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Implementation of a Standardized Suicide Risk Screening Tool: an Improvement Project in a University Counseling Center

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Abstract

This article describes a quality improvement project undertaken at the University of Idaho

Counseling and Testing Center (CTC). This quality improvement project describes the use of the

Ask Suicide Questions (ASQ) screening tool to accurately assess the severity of suicide risk

during an initial assessment or crisis visit. Clinicians were provided with education and

demonstration of the ASQ and shown how to incorporate this tool into their practice. 86 eligible

appointments were included in the project for analysis. Simple descriptive statistics were used to

present the resulting data. Results indicate that 30.3% of eligible appointments were screened.

43.8% of clinicians used this tool during their visits during the four-week implementation period.

Results also indicate an acute positive screening rate of 2.8% and a negative screening rate of

61.1%. During this project, no clear indication for the lack of screening in more significant

numbers was found. Future quality improvement projects would be well served to explore this

phenomenon. This project concludes that continued education about suicide risk assessment is

necessary. This project clarifies the importance of accurate suicide risk screening assessments

for college students who seek mental health services.

Keywords: suicide screening, suicide risk, college mental health, risk assessment

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Introduction

Suicide has a global impact, and it transcends culture and economic status as a significant health problem. Suicide has a far-reaching effect on communities, families, societies, and individuals. The World Health Organization (WHO) has identified the reduction in suicide as a global imperative and has urged individual, relational, and societal changes to accomplish this (Duckers, Reifels, De Beurs, & Brewin, 2019). However, reporting on suicide and data gathering remains difficult. Moreover, this data has significant variances due to legality, religious practices, spiritual prohibitions, stigma, and underreporting of suicide (2019). In urging action to reduce suicide, the WHO aims to clarify data so that suicide risk is accurately identified and these data limitations are resolved (2019).

Suicide risk factors, prevention strategies, and vulnerabilities continue to be debated and studied. Globally, suicide is the second-leading cause of death for people aged 15-29 (Arensman, Scott, De Leo, & Pirkis, 2020). This age group also represents the primary residents of college and university campuses. These students are a growing population that requires access to validated and accurate screening for suicide risk, appropriate referral for care, and competent clinicians to provide this care.

The COVID-19 pandemic (and its variants) has placed additional strain on college students and, as a result, on counseling centers. As of mid-April 2020, 80% of college students reported a negative impact on their mental health due to the pandemic, with 20% reporting a significant worsening of their mental health as a result (Copeland, McGinnis, Bai, Adams, Nardone, Devadanam, & Hudziak, 2021).

With the increasing strain on resources and the exacerbated severity of mental health problems facing college students, it is clear that accurate identification of suicide risk is

necessary. However, simply increasing funding for additional clinical treatment is not likely to reduce suicide in and of itself. First and foremost is the importance of improved access to care and engagement (Stanley & Mann, 2020).

Each clinical encounter presents an opportunity to screen for and mitigate suicide risk (Stanley & Mann (2020). While it cannot be guaranteed that screening for suicide risk will prevent each death, screening is used to identify patients for whom intervention and treatment may reduce the likelihood of this fatal outcome.

Problem Description

The University of Idaho is a public land grant research university located in Moscow, Idaho. It was established in 1889, with four graduates marching in commencement in 1896. It now enrolls a student population of more than 12,000 annually. To service the mental health needs of the student population, the Counseling and Testing Center was established in 1952. Within the University of Idaho Counseling & Testing Center (CTC), incomplete data regarding student suicide assessment and consistency of risk screening is captured. Process improvement projects were generated based on available information on the number of available appointments, appointments kept, total clinician caseload, number of clients served, and average wait time to access an initial appointment. Not previously captured in CTC reports is the number of students expressing suicidal ideation, suicide risk assessment, additional assessment data, and patient outcome information (Urhausen, 2021).   According to the Weekly Contract Trends Report, the CTC at the University of Idaho conducted 6177 appointments across 1195 unique clients of the center during the 2019-2020 academic year (Urhausen, 2021). The 2019-2020 academic year (AY) enrollment was 10,791. This number of unique clients represents more than 11% of the total student body.

The utilization rate for mental health services at the University of Idaho CTC was well below national averages. There are several theories for this underutilization rate: 1. the student body at the University of Idaho has fewer mental health problems, 2. the student body at the University of Idaho is unable to access mental health services, or 3. the CTC is unable to accurately screen and refer for these mental health problems.

The current model of care at the CTC is absorptive. This care model is one in which students are added to a clinician's total caseload without respect to the disposition of current cases. There is no maximum number of clients that a particular clinician can have on their panel. This model of care provides access for all students but does not consider the caseload or management of that access. With greater complexity and quantity of clinician caseloads, accurate and validated screening is necessary.

According to clinicians within the CTC, there is no uniform way students are screened for suicide risk. A clinician may choose to use any screening tool they would like in their work with their caseload. The results are not shared and are not analyzed for trends or broader implications. Process improvement for suicide risk assessment is not part of the current clinical process improvement algorithm.

Available Knowledge

Among surveyed respondents (college students and same-age peers), the lifetime prevalence of suicide ideation is 32.7% (Mortier et al., 2018). Approximately one-half of those who expressed suicidal ideation transitioned into a suicide attempt (2018). These numbers are likely to be much higher as they may not encapsulate all those who access care. On average, 44% of people who die by suicide have met with primary care services one month before death,

and 80% have met with primary care services the same year before death (Stene-Larsen &

Reneflot, 2019).

An increased utilization rate of campus-based mental health services has been noted

globally. The utilization rate for university-based mental health centers was 19% in 2007 and

grew to 34% in 2017 (Lipson, Lattient, and Eisenberg, 2019). When applied to the University of

Idaho, using an average enrollment of 10,000 students per year, this would mean a level of

treatment in 2007 of nearly 2,000 students and would grow to one of nearly 3,400 in 2017. With

the trend of a 1.5% increase annually, 41.5% of the student body is estimated to utilize mental

health services by 2022. If not accurately identified, the need for risk assessment and

intervention will quickly outpace the ability of university-based counseling and mental health

centers to provide it.

Clinicians at the University of Idaho use the Counseling Center Assessment of

Psychological Symptoms (CCAPS) to identify risk items. For example, this item ("I have

thoughts of ending my life") is identified but does not provide a complete risk assessment. This

tool intends to meet counseling centers' research, clinical, and administrative needs. It comprises

thirty-six items, and one focused on suicide ideation in the two weeks preceding the appointment

with the provider (Cummings, 2021). Clinicians interpret the level of risk based on personal

information and clinical judgment. The CTC does not use validated tools to assess suicide risk

severity or engage in routine process improvement screening and standards for their referral

management strategies.

With a greater focus on student mental health and well-being, it has become the role of

university-based counseling centers to promote and foster student mental health, including

personal adjustment counseling, social and emotional stressors, academic problems, and

developmental guidance in addition to conventional psychiatric services (Kay & Schwartz, 2011). Accurate screening of suicidal risk is necessary to improve the quality of care and decrease potential adverse outcomes. Firm limits on time and resources available in university counseling centers present a continuous challenge to meeting demand. Evidence-based assessment information allows for improved care outcomes within time and resource-limited care centers.

Rationale

With the increase in the number of students seeking mental health counseling services growing nationwide, the CTC must transition to evidence-based care that provides strategies for the validated screening of suicide risk. This process improvement initiative within the university-based counseling centers is to create a comprehensive risk mitigation care model to manage students at risk (Bunner, Wallace, Keyes, & Polychronis, 2017). The identified gaps in this process improvement strategy implementation are in triage: how to screen accurately and utilize resources most effectively in a limited-resource community.

The community of Moscow is rural, located in northern Idaho in Latah County, and has a population of little more than 25,000. Latah county is an HRSA designated Professional Shortage Area with a score of 14-20 in its designated boundary. Scores range from 0-to 20, with higher scores defining the areas of highest need (HRSA, 2021). Despite the non-prescriber mental health providers in the community, there are no psychiatric or prescribing mental health providers. The nearest psychiatric specialist, MD, DO, or PMHNP, is 50+ miles away. Due to the greater need for services and mental health care provider shortage, more than 70% of local therapy clinicians maintain full practices and cannot engage with new patients (Palouse

Advocacy League, 2021). As a result, the ability of the local community to accurately screen

and care for mental health patients is severely limited.

For this reason, the CTC is in a unique position to pivot and make evidence-based

improvements and efficient changes that will optimize the best outcomes with minimal

resources. Accurate, high-quality screening and risk assessment must be accessible and

supported by evidence. Screening is an essential first step in this process.

The National Academies of Medicine, in a consensus study report "The Future of

Nursing 2020- 2030: Charting a Path to Achieve Health Equity (2021), recommended that

>All public and private health care systems should incorporate nursing
>
>expertise in designing, generating, analyzing, and applying data to
>
>support initiatives focused on social determinants of health and health
>
>equity using diverse digital platforms, artificial intelligence, and other
>
>innovative technologies (Wakefield et al., 2021).

Outdated assessment models and an over-reliance on individual and non-standardized screening

tools for varied diagnostic presentations is not a timely, effective, or sustainable way to provide

quality care. Additionally, screening tools assist in the differentiation between those patients at

risk for suicide and those truly not at risk for suicide (Ryan & Oquendo, 2020). Validated

screening tools help capture critical assessment information and management of identified risks

(2020).

Specific Aims

This project aims to utilize and implement a standardized screening tool to assess suicide

risk. Effective and high-quality care requires clinician competency and the ability to deliver that

care with evidence-based tools and validated measures. This project also seeks to educate and

develop clinician competency when delivering this screening and assessment tool. The most significant predictor of success in delivering outcomes-based measures is provider proficiency with the intervention (N. Mai, personal communication, September 2, 2021).

The specific aims of this project are:

1. utilize and implement a validated tool for assessing suicide risk,

2. provide clinician education on using a validated tool to assess and document suicide risk.

Methods

Context

The setting for this process improvement project is the University of Idaho Counseling & Testing Center. The CTC exists primarily as a non-profit entity. It is attached to a land-grant university that receives funding from the State of Idaho on an annual budget. Students are the only population on campus that can access services, and they do not pay a fee for individual psychotherapy, group psychotherapy, or case management services. However, students pay a nominal fee ($25) to the university when attending an appointment with a psychiatric nurse practitioner for medication management. The budget office uses this fee to offset the salary of the psychiatric nurse practitioner. This fee is paid to the university and not the CTC. Care must be delivered in this context of a static budget and funding level.

The staff at the CTC is a multidisciplinary team comprised of several disciplines and specialty areas of practice. This staff consists of four doctoral interns in psychology, eight licensed clinical psychologists, three Master's level social workers, and a singular psychiatric-mental health nurse practitioner. The staff delivers various interventions, including

medication management, individual psychotherapy, group psychotherapy, and case management, to the students who access services at the CTC.

Cost-Benefit Analysis

Recent budget cuts require cost-neutral interventions. For example, the State Legislature eliminated $500,000 from the University of Idaho's annual budget in 2020. As a result, the university faced an additional 2% budget reduction leading to the mandatory furlough of every university employee (University of Idaho, 2020). In addition, the university faced a further $22 million budget cut, which will need to be balanced by the fiscal year 2022 (Spelbring, 2019).

These budget cuts did not result in a loss of staff at the CTC, nor did they change service delivery. However, they prevent any increase in staffing levels or increase in clinician compensation for additional work. The CTC does not have additional funding outside the University Budget and does not enjoy the ability to increase clinician compensation, bring in specialized training, or purchase licenses for additional tools.

Implementation of cost-saving measures is imperative within the constraints of a static budget. The use of validated screening tools such as ASQ to identify risk allows clinician engagement with minimal impact on overall workload. Additionally, the ASQ represents a cost-neutral option for validated screening tools. No new staff is necessary. Training for the use of the tool can be accomplished efficiently during scheduled meetings that do not impact patient care hours. The use of the tool is free, as it is in the public domain.

Moreover, no change to intake processes, appointments, or scheduling is necessary. Implementation of the tool within the context of patient care can occur naturally within an appointment already scheduled and can be finished quickly without impacting the quality of patient care. The goals for implementation of the ASQ greatly outweigh the risks: increased

uniformity and efficiency in identifying patients at risk and improved patient outcomes in those

at risk for suicide. The tangible and intangible benefits of this process are enormous.

Interventions

The interventions for this project are 1. implementation of a validated, evidence-based

screening tool for suicide risk and 2. education/training for providers in using this tool. The

proposed tool for use is the Ask Suicide Screening Questions (ASQ) toolkit. The ASQ was

developed, approved, and supported by research for efficacy and application in an outpatient

setting (National Institute of Mental Health, 2020). The ASQ is a short, five-question screening

administered in less than one minute during the patient visit. This tool provides three different

outcomes: a negative screen, an acute positive screen, and a non-acute positive screen. These

results identify the level of risk for each patient and facilitate a guide for the clinician's next steps

in the assessment process.

The ASQ is validated and an effective tool for assessing suicide risk in youth and adults

in outpatient settings with a specificity and sensitivity of 91.2/100%, respectively (Aguinaldo et

al., 2020; Horowitz et al., 2020). The ASQ is well suited for this process improvement project

(LeCloux et al., 2020).

Clinicians were provided with an educational session and demonstration of the ASQ tool

and the purpose of this project. This session was attended by 15 of the CTC clinicians, with one

clinician absent at the time of its offering. A one-on-one session with this clinician was attended

upon their return to the center. The information presented was reviewed with them in the same

manner and exactness as to the initial educational session.

A PowerPoint presentation was shared with clinicians to highlight the validity of the

ASQ and how this is utilized during patient care. The use of the ASQ allows for rapid

assessment of suicide risk severity. This education session also provided information and additional context regarding the need for accurate suicide risk assessment.   Each clinician was presented with the educational and training material from the ASQ toolkit.

Additional education was provided on implementing the ASQ tool, the questions asked, and the time required for each assessment. Individual clinicians were provided with a sample form to complete during the educational session and comprehensive information about the ASQ tool and its use in varied settings (National Institute of Mental Health, 2020). A sample case study and practice session was used to educate clinicians on how to complete an ASQ screening with a student during an appointment. Copies of the ASQ tool were then distributed to each clinician for use with their clients after the educational session.

Appointment types were identified for appropriate screening and eligibility for the administration of the ASQ. Each new appointment to the center and each crisis appointment were identified as eligible and appropriate for screening during the length of this implementation project. These appointment types were selected to allow for a natural opening in establishing the therapeutic relationship to screen for suicide risk severity.

The ASQ provides a positive or negative screening outcome upon completion. The positive outcome is further differentiated between acute positive and non-acute positive screening for suicide risk, noting the risk level. Clinicians are guided to the next steps after the screening is complete.

A negative score on the ASQ does not require additional intervention for suicide risk. For example, if questions 1-4 are answered with "no," it is unnecessary to ask the 5th question regarding the current suicide plan. In addition, clinician judgment can always override a

negative screen if additional information presents during the visit, even if the scoring was

negative.

When the answer of "yes" is given, or if a student refuses to answer any of the questions

1-4, this is considered a positive screening, and question 5 will then need to be asked. This

question focuses on thoughts of killing oneself in the present moment. Therefore, a "yes" to this

question is considered an acute positive (imminent risk), and a "no" to this question is a

non-acute positive (potential risk).

A complete safety evaluation will occur with that clinician if a student is identified as an

acute positive risk. That student will be assigned a 1:1 provider for safety and have a complete

evaluation done to address safety, safety planning, need for emergency care, and transport to a

higher level of care if necessary. During the assessment, if a student is identified as an acute risk

and cannot maintain safety, they will be informed of their health care rights. Then contact will

be made with local law enforcement or EMS personnel to transport that patient to a higher level

of care for additional assessment and stabilization as per current CTC policy and practice.

A brief safety evaluation will occur with the clinician if a student is identified as having a

non-acute risk. This brief evaluation assesses safety, safety planning, access to support

resources, and whether there is a need for additional, comprehensive safety and mental health

evaluation. The student will be placed on a 1:1 until this assessment is finalized. In the case of

student refusal to engage in the safety planning or assessment process, the student will be

informed of their healthcare rights. In addition, as per current CTC policy and practices, local

law enforcement will be contacted to administer a welfare/wellness check for that student.

Study of Interventions

Administration of the ASQ to eligible patients was completed over four weeks, from March 7, 2022, through April 1, 2022. All initial appointments and crisis appointments were eligible for ASQ screening. After this period, a retroactive records review was used to gather and interpret the data. This review focused on the clinician's use of the tool and the number of times it was administered relative to the number of eligible appointment types. Further review was also completed to identify suicide risk severity among those screened. The ASQ was used to differentiate between imminent risk and potential risk or no risk upon completion of screening.

Following the project proposal guidelines, no client data was tracked regarding the tool's outcome, and no personally identifiable or protected health information was gathered on respondents.

Measures

Education was provided to clinicians regarding the implementation of the ASQ and how to complete the form. Further education was also provided on using a validated screening tool to assess suicide risk severity and facilitate appropriate referrals. No exclusion criteria were present during this period of implementation.

A retrospective records review was conducted after the implementation period. The patient record is comprehensive and is a valuable source of data. This record is the gold standard for any study or process improvement project as it provides valuable insight into demographics, interventions, variables, and other aspects related to treatment and assessment (Gregory & Radovinsky, 2012).

A clinical record review is practical when recorded data needs to be analyzed and summarized; it is also useful when data identifies both an appropriate intervention and a specific problem (Sarkar & Seshadri, 2014). Additionally, the records review is less intrusive to patients

and eliminates the need for interviews that take away valuable assessment time to analyze data (2014).

An easy way to collect routinely recorded information is necessary and pertinent to the aims of this project and to answer specific clinical questions (2014). Accessing data from the medical record is cost-effective and can be done for various time frames to gather pertinent data (2012). However, when using the records review, accurate information must be entered into the patient record in the first place. Data entered incorrectly, or is missing, is of little value after the project and can prove disastrous to outcomes.

Specific steps were taken in this project to ensure accurate data collection and entry. Each clinician was provided with physical copies of the ASQ tool for use in appointments. The ASQ screening was completed with the patient present and at the appointment time. No post-appointment data entry was utilized. Each clinician was educated and shown how to record the patient ID number on the form when complete. This was done to ensure that each record was scanned into the correct patient chart. After each appointment, these forms were placed in a designated folder at the front office. One administrative staff member remained responsible for collecting these forms from the folder and scanning them into the patient chart. The patient ID number was verified and checked for accuracy to ensure a match between the physical form and the electronic health record.

After uploading the document to the patient health record, the physical forms remained stored in a locked and secured file cabinet for verification after the implementation period. In addition, each form was cross-checked with its scanned duplicate during the record review to ensure accuracy and complete file upload.

Results

Information gathered from the records review focused on gauging the effectiveness and the implementation rate of the ASQ. As the CTC does not currently use a validated tool to assess suicide risk severity, this focus is vital for initial screening and investigation regarding the need for more comprehensive interventions in the future.

Data gathered included the number of screenings completed compared to the number of eligible patient appointments identified for ASQ screening.   Extracted data includes the number of screens administered in total and those that scored negative, acute positive, and non-acute positive once complete. Due to this project's limited time frame and scope, no additional demographic data were analyzed during the records review.

Data sources used during the records review were the patient chart and completed ASQ screening only. This data was checked for accuracy by matching the paper copies of the ASQ with the electronic file uploaded to the client chart to ensure an accurate recording of the ASQ screening.

After the implementation period & subsequent records review, 83 appointments were expected to complete ASQ screening. However, data revealed that the clinicians completed 36 screens at the CTC. This represents 43.3% of eligible appointment encounters having been screened for suicide risk using the ASQ (see fig. 1).
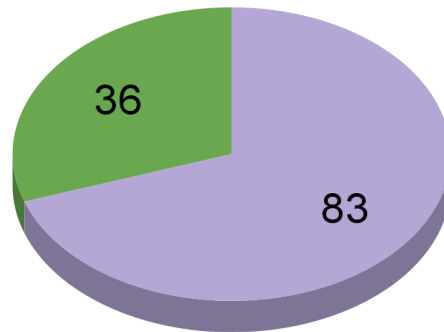
Expected vs Completed ASQ Screening

Figure 1

The completed screenings showed 22 screens with no suicide risk, 13 screenings showing non-acute (potential) suicide risk, and one screening with acute positive (imminent) risk identified. Presenting these numbers with simple descriptive statistics shows that 61.1% of screens had an outcome of no risk, 36.1% were identified as a potential risk, and 2.7% of screenings scored as imminent risk (see fig. 2).
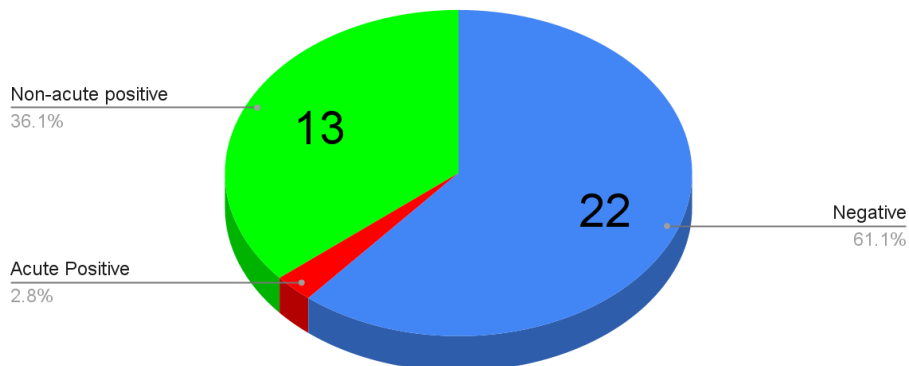
ASQ Screening Results

Figure 2

Results also show that 7 of the 16 clinicians with scheduled appointments completed any number of ASQ screenings. This represents 43.7% of clinicians utilizing the ASQ assessment tool to screen for suicide risk severity (see fig. 3).
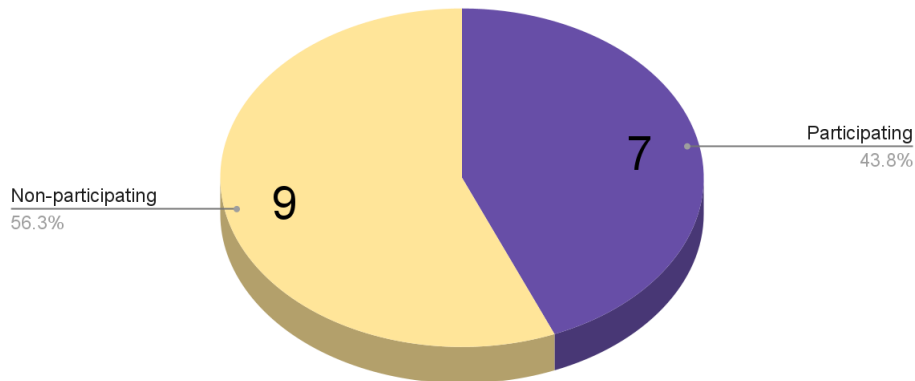
Clinician Participation

Figure 3

Analysis

The ASQ in a QI project at a university counseling center is a novel use of this tool. Current research and review of available literature show that the primary tool to measure suicide risk items in college counseling centers is the CCAPS. It remains so under recommendation by the Center for Collegiate Mental Health (CCMH) and its advisory board (Castonguay, Locke, & Hayes, 2011). Conventional practice at college counseling centers favors the CCAPS over other tools for initial evaluation. The CTC follows CCMH recommendations.

It is recommended that any indication of suicidality on the CCAPS be followed up with an additional screening tool (Polychronis, 2017). The ASQ is one such tool for use as it is highly sensitive and specific. The ASQ is shown to be as effective as other measures and has the added benefit of generating fewer false positives (2017).

The use of the ASQ was developed for medical settings (National Institute of Mental Health, 2020). The ASQ is a generalized assessment tool that can be applied to other populations- not solely focused on college students. The CCAPS focuses on one risk item that must be completed as part of initial documentation prior to meeting with a clinician. The ASQ comprises five items asked during a real-time clinician/client interaction via direct assessment.

Training in suicide risk assessment varies widely across the field of experience in college counseling centers and has severe implications for training programs and those who complete them (Keith, 2014). A consistent finding showed that many clinicians desire additional training for suicide risk assessment, but this training varies across the field (2014).

The CTC currently uses the CCAPS as the sole tool to address any suicidality. Uniform training was offered to each clinician regarding using the ASQ and how to complete it. The results of this QI project show a 43.8% participation rate in using the ASQ to assess suicide risk. Literature review indicates that less than 20% of primary care providers engage in suicide screening for risk factors among adolescents (O'Rourke, Jamil, Siddiqui, 2018).

The identification of suicide risk is of interest to the CTC. As noted earlier, suicide remains the second leading cause of death among 15-29-year-old persons across the globe (Arensman et al., 2020). Furthermore, since 1999, the rate of completed suicide among the population has increased by 33% in the United States when age-adjusted (Ryan & Oquendo, 2020). Therefore, the identification of imminent risk among the student population remains paramount. This is reinforced by identifying a 2.7% imminent risk among screened patients during this implementation period.

The lack of adherence to the use of the ASQ is of concern to this project. Literature review across a broad spectrum of practice environments notes that this adherence problem is not

isolated to mental health settings. One review noted over 200 barriers to clinician adherence to clinal practice guidelines. This review identified significant barriers such as awareness, agreement, self-efficacy, outcome expectancy, and the ability to overcome previous practice habits (Cabana, Rand, Powe, Wu, Wilson, Abboud, & Rubin, 1999). Furthermore, the patient selection also appears to be a driver of clinician adherence, and those same clinicians may still prefer alternatives to the standard of care recommendations based on personal preference and prior practic experience (Aversa, Diggs, Hagerty, Dominguez, Wiemken, Luu, & Hernandez, 2020).

Achieving 100% adherence to screening protocols and standards continue to be an elusive goal. Other research on standardized assessment toolkits reveals low adherence rates of 28% to 94% across patients who qualified for the assessment using a particular protocol (Richards, Malouin, Nadeau, Fung, D'Amours, Perez & Durand, 2019). These findings from the literature review can be applied to this project as possible reasons for clinician non-adherence.

A similar project related to risk assessment also revealed that 24% of clinicians refused to screen their patients for suicide and endorsed the following reasons for this refusal: screening was seen as unethical, treatment was contraindicated, asking about suicide would make a suggestible client have those desires, feeling that screening was inappropriate if the client was not actively suicidal, and even finding screening unnecessary due to the clinician being an expert in what is best for their client (Lang, Uttaro, Caine, Carpinello, & Felton, 2009).

Limitations

This project had several limitations. First, there was no pre-intervention survey of clinicians to address comfort level, experience, or opinion on using additional suicide risk screening tools. A second limitation is the lack of post-intervention interviews or surveys to

review participation, impressions, and outcomes with individual clinicians. This project was designed to address the implementation of a validated suicide risk screening tool in a college counseling center and, as such, focused on using the tool rather than the clinician's opinion of the tool.

Further limitations were present in a multidisciplinary team with various professional licenses and varying degrees of suicide risk training within each professional discipline and accrediting body. This was not addressed in this project. Varying degrees of training likely contributed to clinician participation and comfort in doing so.

Lastly, this project was implemented over four weeks and encompassed a small number of appointments and a duration of time. The data and small sample size reflect this limited time frame and the number of screenings. Future projects should consider expanding these parameters to capture a more substantial sample for analysis.

Recommendations

Concluding the analysis and implementation of the ASQ tool during the project timeline, it is clear that additional screening is necessary to address suicide risk. There are many challenges to overcome when assessing suicide risk: provider attitudes about screening, the stigma associated with the positive endorsement of suicide ideation, as well as minimizing the severity of suicide risk and perceived conflict with other healthcare priorities (King, Horowitz, Czyz, & Lindsay, 2017).

One recommendation suggested is to increase the number of clients screened for suicide risk. Capturing a larger pool of patient visits is necessary to have a complete assessment of risk among clients of the CTC. This would also move the CTC closer to goals identified by the National Strategy for Suicide Preventions' Zero Suicide key objective to "transform healthcare

systems to significantly reduce suicide" (U.S. Department of Health and Human Services, Office

of the Surgeon General, & National Action Alliance for Suicide Prevention, 2012). Extending

the implementation period of future QI projects to capture more data would provide a more

detailed picture of the risk inherent in the population. Adding the ASQ tool to the current suite

of required assessment measures as part of a standard intake process will likely provide greater

clarity regarding this risk. It will meet calls for universal screening as proposed by The Joint

Commission (Canady, 2018).

A second recommendation is further educational sessions and a review with the CTC

clinicians regarding the importance of suicide risk screening. During this project, only 49% of

eligible patients received an ASQ screening, and greater than half of the eligible patients

received no screening for suicide risk. In addition, less than half of clinicians participated in

administering suicide risk screening using the ASQ. This lack of accurate screening reflects

findings by Brodsky, Spruch-Feiner, and Stanley showing that 20% of clinicians are

uncomfortable asking about suicide, and a further 12% would not discuss suicide even if data

indicated risk (2018).

Clinicians are often underprepared to address suicide risk, with many receiving little to

no training. For example, in a survey conducted by the National Action Alliance for Suicide

Prevention, 70% of therapists indicated that they received no education specific to suicide in

therapeutic practice (2014). This is despite accrediting bodies having standards for treating

patients in crisis but not having any specific competencies for doing so. Further compounding

the difficulty in providing education is a recent finding indicating that many clinicians felt

comfortable in their ability to screen for suicide risk and support mandated suicide-specific

education (Schwab-Reese, Kovar, Brummett, & Runyan, 2018).

Making suicide risk assessment a strongly recommended part of clinician training, education, and practice would go to great lengths to identify those clients at risk for suicide more consistently. Evidence-based clinical practice is vital to patient safety and appropriate clinical outcomes. In addition to continued training and education, the American Psychological Association (APA) suggests core competencies in suicide risk assessment and management and guiding incorporation of this into supervision (Rudd, Cukrowicz, & Bryan, 2008). The CTC provides training in an APA accredited program. Additional training, supervision, and education should be incorporated into this program. Additionally, it is suggested that other empirically validated tools such as the ASQ be utilized in addition to the CCAPS.

Data on suicide reporting remains challenging to gather and codify due to several factors across many cultures and practice settings. This QI project illustrates this in unambiguous terms. Duckers et al. identified underreporting as one of the significant difficulties encountered when assessing suicide risk globally (2019). This level of underreporting leads to misinterpretation of results and potentially understating the risk that suicide poses worldwide. Implementing the ASQ at the CTC for just a short time has reinforced both the benefits of suicide risk screening and the challenges of accurately doing so.

Additional assessments, data gathering, and educational training will be necessary to work toward the goal of suicide reduction, prevention, and treatment. Future QI projects would be well served to continue advocating for suicide risk screening for each patient at each visit to address this global problem comprehensively. The importance of continued and relevant education on suicide risk assessment is also evident.

Ethical Considerations

Ethical considerations are the duty of healthcare providers to protect the privacy and confidentiality of consumers of that care. Clients and participants depend on the trust and confidentiality of their reports to clinicians, and the clinician must keep those confidences as a model and standard of care (Surmiak, 2018). Therefore, no personally identifiable data has been gathered or collected on screened patients. Students were not enrolled in a focus group, a study, or an experimental control group- they have been offered a standardized screening for suicide risk and interventions for mental health concerns in a well-established modality of care (individual assessment) targeted to a specific presentation of symptoms. The project aims were completed by implementing an evidence-based and valid tool to screen for the severity of suicide risk.

Equity of access is a solid ethical consideration in any project as well. This project also had no exclusion criteria. Each clinician at the CTC was offered training and education regarding the use of the ASQ. Each initial and crisis appointment was eligible for screening with the tool.

Informed consent is an essential ethical consideration as well. Students consent to care with the CTC on their initial presentation. This consent also covers individual assessment, screening, and referral when necessary. As previously noted, students were not selected for differential services. Care continued within the independent client/clinician relationship and therapeutic framework.

Students who use the services of the CTC do so voluntarily. Each student makes an individual decision to utilize clinician care at the CTC without outside input or mandates. Students are free to discontinue services with the CTC and for any reason if they so choose. A

student is frequently offered safety assessments and screenings for various mental health

problems during this treatment, including suicide risk screening.

    Ethical aspects of this project and the context of its data review are essential

considerations (Sarkar & Seshadri, 2014). This project received approval from the University of

New Hampshire and the University of Idaho IRB boards. These IRB guidelines were followed

in this project's planning, implementation, and data gathering aspects.

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