during either PDSA cycle.

Discussion

Summary

Fifty percent of the SBHC patients were screened for suicide risk over the course of the two PDSA cycles; of those patients, one half were found to be at risk for suicide with two deemed non-acute and four acute. These numbers demonstrate the prevalence of suicidal ideation in this specific youth population and related risk for death by suicide.

Interpretation

While both PDSA cycles failed to meet the aim of screening 75% of eligible patients, with medians of 0% and 25% respectively, several developments led to an increase in ASQ screening. On November 3rd, after several delays, the ASQ became operational as a BPA in Epic. The creation of the ASQ tool as a BPA, which included working with a third-party (OCHIN), was pursued by the clinic as mental health screening for youth in an SBHC is a reportable set of data for insurance reimbursement and certification. BPAs act as reportable alerts aligned with clinical guidelines that necessitate the completion of a step, in this case the ASQ tool, before moving ahead with the appointment.

In early November, the FQHC also implemented an Adolescent Health Assessment Form. The form was meant to be disseminated to all new-and established patients on an annual basis. The ASQ tool was integrated into the form along with other questions pertaining to psychosocial, physical, and environmental factors. As an embedded tool, there was an increase in completed screens; rather than having to compile and input several different sheets, the one form proved easier for MAs, providers, and

patients to use. After the establishment of both the BPA and the Adolescent Health Assessment Form, the first data point after this change reached a median of 50%, with 100% of eligible patients screened during the following data point.

Limitations

Several limitations impacted the quantity of data collected for this project. As the Gresham SBHC is a newly opened clinic that operates out of a van that travels to one other school to provide services, there were several unforeseen clinic closures due the van requiring repairs or unexpected school closures. Additionally, as a newer clinic, there were fewer patients seen due to a lack of clinic advertisement and publicity. Following the SBHC's soft opening in May 2023, several changes were implemented by the overseeing FQHC that included expanding the mobile clinic services to another school, which decreased the Gresham hours from two days weekly to two days biweekly.

With the expansion of services, another provider and medical assistant were added to the team who were not directly involved in the creation of the QI project, thus decreasing buy-in. During the first PDSA cycle, it was discovered that some patients were being screened with the CSSR-S tool. The CSSR-S tool was the most frequently used tool at the FQHC with adolescent patients; when the ASQ was implemented as the most evidence-based tool of choice at the SBHC, there was some reversion back to the previously used tool.

The FQHC Data and Quality team identified that some of the patients were filling out the Adolescent Health Assessment form at the end of the appointment, sometimes leaving the forms unfinished and/or the provider unable to discuss the ASQ results with the patient directly and initiate the requisite follow-up if necessary. Several environmental factors contributed to this phenomenon, including a lack of waiting room or other place for patients to begin working on the form before seeing the provider. The team is currently brainstorming interventions that could help alleviate this problem.

Finally, the process measure checklist was not completed, leaving a vital part of the MFI process unexecuted. In reflection, several factors may have influenced this outcome: lack of periodic formal check-ins with the MA, looping in another member of staff to increase accountability, and involving the MA directly in the conceptualizing of a more accessible and relevant process measure in the context of a new and constantly evolving clinical environment.

Conclusion

This QI project fell short of its stated aim to screen 75% of eligible patients with the ASQ to assess for suicide risk. Further steps need to be taken to increase screening at the SBHC; these could include a more formal investigation into the barriers to screening. If the project were to be repeated now, with the BPA and Adolescent Health Assessment Form in place and firmly established in the clinic flow, it is likely that rates of ASQ screening would be higher and closer to the 75% aim.

Screening for suicide risk with the ASQ is one way to ensure detection of youth at risk for suicide; however, screening is considered secondary prevention as it is geared towards recognizing those exhibiting warning signs (Horowitz et al., 2020). While this project focused on screening and identification of suicide risk, 50% of patients screened for this QI project scoring non-acute or acutely positive for suicide risk. Additional management following identification of youth at risk for suicide is necessary; due to a lack of standardization in management, the requisite next steps are difficult to establish. Lack of knowledge regarding referral options and lack of treatment options have been identified as barriers to screening for suicide risk in youth (Green, Gottschlich, & Burr, 2023).

The use of applicable ICD-10 diagnostic codes for patients at risk of death by suicide can help create “red flag” warnings for the PCP and other clinicians who come into contact with the patient’s chart; when clinicians documented patients’ suicidal ideation and behaviors, it was easier to frequently monitor these patients in the healthcare system (Anderson et al., 2015) . While this step was recommended in the follow-up protocols adapted from Multnomah County, only one patient was

denoted with a “red flag” warning with another diagnosed with “dysthymic disorder”. However, two patients were added to a Care Management Pathway created to help monitor patients at risk for suicide.

Several additional resources were provided for the BH team at the SBHC to aid in the requisite next steps after a patient was positively screened for suicide risk (Brahmbhatt et al. (2019) created a clinical pathway for youth screened positive for suicide risk using the ASQ in an inpatient setting (Appendix I). This pathway helped group patients as “non-acute positive” and “acute positive” as well as to stratify risk as low risk, high risk, or imminent risk (Brahmbhatt et al., 2019). While the pathway was clearest for those deemed imminent risk with active thoughts of harming oneself immediately, the proper follow up for those deemed low or high risk became more variable depending on the resources and support available in the patient’s geographic area. Roaten et al. (2021) found that only 10% of positive screens using the ASQ in 90,000 patient encounters resulted in a true acute positive with a “yes” response to question 5, while nearly half of the positive screens consisted of a sole response to question 4 about suicide attempt history. Similarly, the majority of positive screens at the Gresham SBHC were stratified into the non-acute positive category.

While some guidelines exist to help guide follow-up in the immediate aftermath of suicide risk identification, ongoing primary care management of youth at risk of death by suicide is unclear (Aalsma et al., 2022). Aalsma et al., (2022) found that in a retrospective study of 200 adolescents who endorsed suicide risk at an initial primary care visit, only 17% discussed safety plans with their clinician. Stanley & Brown (2012) developed a Safety Plan Intervention (SPI) that can help mitigate risk of suicide and serve as a valuable complement to risk assessment, especially for patients who do not require acute psychiatric hospitalization. The Stanley-Brown Safety Plan is easy to use, publicly available, accessible in Epic, and can be completed by either the PCP or BHP (Appendix J). Of the six patients with positive ASQ scores, none completed a Stanley-Brown Safety Plan.

Young people want to be provided with practical support and follow-up after suicide risk has been identified (Perry et al., 2020). Next steps for this project include: continuing the iterative process of increasing screening for eligible patients; expanding this project to other SBHCs; creating a more robust follow-up protocol with clinician, MA, and BHP buy-in; and identifying community resources available for patients stratified into non-acute and acute risk for suicide categories.

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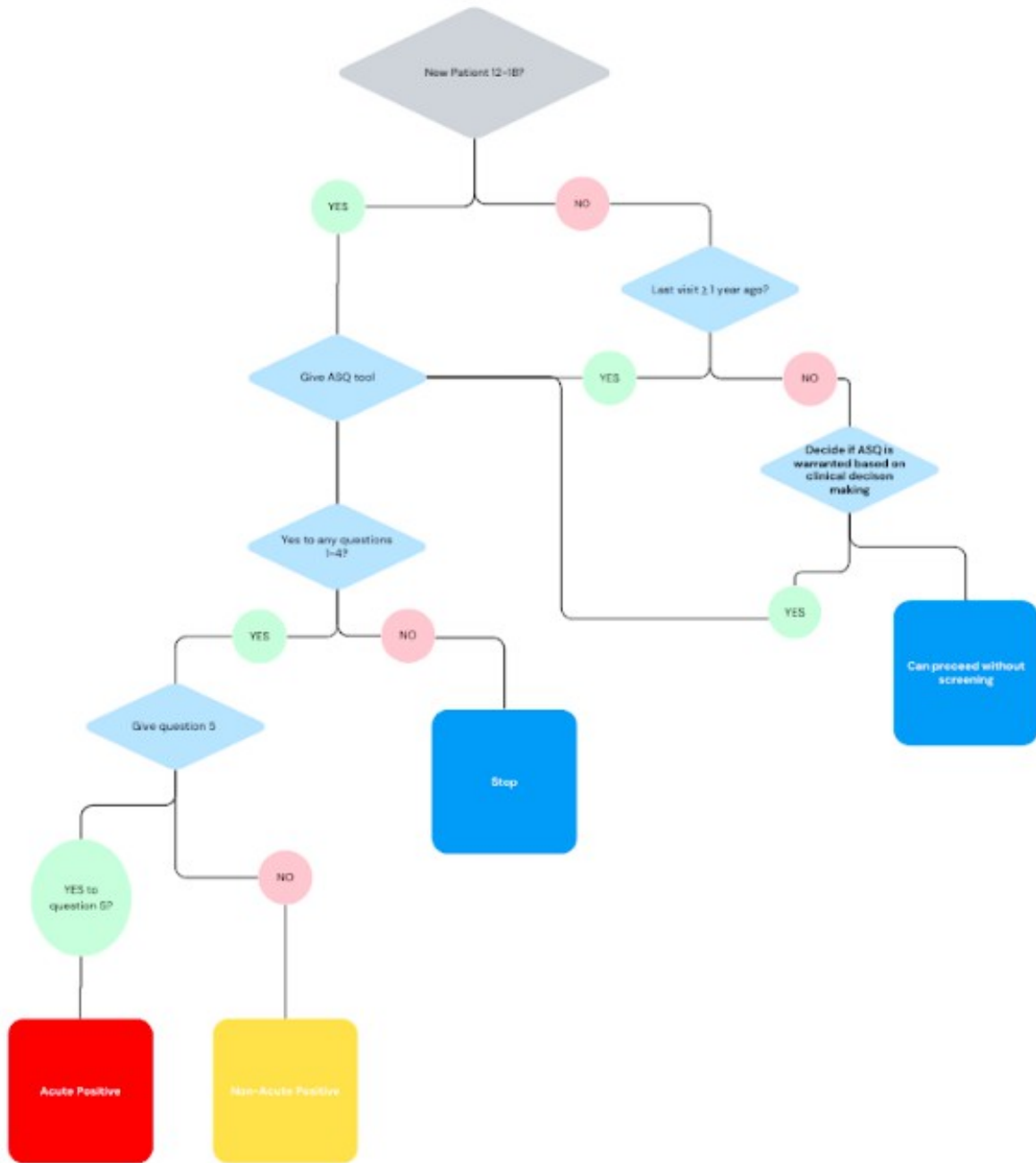
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Screening Algorithm



Appendix B

Screening Tool (English)

ASQ

Ask Suicide-Screening Questions

NIMH TOOLKIT

YES NO

1. In the past few weeks, have you wished you were dead?

2. In the past few weeks, have you felt that you or your family would be better off if you were dead?

3. In the past week, have you been having thoughts about killing yourself?

4. Have you ever tried to kill yourself?
If yes, how? _____
When? _____

If you answered "yes" to any of the questions above, please continue to the next question below.
If you answered "no" to all of the questions above, please hand this form back

YES NO

5. Are you having thoughts of killing yourself right now?

If yes, please describe: _____

ASQ

Ask Suicide-Screening Questions

NIMH TOOLKIT

sí NO

1. En las últimas semanas, ¿ha deseado estar muerto?

2. En las últimas semanas, ¿ha sentido que usted o su familia estarían mejor si estuviera muerto?

3. En la última semana, ¿ha estado pensando en suicidarse?

4. Alguna vez ha intentado suicidarse?
Si contestó que sí, ¿cómo? _____
Cuándo? _____

Si respondió "sí" a alguna de las preguntas anteriores, continúe con la siguiente pregunta a continuación.
Si respondió "no" a todas las preguntas anteriores, devuelva esta forma.

sí NO

5. Está pensando en suicidarse en este momento?

Si es así, por favor describe: _____

Appendix D

Gresham SBHC Suicide Prevention Protocol for Ages 12-18

(Adapted from Multnomah County SHC Suicide Prevention Plan Process)

Risk Stratification

| Non-Acute Positive (Yes Questions 1-4) | Acute Positive (Yes to Question 5) |
|---|---|
| <p>Clinician:</p> <ul style="list-style-type: none"> ● Complete Safety Plan ● Refer to BHP <ul style="list-style-type: none"> ▫ Ensure appointment made within 2 weeks ● Gather necessary ROIs ● Share DotPhrase and AVS resources ● Continue to screen with ASQ at follow-up visits ● Keep Safety Plan “active” until low or no risk is achieved | <p>Clinician:</p> <ul style="list-style-type: none"> ● Enter new Suicide Risk diagnosis to Problem List immediately <ul style="list-style-type: none"> ▫ Enter in PL comments field: <ul style="list-style-type: none"> ■ “High Risk” ■ Safety Plan date and status (done, refused, or needed) ● Add patient to Risk List for tracking ● Complete Safety Plan ● Confirm PCP for patient ● Gather necessary ROIs ● Warm Handoff to BHP |

Follow-Up Steps

| Non-Acute Positive (Yes Questions 1-4) | Acute Positive (Yes to Question 5) |
|--|---|
| <p>BHP:</p> <ul style="list-style-type: none"> ● Assess at appointment within 2 weeks of ASQ completion | <p>BHP:</p> <ul style="list-style-type: none"> ● Ensure that Safety Plan has been created <ul style="list-style-type: none"> ▫ If refuses, get ROI for emergency contact before patient leaves ● Complete Risk Assessment such as the Brief Suicide Safety Assessment (BSSA) ● Seek parent or guardian involvement ● Consider reaching out to school contact ● Consider reaching out to OR Youthline ● Schedule 24-hour follow-up <ul style="list-style-type: none"> ▫ Telehealth or in-person ▫ PCP is backup if BHP is out ● Fridays or before holidays? <ul style="list-style-type: none"> ▫ If additional support needed, call Crisis Line ● If patient unable to agree to safety, call Crisis Line ● If patient is in immediate danger call 911 ● After 24 hour f/u visit: <ul style="list-style-type: none"> ▫ Weekly visits as long as Acute Positive |

DotPhrase (.ASQresources) for Epic:

(Adapted from Multnomah County)

If you are having any thoughts of harming yourself or anyone else, or are having any other mental health emergency, there are resources to help you:

- Multnomah County Crisis Line: Call 503-988-4888 24 hours/7 days per week
- Call or text the National Suicide Prevention Lifeline: Call or text 988 24 hours/7 days per week
- Teen Text Line: Text the word SAFE to 741741 24 hours/7 days per week
- TrevorLifeline and TrevorText for LGBTQ Youth: Call 1-866-488-7386 or Text the word START to 678678 24 hours/7 days per week
- National Domestic Abuse Hotline: Call 1-888-799-7233 24 hours/7 days per week
- Oregon Warmline: 1-800-698-2394 for 24/7 peer support
- SAMHSA National Helpline for substance use - call 1-800-662-4357
- Go to the Cascadia Behavioral Healthcare Urgent Walk-in Clinic - 4212 SE Division Street, Suite 100, Portland, OR 97206. Open Monday-Sunday, 7am to 10:30pm
- Go to Unity Center for Behavioral Health (18 years old and over)- 1225 NE 2nd Avenue, Portland, OR 97232. Open 24/7
- For people under age 18 - go to Children's Emergency Department at Randall Children's Hospital at Legacy Emanuel or OHSU Doernbecher Pediatric Emergency Department
- Go to the nearest emergency department/hospital
- Call 911

Other County Crisis Lines:

- Call the Clackamas County Crisis Line @ 503-665-8724
- Call the Washington County Crisis Line @ 503-291-9111

List to attach to safety plan printouts:

(Adapted from Multnomah County)

Professional agencies I can contact during crisis:

National Suicide Prevention Lifeline

1-800-273-TALK (8255)

Spanish/Español: 1-888-628-9454 OR Text 988 24 hours/7 days per week

Teen Text Line

Text the word SAFE to 741741 24 hours/7 days per week

TrevorLifeline and TrevorText for LGBTQ Youth

1-866-488-7386 or Text the word START to 678678 24 hours/7 days per week

Crisis Text Line

Text HOME to 741-741

National Domestic Abuse Hotline

1-888-799-7233 24 hours/7 days per week

SAMHSA National Helpline for substance use

1-800-662-4357

Websites I can visit for support during crisis:

Safe and Strong Oregon: <https://www.safestrongoregon.org/mental-and-emotional-health>

Suicide Prevention Resource Center: www.sprc.org

National Institutes of Health: www.nimh.nih.gov

Substance Abuse and Mental Health Services Administration: www.samhsa.gov

Mobile Response and Stabilization Services

Mobile Response and Stabilization Services

Mobile Response and Stabilization Services (MRSS) provide support to youth and their families in situations of stress or crisis, and stay involved until supports are in place.



01

Call or text 988

Youth, family, or community contacts 988 for support.



02

Discuss

Some concerns may be solved by phone. Youth and family decide what they think would help most.



03

Mobile Team

If requested, a trained team of two people will be sent for in-person support. The team can provide assessment, screening, safety planning, and decide next steps.



04

Stabilization

The team can stay involved for up to 8 weeks to ensure stability and connection to community resources.

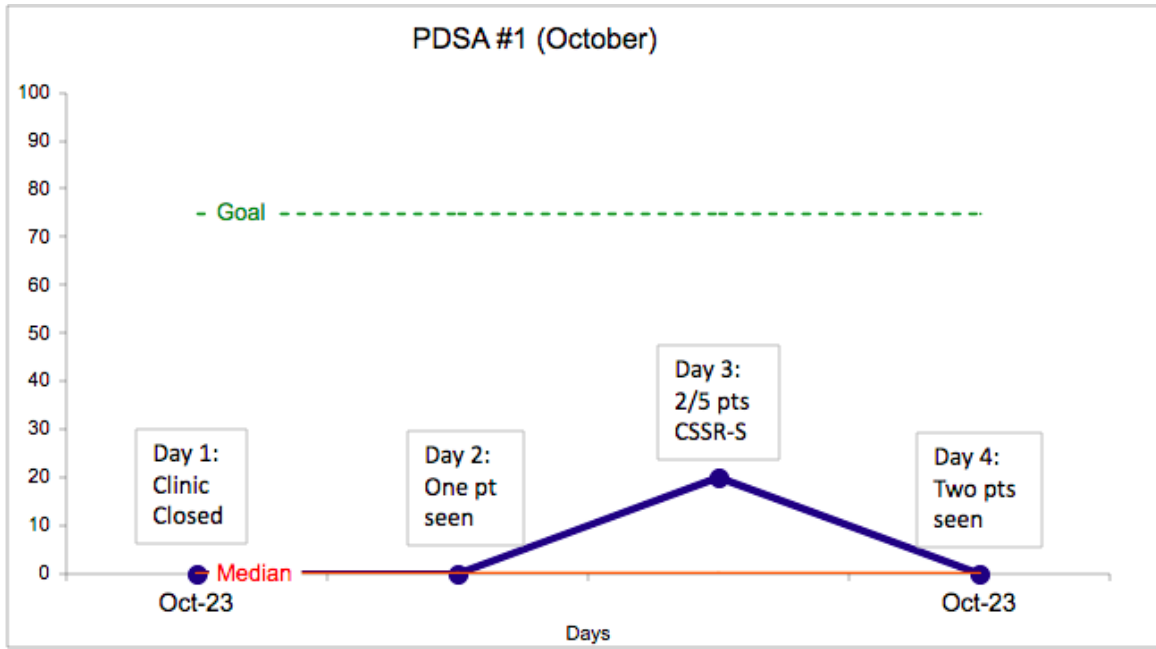


For more information, scan QR code or call 988

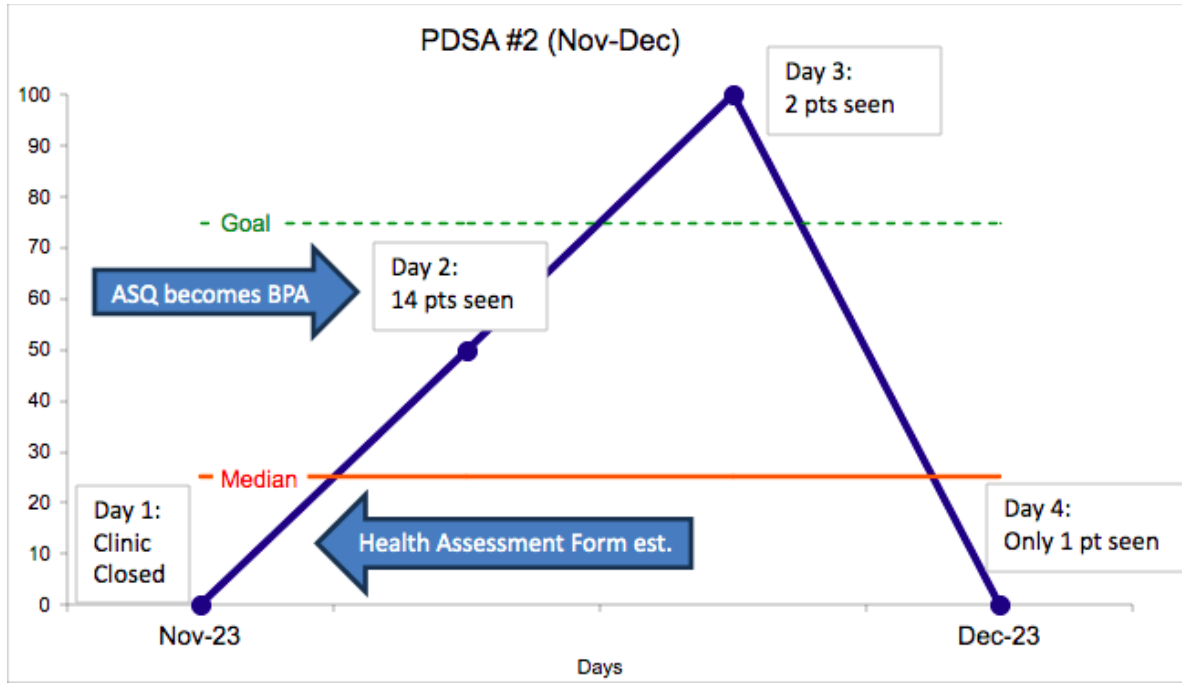


Document accessibility: For individuals with disabilities or individuals who speak a language other than English, OHA can provide information in alternate formats such as translations, large print, or braille. Please contact kids.team@dhs.oha.state.or.us.

Outcome Measure Data




Outcome Measure Data



Appendix I

Clinical Pathway

NIMH TOOLKIT: YOUTH OUTPATIENT



Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

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

- 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

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 (if possible, assess patient alone depending on developmental considerations and parent willingness.)

Review patient's responses from the asQ

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 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.

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 grouchy 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?"

asQ Suicide Risk Screening Toolkit

NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)



2/1/2020



Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

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?"
- "Has anyone in your family/close friend network ever tried to kill themselves?"
- "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)
- "Are you comfortable keeping your child safe at home?"

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.)

5 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.

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

Appendix J

Stanley-Brown Safety Plan

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

| | |
|-----------------|-----------------|
| 1. Name: _____ | Contact: _____ |
| 2. Name: _____ | Contact: _____ |
| 3. Place: _____ | 4. Place: _____ |

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

| | |
|----------------|----------------|
| 1. Name: _____ | Contact: _____ |
| 2. Name: _____ | Contact: _____ |
| 3. Name: _____ | Contact: _____ |


STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

| | |
|---|--------------|
| 1. Clinician/Agency Name: _____ | Phone: _____ |
| Emergency Contact: _____ | |
| 2. Clinician/Agency Name: _____ | Phone: _____ |
| Emergency Contact: _____ | |
| 3. Local Emergency Department: _____ | |
| Emergency Department Address: _____ | |
| Emergency Department Phone: _____ | |
| 4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255) | |

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

The Stanley-Brown Safety Plan is copyrighted by Barbara Stanley, PhD & Gregory K. Brown, PhD (2008, 2021). Individual use of the Stanley-Brown Safety Plan form is permitted. Written permission from the authors is required for any changes to this form or use of this form in the electronic medical record. Additional resources are available from www.suicidessafetyplan.com.



Additional Resources

Letter of Support from Clinical Agency

Date: 06/12/23

Dear Alexa Morrill,

This letter confirms that I, Stephanie Lux, FNP-C, allow Alexa Morrill (OHSU Doctor of Nursing Practice Student) access to complete her DNP Final Project at our clinical site. The project will take place from approximately September 1 to November 30 2023.

This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor and clinical liaison (if applicable):

- Project Site(s):**

Wallace Medical Concern (WMC) Rockwood Medical and Dental Clinic
18633 Stark St., Ste. 401, Portland OR 97233

Mobile Student Health Clinic at Gresham High School
1200 N. Main Avenue, Gresham OR 97030
- Project Plan: Use the following guidance to describe your project in a brief paragraph.**

In light of rising rates of youth death by suicide both nationally and in the state of Oregon, this QI project will help establish a universal, annual screening for suicide risk at WMC's new mobile student health clinic at Gresham High School. This universal, annual screening will utilize the Ask-suicide Screening Questions (ASQ) tool, which is publicly available and validated for outpatient pediatric patients with high sensitivity and specificity. Direct screening for youth suicide risk aligns with the 2022 updated American Academy of Pediatrics (AAP) guidelines as well as the Oregon Health Authority (OHA) Youth Suicide and Annual Prevention Report recommendations. As this is a newly established clinic, the QI project will help to ensure that all new patients are screened appropriately and that there is a system in place to ensure that patients are screened again after one year has passed, with the aim of reaching 75% of the target population between September and November 2023. The Institute of Health (IHI) Model for Improvement will provide a guiding framework for the project through the implementation of multiple Plan-Do-Study-Act (PDSA) cycles. The measures that will be in place to assess the efficacy of this aim will include monitoring the number of ASQ forms printed out weekly, auditing new and established patient charts through Epic with the help of the WMC Data and Quality team, and periodic check-ins with staff about their experience of the QI initiative. Additionally, the student will help to create an algorithm for staff to follow when a patient screens positive on the ASQ that identifies available resources within the area. Both WMC and Gresham High School will be de-identified in the final DNP paper, and all patient data will be de-identified and stored in a password-protected program. WMC will allow the student to visit the clinic site, access patient charts through the Epic EHR system, and work with the Data and Quality team to ascertain and analyze data.

During the project implementation and evaluation, Alexa will provide regular updates and communicate any necessary changes to the DNP Project Preceptor.

Our organization looks forward to working with this student to complete their DNP project. If we have any concerns related to this project, we will contact Alexa at morrilla@ohsu.edu and Rebecca Martinez, DNP, FNP-BC, MPH (student's DNP Project Chairperson) at martire@ohsu.edu.

Regards,

Stephanie Lux, FNP-C

Stephanie Lux FNP 10/12/23

Signature Date Signed

Request for Determination Form (IRB)

IRB > Youth Suicide Screening in a School-Based Health Clinic

Help

Not Human Research

Entered IRB: 7/20/2023 8:25 AM
 Determination: 7/31/2023
 Initial effective: 7/31/2023
 Effective: 7/31/2023
 Last updated: 7/31/2023 11:36 AM

STUDY00026072: Universal Screening for Youth Suicide Risk in a School-Based Health Clinic: A Quality Improvement Project

Principal investigator: Rebecca Martinez **IRB office:** OHSU or Joint OHSU/VA
Submission type: Initial Study **Letter:** [Correspondence_for_STUDY00026072.docx\(0.01\) ...](#)
Primary contact: Alexa Morrill
IRB coordinator: Panel 2 **Regulatory Authority:** 2018 Requirements

Next Steps

- [View Study](#)
- [Printer Version](#)
- [View Differences](#)
- [Create Modification/CR](#)
- [Report New Information](#)



| Name | CoIR Current | Responsible Conduct of Research (RCR) | Human Subjects Research (HSR): Human Researchers | * Good Clinical Practices (FDA GCP) Required for Drug/Device studies | * GCP - Social and Behavioral Research Alternative for non-Drug/Device clinical trials |
|---------------|--------------|---------------------------------------|--|--|--|
| Alexa Morrill | No | Yes | Yes | No | Yes |

* FDA GCP is required for any study involving a drug or device, and always fulfills the requirement for GCP training on other clinical trials. Social and Behavioral Research GCP is only an acceptable alternative for low-risk NIH-funded clinical trials. Click on the View Compliance Data button for more information.

• [Alexa Morrill - Contact](#)

Project Timeline

| | June | July | August | September | October | November | Dec-Mar |
|---------------------------------------|------|------|--------|-----------|---------|----------|---------|
| PDSA Cycle 1 | | | | | X | | |
| PDSA Cycle 2 | | | | | | X | X |
| Final data analysis (703B) | | | | | | | X |
| Complete final paper (703B) | | | | | | | X |
| Prep for project dissemination (703B) | | | | | | | X |

