UNIVERSITY of WASHINGTON
PSYCHIATRY & BEHAVIORAL SCIENCES

Meta-Competency 5: Screening and Assessment

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Meta-Competency 5: Screening and Assessment

Competencies

- 5-a: Utilize appropriate standardized screening tools to identify common behavioral health conditions.
- 5-b: Conduct a suicide risk assessment and provide appropriate intervention under supervision.
- 5-c: Conduct a patient-centered biopsychosocial assessment.
- 5-d: Use measurement-based care to support stepped care approaches and adjust the type and intensity of services to the needs of the patient.

How to Use This Chapter

Screening and assessment are foundational components in the early identification and effective treatment of mental health and substance use disorders, enabling healthcare providers to respond proactively to patient needs. This chapter provides a practical approach to screening and assessment, with a focus on integrated care settings where early detection can significantly improve health outcomes. Many of the strategies used in integrated care are easily transferable to other settings that track population health.

While there is no universally recognized definition of integrated care, the term will be used in this chapter to describe healthcare services that involve systematic collaboration between medical and behavioral health professionals to provide coordinated care for all the components that make humans healthy (i.e., biological, psychological, and social factors). Primary care clinics are often the first point of contact for patients with behavioral health concerns and can offer a vital environment for integrated care models. That said, care integration happens across a wide range of settings, including specialty clinics, emergency departments, hospitals, community health centers, and other social service agencies.

This chapter highlights the use of measurement-based techniques and tools that are both accessible and actionable. These methods support clinical decision making, facilitate the monitoring of patient progress, and draw from established best practices. The strategies outlined aim to build BHSS student confidence and competence in identifying risk factors, assessing symptom severity, and collaborating effectively in care planning.

By presenting foundational knowledge and real-world applications, the chapter equips BHSS students with skills to contribute meaningfully to screening and assessment pathways in primary care or other clinical placements.

Summative Competency Assessment Example for MC5: Screening and Assessment

Case Formulation Assignment

Students will be assigned an example patient registry and corresponding self-reported scores on screening measures commonly employed in integrated behavioral health settings. Using this

information, they will interact with the 4-P model, interpret scores using an example registry, and write a case formulation from a whole health perspective.

- MC5 Summative Assessment Example, Case Formulation Assignment

Sample Readings for MC5: Screening and Assessment

Andrews, J. H., Cho, E., Tugendrajch, S. K., Marriott, B. R., & Hawley, K. M. (2020). Evidence-based assessment tools for common mental health problems: A practical guide for school settings. *Children & Schools*, *42*(1), 41–52. https://doi.org/10.1093/cs/cdz024

Carlo, A. D., Scott, K. S., McNutt, C., Talebi, H., & Ratzliff, A. D. (2024). Measurement-based care: A practical strategy toward improving behavioral health through primary care. *Journal of General Internal Medicine, 40,* 677–681. https://doi.org/10.1007/s11606-024-08877-6

Hays, D. G. (2017). *Assessment in counseling: Procedures and practices* (6th ed.). American Counseling Association.

Melnyk, B. M., & Lusk, P. (2022). *A practical guide to child and adolescent mental health screening, evidence-based assessment, intervention, and health promotion* (3rd ed.). Springer Publishing Company.

Sample Learning Sequence

Pre-BHSS (Recommended)

- Basic knowledge of research methods, including understanding and appreciation of validity, reliability, and statistics.

FOUNDATIONS	ADVANCED	PRACTICUM
LO-1 Name and describe the purpose and application of commonly used screening tools for anxiety, depression, substance use, suicide risk, and early-onset psychosis. LO-2 Identify clinical, cultural, and literacy relevance of screening tools to a patient or patient population. LO-3 Describe how using screening tools informs measurement-based care, adjustment of service types and intensities, and treatment to target.	LO-6 Conduct a patient-centered biopsychosocial formulation. LO-7 Use the results of screening data to identify areas of concern, symptom severity, and initial patient needs. LO-8 Review and interpret a valid suicide risk assessment tool, including estimated risk level and next step recommendations.	LO-9 Demonstrate the ability to administer, interpret, and discuss results from behavioral health screening tools utilized in a practice setting with a patient. LO-10 Collaborate with care team and supervisor to develop patient safety plans when appropriate.

LO-4 Explain the key elements and goals of suicide risk screening, assessment, and management. LO-5 Describe the key components and principles of developing a safety plan.		

BHSS Foundations

LO-1 Name and describe the purpose and application of commonly used screening tools for anxiety, depression, substance use, suicide risk, and early-onset psychosis.

Key Terms and Concepts for LO-1

- **screening tool**: a brief validated questionnaire designed to help identify symptoms or risks for mental health conditions, such as anxiety, depression, substance use, or suicide risk. Questions on a screening tool rely on the patient's self-report and often utilize rating scales to quantify the severity or frequency of symptoms.
- **universal screening**: a proactive systematic approach to assessing an entire population for behavioral health concerns or risks. Universal screening involves administering validated screening tools to all members of a specified group (e.g., all patients aged 12–99, etc.) to identify those who may benefit from further assessment or intervention. It thus promotes early identification and more equitable access to care. (See MC4 for background on relationship to whole person care.)

Key Teaching Points for LO-1

Purpose of Screening Tools

- Amid rising mental health treatment needs, specialist shortages, and inequities in access to quality care, the importance of equitable practices in screening and identifying at-risk individuals is more evident than ever (Bailey et al., 2018). While hundreds of mental health screening measures exist, studying all of them is neither feasible nor necessary. Instead, students are encouraged to learn about the intended use and application of a few commonly utilized tools. By studying these examples, students develop a foundational understanding of common screening measures and principles, which they can generalize across diverse clinical settings and patient populations.

Early Detection of Mental Health Symptoms

- Screening for behavioral health concerns first gained traction in primary care settings as part of efforts to integrate mental health into general healthcare. This integration was driven by the recognition that many patients with behavioral health needs initially present in primary care, and early detection could improve treatment outcomes. As a result, the screening measures presented here are those that have widespread use across primary care settings. These measures are versatile and frequently applied in other clinical environments, such as specialty

clinics, schools, and justice systems, where early detection and intervention are equally critical to improving behavioral health outcomes.

Validity and Screening Measures

- Screening tools ought to effectively advance their intended goals (e.g., promoting earlier identification of concerns, facilitating access to services that are matched to patient needs, monitoring progress, etc.). The following principles serve as guideposts for valid screening measures:
    - **Evidence-based**. Any and all screening tools selected for use must be psychometrically sound and have reasonable justification for use with the intended patient population. In other words, research has demonstrated that the screening tool is 1) valid (i.e., it measures what it is intended to measure), 2) reliable (i.e., it is consistent over several administrations), and it has standardized norms (i.e., there are accepted "normative values" from which patient scores can be compared).
    - **Easy to administer**. The screener includes a brief set of questions with clear, user-friendly instructions for both patients and clinicians. Simplicity in language and structure improves accessibility, minimizes response burden, and reduces the likelihood of errors. Integrating tools into electronic health record (EHR) systems is ideal, when possible, as it enables seamless administration, scoring, and tracking. When integrated into an EHR, patients with technology access and literacy can complete any assigned screeners in advance of a visit as part of their pre-visit check-in. All these factors support efficiencies that help facilitate system adoption while also reducing burden.
    - **Repeatable across time**. To track symptom severity or treatment progress, screening tools should be sensitive to changes over time. Repeatability ensures that fluctuations in scores reflect true changes in a patient's condition rather than inconsistencies in measurement. Tools like the Patient Health Questionnaire-9 (PHQ-9) are designed for periodic reassessment, enabling clinicians to adjust treatment plans based on measurable outcomes. This capacity to monitor trends supports the principles of measurement-based care (MBC) and treatment to target. (See LO-3 and MC6 for further discussion.)
    - **Freely available.** Using tools that are in the "public domain" ensures accessibility and equity, removing financial barriers for healthcare providers and organizations. Freely available tools can be widely implemented without additional costs for licensing, training, or payment per use.
    - **Can be administered by licensed clinicians and trained support staff alike**. Screening tools that can be administered and scored by a range of healthcare team members, including trained support staff, provide many benefits. This flexibility supports efficient workflows, even in resource-limited settings. It also helps promote the use of screening tools in high-volume practices, like primary care clinics.
- A list of common evidence-based screening tools covers a breadth of common patient concerns likely encountered across a variety of settings. (See Examples of Screening Instruments in LO-1 Resources for a visual example.)

Screening for Early-Onset Psychosis

- Evidence-informed screening and assessment for early-onset psychosis involves the use of validated tools and structured clinical approaches to identify individuals, typically adolescents and young adults, who may be experiencing early signs of psychotic disorders. Tools such as the

Prodromal Questionnaire-16 (PQ-16) commonly detect attenuated psychotic symptoms, which may precede a full episode of psychosis. Below is a guide for psychosis screening in primary care, including adults, adolescents, and children. (See Psychosis Screening in Primary Care in LO-1 Resources for a visual example.)

Sample Activities/Assessments for LO-1

Activity: Population and Screening Measure

Students select a patient population and setting that they are interested in working with. A student may choose to think broadly about a particular population demographic (e.g., general adult population, LGBTQIA+ population, individuals seeking services for substance use concerns, vulnerable and/or underserved communities, etc.). Then the student identifies a screening measure applicable to a clinical setting of interest (e.g., primary care clinic, specialty mental health clinic, substance use clinic, etc.) that serves their patient population of interest. Students prepare a write-up describing their rationale for selecting this particular measure, incorporating how the suggested guiding principles do or do not apply. Students are encouraged to find at least one peer-reviewed article for citation. This activity will work for pairs or triads.

Activity: Screening Measure Deep Dive

In small groups, each student serves as an expert on a unique screening measure. In a discussion format, students present the measure's psychometric properties, the population/s the measure has been normed on, the meaning of scoring patterns, and any potential strengths or limitations of the screening tool.

Activity: Practice with Screening Measures

There are numerous web-based self-administered screening tools available online, including the PHQ-9, Generalized Anxiety Disorder-7 (GAD-7), and the pilot screening tool for early-onset psychosis. Invite students to complete the measures and comment on their experience interacting with the screening tool. Students do not need to share protected health information or the results with the instructor or class. Students may opt to interact with the tool as someone else to view different prompts for the next steps.

Specific Resources for LO-1

Resource: Psychosis Screening in Primary Care

Psychosis Screening: This user-friendly guide is for screening for psychosis. It outlines a patient-centered process from a whole-person care perspective.

- Woodberry, K., Johnson, K., & Graham, M. (2019). *Psychosis Screening in Primary Care.* CEDAR and Boston Children's Hospital. https://www.psychosisscreening.org/uploads/1/2/3/9/123971055/bidmc_psychosis_pcp_booklet_final.pdf

Resource: Screening and Assessment Tools Chart

Substance Abuse and Mental Health Services Administration: This resource provides a comprehensive chart of validated screening and assessment tools for substance use and co-occurring mental health disorders.

- Substance Abuse and Mental Health Services Administration. (2025). *Screening and assessment tools chart.* https://www.samhsa.gov/resource/dbhis/screening-assessment-tools-chart

Resource: Health Screening Tools

Measures: A nationally recognized repository for health screening tools utilized in Collaborative Care settings.

- AIMS Center. (n.d.). *Measures*. https://aims.uw.edu/resource-library/?resource-cat=measures

Resource: Measurement-Based Care

Measurement-Based Care for Mental Health and Substance Use Disorders: Descriptions of both adult and pediatric screening measures for mental health and substance use disorder treatment settings.

- Alter, C.L., Mathias, A., Zahniser, J., Shah, S., Schoenbaum, M., Harbin, H.T., McLaughlin, R., & Sieger-Walls, J. (2021, February). *Measurement-based care in the treatment of mental health and substance use disorders.* Dallas, TX: Meadows Mental Health Policy Institute. https://mmhpi.org/project/measurement-based-care-in-the-treatment-of-mental-health-substance-use-disorders/

Resource: Screening in Primary Care

Screening for Behavioral Health Conditions in Primary Care Settings: A Systematic Review of the Literature: This includes types of screening measures commonly used within primary care and integrated settings to detect symptoms related to behavioral health concerns.

- Mulvaney-Day, N., Marshall, T., Piscopo, K. D., Korsen, N., Lynch, S., Karnell, L. H., Moran, G. E., Daniels, A. S., & Ghose, S. S. (2018). Screening for behavioral health conditions in primary care settings: A systematic review of the literature. *Journal of General Internal Medicine*, *33*, 335–346. https://doi.org/10.1007/s11606-017-4181-0

Resource: Defining Screening and Assessment

Distinguishing Between Screening and Assessment for Mental and Behavioral Health Problems: This provides operational definitions of screening and assessment. In addition to detailing the benefits of each process, it helps develop an understanding of assessment and the relationship with case conceptualization.

- American Psychological Association. (2014, December). *Distinguishing between screening and assessment for mental and behavioral health problems*. https://www.apaservices.org/practice/reimbursement/billing/assessment-screening

Resource: Screening Measures in School Settings

Evidence-Based Assessment Tools for Common Mental Health Conditions: This article describes the purpose, validity, and reliability of measures commonly used with children and adolescents in school settings.

- Andrews, J. H., Cho, E., Tugendrajch, S. K., Marriott, B. R., & Hawley, K. M. (2020). Evidence-based assessment tools for common mental health problems: A practical guide for school settings. *Children & Schools*, *42*(1), 41–52. https://doi.org/10.1093/cs/cdz024

Resource: Screening and Health Equity

Mental Health Care Disparities Now and in the Future: This article discusses universal screening in the context of health equity by detecting signs and symptoms for a specified population and developing interventions to prevent mental health concerns from escalating.

- Bailey, R., Sharpe, D., Kwiatkowski, T., Watson, S., Samuels, A. D., & Hall, J. (2018). Mental health care disparities now and in the future. *Journal of Racial and Ethnic Health Disparities, 5,* 351–356. https://doi.org/10.1007/s40615-017-0377-6

Resource: Patient Health Questionnaire for Depression

Validating PHQ-2 and PHQ-9 to Screen for Major Depression: This article provides an overview of the process of testing the PHQ for both validity and reliability in measuring depression severity.

- Arroll, B., Goodyear-Smith, F., Crengle, S., Gunn, J., Kerse, N., Fishman, T., Falloon, K., & Hatcher, S. (2010). Validation of PHQ-2 and PHQ-9 to screen for major depression in the primary care population. *Annals of Family Medicine*, *8*(4), 348–353. https://doi.org/10.1370/afm.1139

Resource: PHQ-2 Screener

The PHQ-2: This resource acquaints the reader with the PHQ-2 as a universal screening tool that is easy to administer, score, and track within a patient population.

- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2003). The Patient Health Questionnaire-2: Validity of a two-item depression screener. *Medical Care*, *41*(11), 1284–1292. https://doi.org/10.1097/01.mlr.0000093487.78664.3c

Resource: Self-Check for Signs of Psychosis

Psychosis Self-Check: This tool is in a pilot phase of study and offers options for both an individual concerned with their own symptoms and for someone who is concerned about another person.

- Center of Excellence in Early Psychosis. (2025). *Take a self-check for signs of psychosis.* https://www.wa-ceep.org/en/questionnaire

Resource: Mental Status Examination (MSE)

MSE: This is a common assessment tool to identify signs of mood, thought, and behavioral disorders. The MSE requires supervised training and education to complete.

- TherapistAid. (2013). *Mental Status Exam*. https://www.therapistaid.com/therapy-worksheet/mental-status-exam

Resource: Examples of Screening Instruments

Common Screeners: A list of common screening tools provides examples of purpose, administration, and psychometric properties.

- Albert, S. (2025). *Examples of Screening Instruments*. Behavioral Health Support Specialist Clinical Training Program. https://bhss-wa.psychiatry.uw.edu/educatorsguide/part2/mc5/

LO-2 Identify clinical, cultural, and literacy relevance of screening tools to a patient or patient population.

Key Terms and Concepts for LO-2

- **literacy:** skills that help people accomplish tasks and realize their purposes. Skills are not static, and even adults with limited skills can get better results when their environments accommodate the skills they have (Centers for Disease Control (CDC), 2024).
- **personal health literacy:** the degree to which individuals can find, understand, and use information and services to inform health-related decisions and actions for themselves and others (Office of Disease Prevention and Health Promotion (ODPHP), n.d.).
- **organizational health literacy:** the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others (ODPHP, n.d.).
- **tailored approaches**: modifications made to screening tool selection or delivery to fit clinical, cultural, and literacy needs. Common examples include translating into the patient's primary language, printing in large font for individuals with visual impairments, offering visual aids, etc.

Key Teaching Points for LO-2

Cultural and Literacy Considerations with Screening

- Cultural and literacy considerations are crucial to the equitable administration and interpretation of screening tools. When the organizational systems designed to support population health improvements are not well matched to a patient's literacy, cultural background or identities, or accessibility, the implications increase health disparities. (See MC1 and MC3 for additional information on health equity and cultural responsiveness.

Meeting Patients Where They Are

- While literacy, cultural perspectives, and clinical relevance might be considered distinct concepts, there are many ways in which they are interconnected. Patients with varying levels of literacy may face challenges in understanding screening questions or instructions, which potentially impacts the accuracy of self-reported symptoms. Patients from varied cultural backgrounds might interpret symptoms or behaviors differently. For example, in some East Asian cultures, individuals may be more likely to describe psychological distress through physical symptoms, such as headaches or stomach pain, rather than identifying with emotions like sadness or anxiety. At a practical level, electronic administration of a screening tool may not be accessible to someone without access to the required technologies or with low digital literacy. Several considerations can help meet patients where they are and enable them to use their skills and health literacy.
    - **Get to know your patient population**. What are their cultural beliefs and practices? What are their preferred communication channels for interfacing with their healthcare team? Efforts to adapt to the cultural and linguistic norms of the population served will increase accuracy in measuring the targeted symptoms or conditions.
    - **Know and use a patient's preferred language**. In practicum placements, this information should be clearly displayed in an accessible field in the patient's chart. Do your research to determine which screening tools are readily available in the patient's preferred language. For example, the PHQ-9 has been translated into over 30 languages. When a screening tool does not have a validated translation, students are encouraged to explore any available site resources to help address this gap. For example, a certified translator (to translate the written screener) or a certified interpreter (to translate

verbally the screening tool instructions, either by phone or in person) may be available resources. Some agencies may also have community health workers who can assist.

- **Consider alternative administration formats.** Consider a patient's level of comfort with or ability to access technology-enabled screening tools, e.g., via an electronic patient health portal, mobile app, or in-clinic iPad presented at check-in.
- **Use clear and simplified language where possible.** While it is generally important for verbal administration of screeners to provide instructions as written by the test developers, a patient's response gives you important information for potential collaboration and tailoring. For example, if a patient seems confused, this could be due to difficulty hearing, needing a slower pace, or needing a visual presentation of the information. If administering the screening tool verbally, first read the questions verbatim at a steady pace, clearly enunciated. If using a certified interpreter, ensure they understand that questions need to be provided exactly as read to them. Simplifying language and providing guidance supports accurate responses.
- **Consider and advocate for the utilization of the patient's trusted sources.** For example, a patient may feel uncomfortable providing responses to questions pertaining to behavioral health symptoms to an individual with whom they don't have a previously established relationship. Inviting a colleague who knows the patient well to join or including a support person (with patient consent) may alleviate anxiety related to intimate information sharing.

Sample Activities/Assessments for LO-2

Activity: Case Study

Students analyze a case study developed by the instructor in which a standard screening tool is ineffective due to cultural or literacy issues. They then identify the challenges described in the case study and suggest modifications to the tool. Examples of ineffective tools include screening instruments only offered in a language different from the patient's, a screening tool that is lengthy and addresses non-relevant elements, a screening tool that has not been normed across cultural groups, or a screening tool that requires the patient to read and identify items when the patient is not literate.

Specific Resources for LO-2

Resource: Health Literacy Basics

What is Health Literacy?: The CDC's website overviews health literacy and its importance.

- Centers for Disease Control and Prevention. (n.d.). *What is health literacy?* https://www.cdc.gov/health-literacy/php/about/index.html

Resource: Organizational Health Literacy

Five Things to Know About Health Literacy: This short video discusses strategies that organizations can use to make health information and services easier to find, understand, and use.

- U.S. Department of Health and Human Services. (2022, October 21). *5 things to know about health literacy* [Video]. YouTube. https://www.youtube.com/watch?v=BG-iY-em7mk

Resource: Example Adaptations of PHQ-9

PHQ-9 Visual Answer Aid**:** This visual aid assists patients in answering questions on the PHQ-9.

- AIMS Center. (2021, October 7). *PHQ-9 visual answer aid*. https://aims.uw.edu/wordpress/wp-content/uploads/2023/06/PHQ9Visual-AnswerAid.pdf

LO-3 Describe how using screening tools informs measurement-based care, adjustment of service types and intensities, and treatment to target.

Key Terms and Concepts for LO-3

- **measurement-based care (MBC):** a systematic approach to using validated screening tools to track a patient's symptoms, treatment progress, and outcomes. MBC informs clinical decision making, ensuring care is tailored to patient progress (Scott & Lewis, 2015).
- **treatment to target:** a model that uses MBC data to set specific goals for symptom improvement, adjusting care intensity or type based on the patient's response.
- **decision making***:* a collaborative process between the BHSS and clinical supervisor to adjust treatment according to patient needs.

Key Teaching Points for LO-3

Measurement-Based Care

- In LO-1 and LO-2, students learned about the selection and use of validated screening tools at a single point in time to aid in detecting symptoms or conditions. Building on this, MBC provides a framework for routinely monitoring changes in scoring patterns over time. This longitudinal approach to measurement prompts timely adjustments to treatment plans, so interventions can be responsive and matched to a patient's needs and goals (Fortney et al., 2017). MBC aligns well with the culture of a primary care setting, where repeated measurement is a standard of care—think about how vitals, including blood pressure and weight, are routinely taken at adult visits, or how developmental milestones are tracked at child visits.

MBC Core Components

MBC Core Components	Goals
Administration of a validated patient self-report instrument assessing relevant treatment domains (symptoms, quality of life).	• Evaluate overall patient treatment progress. • Assess at regular intervals and following changes in treatment. • Assess changes in specific domains that are the focus of treatment. • Provide space for patient self-reflection prior to or during encounter.
Provider and patient review of self-report instrument responses.	• Identify changes in treatment-relevant domains since last encounter. • Provide space for patient elaboration/provider clarification regarding instrument responses.

Provider and patient discuss changes to focus of current encounter and/or treatment plan in response to instrument.	• Facilitate shared decision making regarding the focus of the current encounter and future treatment planning. • Facilitate treatment planning targeted to changing patient needs. • Enable discussion of change in treatment-relevant domains over time.
Documentation of instrument responses and associated encounter or treatment plan changes in EHR.	• Enable monitoring of change in instrument responses over time. • Allow patient access to information about change in treatment domains over time.

*Note: Adapted from "Table 1 Core Components of MBC with Associated Goals and Specific Applications in Primary Care BHI" (Carlo et al., 2024).

Measurement-Based Care and Screening Tools

- MBC relies on routine, standardized assessments to guide clinical decisions, allowing providers to tailor treatment in real time. By incorporating screening tools, MBC establishes objective benchmarks for patients' symptoms and progress. Fortney et al. (2017) emphasize that MBC is particularly impactful in behavioral health, where it can improve clinical outcomes by identifying symptom fluctuations and treatment effects. Screening tools help ensure that treatment approaches are responsive to individual needs, enhancing both the quality and precision of care provided.

Adjustment of Service Types and Intensities

- Screening tools also support adjusting service types and intensities to meet patients' evolving needs. As Carlo et al. (2024) explain, regular assessments in primary care settings allow more flexible treatment intensities, such as stepping up care for patients showing limited progress or reducing the frequency of visits for those who are improving. This approach helps ensure that resources are used efficiently and that patients receive appropriate levels of support, reflecting a patient-centered approach that is adaptable and effective in managing diverse behavioral health challenges.

Treatment to Target

- Finally, MBC enables healthcare team members to adopt a "treatment-to-target" approach, where specific goals are set based on the screening data, guiding providers to achieve quantifiable improvements in patients' health. Fortney et al. (2017) highlight that when treatment targets are established, providers can more precisely measure outcomes, leading to timely adjustments that can improve patient satisfaction and overall outcomes. This targeted approach enhances clinical care and aligns with outcome-based models prioritizing measurable health improvements for patients.

Sample Activities/Assessments for LO-3

Activity: Prioritizing Patients for Systematic Case Review

Students review the scores from routine screening measures in an example patient registry. In small groups, they identify which patients meet different prioritization criteria. Then, individually, they select four patients representing the highest prioritization and describe their rationale.

Specific Resources for LO-3

Resource: MBC and Treatment Enhancement

Using MBC to Enhance Any Treatment: This article discusses the application of MBC in clinical settings, including benefits to improving outcomes for patient care.

- Scott, K., & Lewis, C. C. (2015). Using measurement-based care to enhance any treatment. *Cognitive and Behavioral Practice, 22*(1), 49–59. https://doi.org/10.1016/j.cbpra.2014.01.010

Resource: MBC Guidelines

The Need for an MBC Professional Practice Guideline: This article argues for an MBC practice guideline to help standardize the process of tracking care and identifying priorities in patient care.

- Boswell, J. F., Hepner, K. A., Lysell, K., Rothrock, N. E., Bott, N., Childs, A. W., Douglas, S., Owings-Fonner, N., Wright, C. V., Stephens, K. A., Bard, D. E., Aajmain, S., & Bobbitt, B. L. (2022, June 30). The need for a measurement-based care professional practice guideline. *Psychotherapy, 60*(1), 1–16. https://doi.org/10.1037/pst0000439

Resource: MBC in Clinical Practice

A Tipping Point for Measurement-Based Care: A resource discussing findings in the literature regarding the systematic application of MBC within integrated care settings, including both effective and ineffective implementation of MBC.

- Fortney, J. C., Unützer, J., Wrenn, G., Pyne, J. M., Smith, G. R., Schoenbaum, M., & Harbin, H. T. (2017). A tipping point for measurement-based care. *Psychiatric Services*, *68*(2), 179–188. https://doi.org/10.1176/appi.ps.201500439

Resource: MBC in Mental Health

A Tipping Point for MBC in Mental Health: A video recorded follow-up to the article by Fortney et al. (2017).

- UWMedicine Psychiatry. (2017, March 22). *A tipping point for measurement-based care in mental health* [Video]. YouTube. https://www.youtube.com/watch?v=SQ9t2Fz4eFA

Resource: MBC and Primary Care

A Practical Strategy Toward Improving Behavioral Health Through Primary Care: This article describes the implementation of MBC within an integrated primary care setting and the impact on patient care.

- Carlo, A. D., Scott, K. S., McNutt, C., Talebi, H., & Ratzliff, A. D. (2024, October 8). Measurement-based care: A practical strategy toward improving behavioral health through primary care. *Journal of General Internal Medicine, 40,* 677–681. https://doi.org/10.1007/s11606-024-08877-6

LO-4 Explain the key elements and goals of suicide risk screening, assessment, and management.

Key Terms and Concepts for LO-4

- **risk factors**: a range of factors that make it more likely that individuals will consider, attempt, or die by suicide.

- **protective factors**: a range of factors that make it less likely that individuals will consider, attempt, or die by suicide.
- **warning signs**: observable behaviors or indicators that suggest an increased likelihood of imminent suicidal actions (i.e., within minutes to days). Warning signs are concrete signals that someone is at heightened risk for suicide in the short term.
- **suicide attempt**: intentional, self-enacted, potentially injurious behavior with any (i.e., non-zero) intent to die, with or without injury.
- **non-suicidal self-injury:** intentional, self-enacted, potentially injurious behavior with no (i.e., zero) intent to die, with or without injury.
- **suicidal ideation:** thoughts of ending one's life or enacting one's death.
- **non-suicidal morbid ideation:** thoughts about one's death without suicidal or self-enacted injurious content. Also referred to as "non-lethal morbid ideation" or "death thoughts."

Key Teaching Points for LO-4

Destigmatizing Suicide and Defining Our Role

- Understanding suicide risk and management begins with a compassionate, destigmatized approach. Suicide touches nearly everyone; among any group of 50 people, it is likely that at least one has struggled with thoughts of suicide or has made a suicide attempt.
- The role of any healthcare professional is not to act as guardians, saviors, or friends but to provide a standard of care that is grounded in empathy, knowledge, and best practices. While there is a prevailing myth that asking someone about suicidal ideation will plant ideas or otherwise increase their risk, there is no evidence that asking about suicide elevates risk. Rather, screening and assessment are an avenue for opening the door to honest discussion. Through active listening and compassionate language, it is possible to help patients feel seen, valued, and understood. This is key to addressing immediate risk and fostering trust.
- Instructors can model this compassionate approach through thoughtful presentation of material and by fostering a learning environment where students feel encouraged to discuss sensitive topics, ask questions, and reflect on their biases or assumptions. This modeling helps create a space where students can engage with the subject matter openly and bravely.

Choosing Compassionate and Accurate Language

- Using respectful, non-stigmatizing language is essential when discussing suicide, as terminology can either foster space for honest discussions or perpetuate feelings of shame, blame, and stigma. For example, many individuals who have considered or attempted suicide report that terms like "committing" suicide deterred them from sharing their thoughts; the word "commit" is often used in reference to a crime or sin, carrying an implicit stigma. Preferred language fosters compassion and clarity by describing behaviors objectively rather than assigning subjective and positively or negatively associated labels.
- The table below provides guidance for language that can reduce stigma and increase an individual's willingness to discuss suicidal thoughts and behaviors.

Accurate and Preferred	Inaccurate or Stigmatizing—Eliminate
• "Died of/by suicide"	• "Committed suicide"
• "Suicide"	• "Successful attempt"

• "Suicide attempt"	• "Unsuccessful attempt"
• Describe behavior	• "Manipulative or attention-seeking"
• Describe behavior	• "Suicidal gesture" or "cry for help"
• "Diagnosed with"	• "They're borderline" or "he's manic"
• "Working with"	• "Dealing with" suicidal patients

Goals for Suicide Risk Screening and Assessment

- The goal of suicide risk screening is early identification of patients who exist somewhere on a risk continuum for suicide. In other words, screening tools cast a wide net to help identify individuals who exist somewhere on the risk continuum from fleeting thoughts of not wanting to be here to actively planning to enact one's death. Screening tools are limited in that they do not help healthcare team members understand the unique patient's details related to morbid or suicidal thoughts, planning, or behaviors. Suicide risk assessment builds on screening by adding a framework for gathering salient details that contribute to suicide risk estimates. The goals for suicide risk assessment are to estimate the level of risk and guide corresponding action steps to manage the level of risk.

Suicide Risk Screening and Assessment Tools

- While there are several validated suicide risk identification and measurement tools (e.g., Suicide Assessment Five-Step Evaluation and Triage (SAFE-T), Beck Hopelessness Scale, etc.), the most widely utilized measure across integrated care settings is the Columbia Suicide Severity Rating Scale (C-SSRS). Hopefully, by providing the general principles related to suicide prevention, screening, and assessment outlined by the C-SSRS, the key components can be contextualized for a given setting. Clinical sites may utilize other tools based on considerations such as population served or other setting characteristics.

Key Elements of Assessment

- A thorough and complete assessment of suicidal ideation involves inquiring into the following four areas in sequential order:
    1. Whether the patient has wished to be dead or wished not to be here in the past month.
    2. Whether the patient has had thoughts of suicide or ending one's life in the past month.
    3. If the patient endorses any thoughts of suicide in the past month, ask about:
        a. Specific, detailed plan and intention.
        b. Suicidal behavior or preparation (over their lifetime and specifically in the past 3 months).
        c. Context and stressors.
        d. Reasons for living and protective factors.
    4. Accurately categorize the suicide risk level of the patient.

Estimating Level of Risk

- A patient's responses to the key elements of assessment help inform whether someone is at risk of suicide, the severity and immediacy of that risk, and the level of support needed. The C-SSRS provides a structured approach to suicide risk assessment (see the C-SSRS Risk Assessment in LO-4 Resources for a visual example).

- The color coding on the C-SSRS depicts the risk stratification based on responses to sequential items. Estimated Risk Stratification color code:
    - High risk (red): In need of immediate clinical intervention to address suicidal symptoms.
    - Medium risk (orange): At elevated risk of suicidal behavior in the future and needs clinical intervention.
    - Low risk (yellow): Risk of suicide is not significantly elevated but may benefit from intervention.
- Management plans based on estimated risk level:
    - Low-to-moderate risk: Manage estimated risk with matched safety plan.
    - Severe risk: Refer to emergency services for medical/psychiatric evaluation.

Sample Activities/Assessments for LO-4

Activity: Screening for Suicide Risk

Students complete the self-paced module on assessing and managing suicide risk. This module is provided through the UW Intelligent Tutoring System (ITS).

- Raue, P. (2024). *Discover ITS.* Behavioral Health Support Specialist Clinical Training Program. https://bhss-wa.psychiatry.uw.edu/discover-its/

Specific Resources for LO-4

Resource: C-SSRS Risk Assessment

C-SSRS Protocol: The color coding on the C-SSRS depicts risk stratification.

- Columbia Lighthouse Project. (n.d.). *C-SSRS: About the protocol*. https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/

Resource: Identification & Triage Using the Columbia-Suicide Severity Rating Scale (C-SSRS)

C-SSRS Screener Training: A 25-minute training video produced by the Columbia Lighthouse Project.

- Columbia Lighthouse Project. (2016, October 18). *C-SSRS screener training - English (USA)* [Video]. YouTube. https://www.youtube.com/watch?v=_XTg8nCDoTo

Resource: Preparation for ITS Suicide Screening Modules

Suicide Screening, Assessment, and Management Pre-ITS: This guide is intended to help education partners prepare students for the ITS Modules on Suicide Screening, Assessment, and Management.

- McGuire, A., & O'Connell, W. (2024). *Suicide screening, assessment and management*. Behavioral Health Support Specialist Clinical Training Program. https://bhss-wa.psychiatry.uw.edu/wp-content/uploads/2024/07/Pre-ITS-Suicide.pdf

Resource: Suicide Prevention in Primary Care

Suicide Prevention Toolkit for Primary Care Practices: This toolkit contains tools, information, and resources to implement suicide prevention practices in the primary care setting.

- Suicide Prevention Resource Center. (n.d.). *Suicide prevention toolkit for primary care practices.* https://sprc.org/settings/primary-care/toolkit/

Resource: Zero Suicide Project

Zero Suicide Website: Resource library for developing a suicide prevention plan within an organization.

- Zero Suicide. (n.d.). *Home page.* https://zerosuicide.edc.org/

Resource: Suicide Prevention

American Foundation for Suicide Prevention: This website provides numerous materials to help educate the public about suicide and suicide prevention strategies.

- American Foundation for Suicide Prevention. (n.d.). *Home page.* https://afsp.org/

Resource: Columbia Lighthouse Project

The Columbia Lighthouse Project: This organization's website focuses on the importance of screening and developing action plans to prevent suicide.

- The Columbia Lighthouse Project. (n.d.). *Home page.* https://cssrs.columbia.edu/

LO-5 Describe the key components and principles of developing a safety plan.

Key Terms and Concepts for LO-5

- **safety plan** (also known as a "crisis response plan"): a living document that outlines personal warning signs, coping strategies, and resources to use during a crisis.

Key Teaching Points for LO-5

Safety Plans

- Safety plans are essential for providing individuals with personalized strategies to manage suicidal thoughts and behaviors. The essential components of a safety plan are based on decades of research.
- Safety plans are an ongoing and modifiable plan for coping, helping to teach and expand skills in how to cope with suicidal thoughts or intense distress, until patients have not had those thoughts for at least 30 days.

The Importance of Collaboration

- The development of a collaborative and empathic partnership between BHSSs and patients is central to contemporary approaches to suicide risk assessment. A collaborative approach is an essential ingredient of a shared understanding and consensus on treatment strategies. This approach, centered around the patient, is crucial for fostering participation and adherence to treatment plans, thereby enhancing the efficacy of suicide prevention efforts. By adopting a holistic and collaborative approach, it is possible to make significant advances in suicide prevention broadly, ultimately saving lives and fostering resilience among those at risk.

Sample Activities/Assessments for LO-5

Activity: Developing a Safety Plan Based on Risk Stratification

The instructor or students create or identify three cases with variable levels of risk ranging from low to moderate to high. In pairs or teams, students develop a safety plan for each level of risk, then compare strategies with other students or groups. Students modify their plans based on ideas gathered from colleagues. This approach is intended to encourage consultation and collaboration, which is a paramount skill throughout a BHSS's career.

Specific Resources for LO-5

Resource: Stanley-Brown Safety Planning

Safety Planning Intervention (SPI): This website provides a detailed explanation of the process for safety planning with easy-to-follow instructions. It is well aligned with the needs of novice practitioners and their mentors.

- Stanley, B. & Brown, G. (n.d.). *Stanley-Brown Safety Planning Intervention.* https://suicidesafetyplan.com/

BHSS Advanced

LO-6 Conduct a patient-centered biopsychosocial formulation.

Key Terms and Concepts for LO-6

- **biopsychosocial (BPS) model**: an approach that considers biological, psychological, and social factors, and their intersections, in understanding and addressing a patient's health and well-being.
- **biopsychosocial formulation** (also known as "case formulation"): a structured method to understand and organize information about a patient's presenting problems, drawing from the biopsychosocial model. (See MC4.)

Key Teaching Points for LO-6

History of the Biopsychosocial Model (BPS)

- The BPS model was introduced by George Engel in 1977 and has gained widespread acceptance as the most comprehensive approach to understanding health and illness (Gatchel et al., 2007; Wade & Halligan, 2017). The BPS model continues to be used for case conceptualization across all sectors of healthcare.

Teaching the BPS Model

- The BPS model (see LO-6 Resources) examines how three aspects—biological, psychological, and social—occupy roles in relative health or disease. The BPS model stresses the interconnectedness of these factors. A simple breakdown could include the following:
    - **biological domain (bio):** focuses on the physiological and genetic factors that influence health. This includes a patient's medical history, physical health conditions, genetic predispositions, neurobiology, prescribed medications, and non-prescribed substance use. These factors help identify how the body's systems contribute to the presenting health concern. For example, hormonal imbalances, chronic illnesses, neurological conditions, or substance use disorders may play a significant role in mental health or behavioral disorders.
    - **psychological domain (psycho):** examines emotional and cognitive factors, such as thought patterns, emotions, coping mechanisms, and personality traits. This includes understanding a patient's mental health history, current emotional states (e.g., anxiety, depression), and behavioral tendencies. For instance, stress or trauma can exacerbate physical symptoms and vice versa, highlighting the interplay between mind and body.

- **social domain (social):** emphasizes the influence of relationships, cultural background, socioeconomic status, and environmental factors on health. It includes assessing the patient's support system, work or home environment, and access to resources like healthcare or community support. Social stressors, such as financial strain or social isolation, are key factors that may contribute to or worsen a patient's health challenges.

A Helpful Approach to Gathering and Organizing Biopsychosocial Patient Details

- The biopsychosocial formulation grid provides a structure that can be useful for students. Information gathered from a patient interview, their screeners, and the patient's medical chart can be pulled into a biopsychosocial framework, which addresses each of the three domains. These can be further broken down into the "4 Ps" (see Biopsychosocial Formulation Grid with 4P Factors in LO-6 Resources for a visual example):
  - **predisposing factors (vulnerabilities)**: areas of vulnerability that increase the risk for the presenting problem.
  - **precipitating factors (stressors)**: typically thought of as stressors or other events (they could be positive or negative) that have a time relationship with the onset of the symptoms and may serve as precipitants.
  - **perpetuating factors (maintaining):** any conditions in the patient, family, community, or larger systems that serve to perpetuate rather than ameliorate the problem.
  - **protective factors (strengths):** the patient's own areas of competency, skill, talents, interests, and supportive elements in relationships.

Sample Activities/Assessments for LO-6

Activity: Applying the 4 P Model to BPS Case Conceptualization

Students are provided with a case study and apply the BPS model to identify factors contributing to the patient's presenting concerns. Then they complete a 4 P table summarizing these factors and propose interventions (See LO-6 Resources for example).

Specific Resources for LO-6

Resource: Biopsychosocial Model in Medicine

Three Aspects of Health: A detailed description of the three domains making up the BPS model, including the intersection of each domain and implications for healthcare.

- Megan. (2021, October 10). *Three aspects of health: The biopsychosocial model in medicine.* WashU Medicine Department of Surgery. https://surgery.wustl.edu/three-aspects-of-health-and-healing-the-biopsychosocial-model/

Resource: Proposal for a Biopsychosocial Model

The Need for a New Medical Model: This article proposes a BPS model that provides a blueprint for research, a framework for teaching, and a design for action.

- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(4286), 129–36. https://doi.org/10.1126/science.847460

Resource: Biopsychosocial Formulation Grid with 4 P Factors

4 Ps: This resource depicts the framework with examples of categories that may be included to create a holistic case conceptualization of the patient or client.

- Winters, N. C., Hanson, G., & Stoyanova, V. (2007). The case formulation in child and adolescent psychiatry. *Child and Adolescent Psychiatric Clinics of North America, 16*(1), 111–132. https://www.academia.edu/figures/4102576/table-1-biopsychosocial-formulation-grid-with-examples-of

Resource: Formulation and the BPS Model

Formulation: This resource is designed for teaching the 4 P factor model and provides examples of case study formulations using fairy tale characters.

- EMentalHealth.ca. (n.d.). *Formulation and the biopsychosocial model: Introduction for psychiatry residents.* https://www.ementalhealth.ca/index.php?m=articlePDF&ID=69575

LO-7 Use the results of screening data to identify areas of concern, symptom severity, and initial patient needs.

Key Terms and Concepts for LO-7

- **cutoff scores:** a specific numerical point on a screening tool that determines whether an individual is considered likely to have a mental health concern, with scores above the cutoff indicating a potential need for additional assessment or treatment. These scores are typically established based on research to balance sensitivity (identifying true cases) and specificity (excluding false positives) for a particular population and screening tool.

Key Teaching Points for LO-7

What to Do with the Results of Screening Data

- What do the results mean? Building on the teaching points in LO-1, screening tools can serve different functions. They may cast a wide net to identify individuals at risk for mental health or substance use concerns (e.g., PHQ-2), or they may measure symptom severity, frequency, or functioning in a more targeted manner (e.g., PHQ-9). Every time a screening tool is administered, it is imperative that the results are reviewed and scored, and the appropriate care team member initiates any indicated procedural steps.

Importance of Reviewing Individual Items and Total (or Subcategory) Score

- Consider question nine on the PHQ-9, which asks the patient if they have experienced any thoughts that they would be better off dead or hurting themself in some way in the past two weeks. A failure to notice if a patient has endorsed this question could be the difference between the patient receiving further assessment to decipher their level of suicide risk and safety planning, or missing the opportunity to provide potentially life-saving interventions matched to the needs of the patient. Further, failure to act may expose care team members and organization to liability related to standard of care. Of note, many settings with screening tools built into their EHR will have methods for flagging or alerting members to individual response items or total scores that are considered higher risk. BHSSs will benefit from reviewing any written policies, i.e., specific workflows related to patient safety, including suicide risk.

Strategies for Entering a BHSS Practicum Setting

- BHSS students are encouraged to prepare for a practicum setting by completing the following steps:
  - Review the practicum setting's policies for scoring thresholds, high-risk alert procedures, and follow-up workflows.
  - Become familiar with automated flagging systems in the EHR and the BHSS role in escalating any flagged results, for example, identify which care team members are automatically alerted directly to their inbox.
  - Be equipped with screener-specific knowledge of what to do if single items are left blank.

Sample Activities/Assessments for LO-7

Activity: Analyzing a Mock Patient Dataset

Students analyze a mock patient dataset by independently scoring the results, including any relevant severity classifications, and defining areas of concern and potential interventions.

Specific Resources for LO-7

Resource: Example Workflow Policy for High-Risk Patients

Example Workflow: This example highlights a workflow for a BHSS working as a Behavioral Health Care Manager on a Collaborative Care team.

- AIMS Center. (n.d.). *PHQ-9 workflow sample.* https://aims.uw.edu/nyscc/training/wp-content/uploads/2024/03/PHQ-9-Sample-Workflow.pdf

Resource: Protocols for Flagging Patients with Behavioral Health Needs

Protocol Guidance: This guidance provides step-by-step instructions for establishing protocols and may be used as a resource for a classroom activity.

- Agency for Healthcare Research and Quality. (2025). *Establish protocols to identify patients who could benefit from integrated care.* https://integrationacademy.ahrq.gov/products/playbooks/behavioral-health-and-primary-care/implementing-plan/establish-protocols-identify-patients-who-could-benefit-integrated-care

LO-8 Review and interpret a valid suicide risk assessment tool, including estimated risk level and next step recommendations.

Key Teaching Points for LO-8

Importance of Structured Suicide Risk Assessment

- As was covered in LO-1, LO-4, and LO-5, using validated assessment tools is an important component in estimating a patient's risk stratification (e.g., low, medium, or high risk) and gauging the interventions best matched to a patient's estimated risk. The Columbia-Suicide Severity Rating Scale (C-SSRS) is widely used in integrated care settings.

Interpreting Risk Levels

- Responses to suicide risk assessment tools guide risk categorization (e.g., low, moderate, high) and inform immediate care decisions.
- Examples of ineffective approaches and common pitfalls:
    - Skipping questions or moving on prematurely.
    - Minimizing the patient's feelings or experiences.
    - Conveying disapproval or negative judgment about a patient's experience.
    - Asking questions that lead a patient toward denying suicidal thoughts.
    - Failing to inquire specifically about suicidal thoughts in the past month.
    - Not asking about suicidal behavior or preparations for both lifetime and the past three months.
    - Stating they will seek out their supervisor without completing the full suicide risk assessment.

Supervisory Expectations

- The supervisor will prepare for a BHSS student's arrival in the clinical setting by engaging the organization's stakeholders in discussion and agreement on the role and scope for the BHSS student.
    - Stakeholders will benefit from knowing that students receive instruction and interactive training covering suicide risk assessment and safety planning. Parties should define and agree on processes and procedures for how the BHSS will respond when encountering patients at some level of risk of suicide.
    - Discuss in detail, and as part of initial onboarding, what role a BHSS student will have in suicide risk assessment during their practicum. A scaffolding training model can be a valuable and developmentally appropriate approach to supporting the BHSS across their practicum. Some example steps in scaffolding could include the following:
        - BHSS observes supervisor performing suicide risk assessment and safety planning.
        - BHSS role plays conducting a suicide risk assessment and safety planning with supervisor in hypothetical patient role.
        - BHSS observes and documents suicide risk assessment and safety planning.
        - BHSS conducts suicide risk assessment while supervisor observes.
- The supervisor documents the suicide assessment role, scope, and procedures for the BHSS student.

Recommendations for Students

- BHSS students should clarify their role in suicide risk assessment within their practicum, including required supervisory oversight for assessment and safety planning.

Sample Activities/Assessments for LO-8

Activity: C-SSRS Case Scenario

Students receive a case scenario with completed C-SSRS responses and determine the risk level and appropriate next steps.

Activity: Assessing and Managing Suicide Risk

ITS uses productive struggle theory to help teach students the application of the C-SSRS using patient case examples.

- Raue, P. (2024). *Discover ITS.* Behavioral Health Support Specialist Clinical Training Program. https://bhss-wa.psychiatry.uw.edu/discover-its/

Specific Resources for LO-8

Resource: Suicide Screening and Assessment

Suicide Screening: A helpful guide distinguishing screening from assessment with steps to stratifying risk in patients and clients.

- Suicide Prevention Resource Center. (2014, September). *Suicide Screening and Assessment*. Waltham, MA: Education Development Center, Inc. https://sprc.org/wp-content/uploads/2022/12/RS_suicide-screening_91814-final.pdf

BHSS Practicum

LO-9 Demonstrate the ability to administer, interpret, and discuss results from behavioral health screening tools utilized in a practice setting with a patient.

Key Teaching Points for LO-9

Observe, Assist, Do

- Practicum supervisors are encouraged to immerse students in opportunities to administer and interpret behavioral health screening results with patients and clients. Using the "observe, assist, do" framework, supervisors may delegate responsibilities to experienced team members to guide the practicum student from beginning to proficiency with one or more screening tools.

Sample Activities/Assessments

Activity: Screening Measure Role Play

This activity may be used in the practicum setting or a seminar hosted by the higher education institution. In groups of three, students participate in role plays with one BHSS, one hypothetical patient, and one observer. Students practice introducing a screening measure, then verbally administering the measure with the patient's consent, followed by providing the patient with a patient-centered explanation of the results.

Specific Resources for LO-9

Resource: Best Practices for School Settings

Sharing Screening Results: A guide for practitioners supporting school-based mental health. Provides step-by-step instructions for selecting, administering, interpreting, and discussing results with students and families.

- Connors, E. (2024). *Best practices for sharing screening or assessment results with students and families*. University of Maryland. https://health.maryland.gov/mchrc/Documents/002%20-%20MD%20Consortium%20Documents%20&%20Info/03%20-%202025%20Documents/Best%20Practices%20for%20Sharing%20Screening%20or%20Assessment.pdf

Resource: Mental Health Screening Guide

Screening Guide: Provides an overview of developing, implementing, and monitoring screening procedures across a variety of settings, including schools, specialty mental health, and integrated care settings.

- Texas Education Agency. (n.d.). *Mental health screening guide.* https://schoolmentalhealthtx.org/wp-content/uploads/2021/09/MentalHealthScreeningGuideTool.pdf

LO-10 Collaborate with care team and supervisor to develop patient safety plans when appropriate.

Key Terms and Concepts for LO-10

- **safety planning**: A collaborative, evidence-based intervention designed to help individuals at risk of suicide manage their thoughts and urges in moments of crisis. It is a practical, personalized plan developed between a clinician (or trained professional) and the individual, focusing on immediate coping strategies and support resources.

Key Teaching Points for LO-10

Teaching New Practitioners Safety Planning

- The Stanley-Brown Safety Planning Intervention is a recognized model with structured steps:
  - Recognize warning signs.
  - Use internal coping strategies.
  - Engage social contacts.
  - Contact support individuals.
  - Reach out to supervisors and care team members.
  - Reduce access to lethal means.

Sample Activities/Assessments for LO-10

Activity: Practicum Preparation

Supervisors are encouraged to review the Stanley-Brown Safety Planning Intervention and apply it with a patient that the BHSS student may observe or assist with during their practicum. Debriefing the intervention with the student is an optimal learning experience.

Activity: Round Robin

Use a round robin technique whereby one person is a patient or client for a group of students. Pairs of students collaborate to deliver each of the structured steps of the Stanley-Brown Safety Planning Intervention. The instructor may act as a guide, ask questions, and discuss possible consequences of decisions with students.

Specific Resources for LO-10

Resource: Stanley-Brown Safety Planning

SPI: This website explains in detail the process for safety planning with easy-to-follow instructions. It is well aligned with the needs of novice practitioners and their mentors.

- Stanley, B., & Brown, G. (n.d.). *Stanley-Brown Safety Planning Intervention.* https://suicidesafetyplan.com/

Chapter or Unit Summary

This chapter explores the foundational role of systematic screening and assessment in improving behavioral health outcomes across integrated care and specialty settings. It begins by outlining the importance of mental health and substance use screening in primary care and other non-specialty environments, emphasizing early identification and intervention. Tools such as the PHQ-9, GAD-7, and AUDIT-C (Alcohol Use Disorders Identification Test-Consumption) are highlighted for their reliability, ease of use, and adaptability across diverse populations.

The chapter then transitions to suicide screening and risk assessment, underscoring the urgency of routine suicide risk evaluation in both general and high-risk populations. Evidence-based tools like the C-SSRS and the Ask Suicide-Screening Questions (ASQ) are discussed, along with best practices for follow-up assessment and safety planning. The importance of clinician training and system-level protocols to ensure a timely response to positive screens is emphasized.

Finally, the chapter introduces measurement-based care (MBC) as a transformative approach to behavioral health treatment. MBC involves the regular use of validated outcome measures to monitor patient progress and inform clinical decision making. The chapter reviews the evidence supporting MBC's effectiveness in improving engagement, treatment outcomes, and provider accountability. Implementation strategies, including digital tools and feedback systems, are discussed to support integration into routine care.

Together, these practices form a cohesive framework for delivering proactive, data-informed, and patient-centered behavioral health services.

Annotated Bibliography

Ki, M., Lapierre, S., Gim, B., Hwang, M., Kang, M., Dargis, L., Jung, M., Koh, E. J., & Mishara, B. (2024). A systematic review of psychosocial protective factors against suicide and suicidality among older adults. *International Psychogeriatrics, 36*(5), 346–370. https://www.intpsychogeriatrics.org/article/S1041-6102(24)00188-1/fulltext

- This 2024 systematic review focuses on psychosocial protective factors that reduce suicidality in older adults. Analyzing 70 empirical studies, the authors identify 15 key factors (e.g., resilience, purpose in life, and social connectedness) that are consistently associated with lower suicidal ideation. The review emphasizes the importance of enhancing these protective elements in late-life suicide prevention strategies, shifting the focus from risk factors to strengths-based interventions. It also suggests that using comprehensive scales to measure these factors yields more accurate insights than single-item assessments.

Lewis, C. C., Boyd, M., Puspitasari, A., Navarro, E., Howard, J., Kassab, H., Hoffman, M., Scott, K., Lyon, A., Douglas, S., Simon, G., & Kroenke, K. (2021). Implementing measurement-based care in

behavioral health: A review. *JAMA Psychiatry, 78*(3), 259–268. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2718629

- This narrative review synthesizes the current evidence base for MBC in behavioral health, highlighting its effectiveness in improving patient outcomes and identifying deterioration early. The authors explore barriers to implementation at multiple levels—patient, provider, organizational, and systemic—and propose strategies grounded in implementation science to overcome them. These include the use of feedback systems, leadership training, and aligning reimbursement structures. The article also presents a 10-point research agenda to advance MBC integration, making it a foundational resource for clinicians and administrators who aim to adopt MBC practices.

Mann, J. J., Michel, C. A., & Auerbach, R. P. (2021). Improving suicide prevention through evidence-based strategies: A systematic review. *American Journal of Psychiatry, 178*(7), 611–624. https://doi.org/10.1176/appi.ajp.2020.20060864

- This comprehensive systematic review evaluates 97 randomized controlled trials and epidemiological studies to identify scalable, evidence-based suicide prevention strategies. The authors highlight the effectiveness of training primary care physicians, educating youth, and providing active follow-up after psychiatric discharge. They also discuss the potential of emerging technologies such as EHR algorithms and smartphone monitoring. The review underscores the importance of combining multiple strategies within healthcare systems and calls for broader implementation of proven interventions, including means restriction and cognitive behavioral therapies.

Resnick, S. G., Oehlert, M. E., Hoff, R. A., & Kearney, L. K. (2020). Measurement-based care and psychological assessment: Using measurement to enhance psychological treatment. *Psychological Services, 17*(3), 233–237. https://doi.org/10.1037/ser0000491

- This article explores the intersection of psychological assessment and MBC, emphasizing the use of patient-reported outcome measures (PROMs) to guide treatment decisions. The authors argue that integrating MBC into routine care enhances collaboration between patients and providers, supports goal setting, and improves treatment outcomes. The paper also discusses the application of MBC in special populations and highlights advances in psychological assessment that support its implementation. It serves as a practical guide for mental health professionals seeking to embed MBC into their clinical workflows.

Woodward, D., Wilens, T. E., Glantz, M., Rao, V., Burke, C., & Yule, A. M. (2023). A systematic review of substance use screening in outpatient behavioral health settings. *Addiction Science & Clinical Practice, 18*(1), Article 18. https://doi.org/10.1186/s13722-023-00376-z

- This systematic review examines the prevalence and implementation of substance use screening in outpatient behavioral health clinics. The authors found that while screening rates varied widely (48–100%), many clinics successfully screened over 75% of patients. However, the review highlights a lack of consistency in screening practices and limited demographic data. The findings underscore the need for standardized, routine screening protocols and further research into clinic-level factors that influence implementation success.

References for this Chapter

Bailey, R., Sharpe, D., Kwiatkowski, T., Watson, S., Samuels, A. D., & Hall, J. (2018). Mental health care disparities now and in the future. *Journal of Racial and Ethnic Health Disparities, 5*, 351–356. https://doi.org/10.1007/s40615-017-0377-6

Carlo, A. D., Scott, K. S., McNutt, C., Talebi, H., & Ratzliff, A. D. (2024, October 8). Measurement-based care: A practical strategy toward improving behavioral health through primary care. *Journal of General Internal Medicine, 40,* 677-681. https://doi.org/10.1007/s11606-024-08877-6

Centers for Disease Control and Prevention. (2024, October 16). *Understanding literacy and numeracy*. https://www.cdc.gov/health-literacy/php/about/understanding-literacy.html

Fortney, J. C., Unützer, J., Wrenn, G., Pyne, J. M., Smith, G. R., Schoenbaum, M., & Harbin, H. T. (2017). A tipping point for measurement-based care. *Psychiatric Services*, *68*(2), 179–188. https://doi.org/10.1176/appi.ps.201500439

Gatchel, R. J., Peng, Y. B., Peters, M. L., Fuchs, P. N., & Turk, D. C. (2007). The biopsychosocial approach to chronic pain: Scientific advances and future directions. *Psychological Bulletin*, *133*(4), 581–624. https://doi.org/10.1037/0033-2909.133.4.581

Office of Disease Prevention and Health Promotion. (n.d.). *Health literacy in healthy people 2030.* U.S. Department of Health and Human Services. https://odphp.health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030

Scott, K., & Lewis, C. C. (2015). Using measurement-based care to enhance any treatment. *Cognitive and Behavioral Practice, 22*(1), 49-59. https://doscotti.org/10.1016/j.cbpra.2014.01.010

Wade, D. T., & Halligan, P. W. (2017). The biopsychosocial model of illness: A model whose time has come. *Clinical Rehabilitation*, *31*(8), 995-1004. doi:10.1177/0269215517709890