D.10 SUICIDE PREVENTION

U.S. Department of Veterans Affairs New York/New Jersey VA Health Care Network Albany VA Medical Center Stratton VAMC SP SOP 116-001 February 2, 2018

SUICIDE PREVENTION

1. **<u>PURPOSE</u>**: To outline the procedures and provide guidance for the assessment and management of patients at risk for self-directed violent behavior with suicide intent.

2. <u>**RESPONSIBILITIES**</u>:

- a. The Medical Center Director or designee is responsible for assuring their facility is in compliance with these procedures.
- b. The facility Chief of Mental Health Services is responsible to ensure staffing is provided to fulfill suicide prevention requirements and that all facility staff are educated about and implement these responsibilities, procedures and requirements.
- c. The facility Suicide Prevention Coordinator (SPC) is responsible to oversee the management of referrals from the Veterans Crisis Line, all suicide prevention outreach initiatives, and the implementation of nationally directed and otherwise evidence-supported suicide prevention practices. The SPCs assign Category I Patient Record Flags (PRF) for patients identified as being at high risk for suicide, and, working collaboratively with the high risk Veteran's Mental Health Treatment Coordinator, initiate and oversee the implementation of enhanced care and monitoring protocols throughout the medical center.
- d. The facility Suicide Prevention Case Manager(s) provide enhanced care and monitoring (above and beyond usual care) in support of the suicide prevention program and provide back-up to the Suicide Prevention Coordinator if/as needed.
- e. VA clinical staff are responsible to ensure that all Veterans are appropriately screened for depression and assessed for suicide risk as established herein, and to utilize the appropriate mental health screening tools, assessment tools, and notification processes.
- f. All licensed independent practitioners (LIPs) are responsible for ensuring that the patients are appropriately managed, even when the patient requires additional care such as one to one observation, seclusion and/or restraints, or an involuntary admission.
- g. All VA employees who learn about a Veteran who has made preparations for or has engaged in an act of a self-directed violence within the past 90 days are responsible to report this information to the local Suicide Prevention Coordinator or Suicide Prevention Case Manager directly and immediately. VA clinical staff have additional CPRS reporting responsibilities outlined in the procedures section.

h. All VA employees are required to receive SAVE and additional suicide prevention training as required and follow their facility's local procedure for responding to suicide crises, whether in person or by phone.

3. <u>PROCEDURES</u>:

- a. All VA employees who learn of a Veteran patient who has made preparations for or has engaged in an act of a self-directed violence, including a suicide, are required to report this information to the local Suicide Prevention Coordinator or his/her designee directly (by phone or in person) as soon as possible.
- b. The behavioral health suicide risk assessment (BHSRA) will be completed by the treating behavioral health clinician at the start of their behavioral health treatment (i.e., first behavioral health face-to-face encounter), and then annually thereafter by their mental health treatment coordinator (MHTC) or designee. (Refer to Attachment A.)
 - (1) Behavioral health clinicians must indicate the Veterans' current suicide risk level determination, specifically "high," "moderate," or "low," on every behavioral health individual encounter note.
 - (2) In addition, behavioral health clinicians must note indications of changes in Veterans' current suicide risk level (or lack thereof) in all group encounter notes.
- c. Clinical staff must complete the annual post traumatic stress disorder (PTSD) screen and depression screen (PHQ-2 or PHQ-9) reminders (for VA patients who do not already have these diagnoses and are not actively involved in behavioral health care).
 - When either the PTSD or depression screen is positive, the clinical staff person completing the screen must initiate the process of the completion of the positive depression screen (or positive PTSD screen) reminder. A qualified licensed independent provider (LIP) must complete the positive depression reminder (or positive PTSD screen) within 24 hours . (See process described in Attachment B). The following lists the approved LIPs to do this: MD, NP, DO, PhD, or PsyD. LMSW, LCSW, APN or PA.
 - (2) When the LIP following up on the positive PTSD or positive depression identifies elevated suicide risk, he/she must complete the Behavioral Health Suicide Risk Assessment in CPRS (Attachment A), or when possible and appropriate, ensure that a mental health provider is assigned to complete it.
- d. When it is determined that a patient is at high risk for suicide or self-directed violence, the LIP is required to address the nature of the situation in a manner that is clinically indicated such as: one-to-one observations, admission to acute inpatient

psychiatry, etc. In addition, the provider must notify the facility SPC who will initiate the Category I PRF and place the patient on the high risk list.

- e. The Suicide Prevention Coordinator will place on the high risk list any patient admitted for psychiatric hospitalization after having made preparations for or engaged in self-directed violence with any level of suicide intent, or who is otherwise assessed as high risk for suicide. The PRF is to be placed on the day of discharge and maintained on the high risk list with corresponding enhanced care and monitoring protocols for a period of at 90 days (or longer as indicated).
 - (1) Each time there is an act of self-directed violence with any level of suicide intent, a peer review screening will be conducted by the SPC. If indicated, the SPC will recommend to the corresponding Chief of the Service Line additionally review the case, ultimately to make a recommendation to the Chief of Staff about whether or not a peer review should be conducted.
 - (2) Other reporting and reviews such as Root Cause Analyses, Quality Peer Reviews, and Issue Briefs will be done in accordance with the guidelines outlined by the "10N Guide to Issue Briefs," last updated in September, 2015.
- f. When behavioral health clinicians learn of a recent (within 90 days) act of self₋ directed violence (SDV) or that suicide preparations were made and there was indication of any level of suicide intent, a "high risk" determination is required, and the following actions must be initiated by that behavioral health clinician:
 - (1) Complete a Suicide Behavior Report (SBR) with as much detail as possible about the event. (Attachment C)
 - (2) Complete and/or update of the Behavioral health Suicide Risk Assessment.
 - (3) Complete a safety plan (Attachment D) during the same visit if possible (when patient is not immediately hospitalized), and
 - (4) Directly notify the SPC by phone and/or email (and not just view alert).
 - (5) In addition, the behavioral health clinician who learns of any suicide attempt within the past year should complete the Suicide Behavior Report.
- g. When a patient is placed on the high risk list, the Mental Health Treatment Coordinator or designee must:
 - (1) Provide a face to face encounter visit with the patient within 7 days of discharge (or placement of the PRF) and then no less that one additional visit per each subsequent 7 day period until 30 days from that time.

- (2) Provide face to face encounters that include a clinical assessment of the high risk Veterans current suicide risk. All efforts to achieve a face to face meeting are to be pursued as clinically appropriate, which may be determined in collaboration with the facility suicide prevention staff. Phone encounters may be a substitute for face to face encounters, based on the Veterans' needs and desires. These encounters must be documented and should be no less than 11 minutes as possible and appropriate.
- (3) Complete a Suicide Prevention Safety Plan and review it each session, along with updated documentation specifying risk level.
 - (a) If the patient is admitted to an acute psychiatry unit with self-directed violence preparations, acts or ideation with suicide intent, a Suicide Prevention Safety Plan is to be completed with the patient prior to discharge.
 - (b) When the patient is being seen as an outpatient, the behavioral health provider is to complete the safety plan with the patient as soon as possible after a high risk designation, but no later than the next scheduled appointment.
 - (c) The safety plan is to be reviewed at every outpatient encounter while the patient is on the high risk list.
- (4) Review the patient's mental health diagnosis in light of the self- directed violent behavior and make sure there is a care plan in place that:
 - (a) Addresses the patient's conditions and limitations;
 - (b) Includes ongoing monitoring for suicidality and/or self directed violence and plans for periods of increased risk
 - (c) Includes processes for following up on missed appointments
 - (d) Includes education and a plan for means reduction (means of suicide)
 - (e) Identifies a family member/friend to be involved in care or contacted if necessary
 - (f) Ensures that specific treatments with the potential for decreasing suicidal risk have been considered (e.g., clozapine for schizophrenia and lithium for bipolar illness)
- (5) Consult with the SPC or SPCM on matters pertaining to patient safety, including but not limited to times when:
 - (a) There is a need for clarification about a suicide prevention procedure.

- (b) When in need of assistance in determining risk level, especially when ruling in or out a "high risk" determination.
- (c) A high risk patient does not show for an appointment and cannot be located.
- (d) A high risk patient terminates treatment or reduces the frequency of treatment to the extent that enhanced care and monitoring will likely not be effective.
- (6) When a high risk Veteran is a no call and no show to his or her scheduled appointment, a "no show" note is to be entered by the treating mental health clinician that automatically generates a letter sent to the Veteran. In addition, at least three attempts should be made to reach the Veteran by the behavioral health clinicians. As indicated, suicide prevention team staff members may be asked to assist with these follow-up calls. When contact is made, the reasons for the no-show as well as the documentation of risk level impressions should be made. If contact is not made, consideration should be given to conducting a welfare check; this may be done in consultation with the suicide prevention team or supervisory staff. The documentation of the no-show and related steps must be fully documented.
- h. The facility SPC will maintain the high risk list.
 - (1) All patients identified as high risk must have a Category I Patient Record Flag (PRF) that is to be initiated by the SPC or designee. The PRF will indicate the patient is at high risk for suicide, explain the reasons for the high risk determination, and offer specific enhanced care and monitoring instructions. An electronic progress note will accompany each flag. The processes related to the Category I PRF's will comply with VHA Memorandum 10/17/12, "National Patient Record Flag for High Risk for Suicide."
 - (2) The PRF will be reviewed after 90 days; it will be removed unless the patient continues to be at high risk, and this will be determined by the SPC by chart review and/or in consultation with the MHTP.
 - (3) When possible, if a Veteran is identified as high risk and is placed on the facility high risk list, the SPC, SPCM or designee will make face-to-face contact with the Veteran to explain the enhanced care and monitoring protocols.
 - (4) Referrals to the US Mail program will be made by the Mental Health Treatment Coordinator (MHTC) or other treating clinicians by direct communication to the SPC when a patient (actively or recently on the high risk list) prematurely disengages from recommended behavioral health treatment. Other Veterans at risk may who disengage from treatment may be added to the US Mail outreach program list as well by any clinician. The SPC team will send friendly letters to

those added to the high risk list routinely for up to two years or until the Veteran re-engages in behavioral health treatment.

- (5) Behavioral health clinicians should conduct a welfare check for high risk and other patients when there are indications of potential imminent suicide risk. The Suicide Prevention Welfare Check template (Attachment E) can be used to document the details of such a welfare check.
- (6) The SPC and SPCM will initiate the process of a "psychiatric time out" for all high risk Veterans on the inpatient psychiatry unit who engaged in preparations or acts of self-directed violence with a high level of intent that was interrupted, prior to admission. Additionally, any inpatient or outpatient clinical staff member involved with a high risk Veteran's care may request a "psychiatric time out" for a high risk patient at any time prior to the scheduled discharge date, and these will be carried out at the discretion of the attending psychiatrist. The "psychiatric time out" process that includes a review of the "Discharge Readiness Checklist" will be conducted prior to the patient's discharge from the psychiatric unit, and the results will be documented in CPRS.
- i. The facility SPC and SPCM will process Veterans Crisis Line Referrals in a manner consistent with national policies.
 - (1) The facility SPC and/or SPCM will review, respond to referrals within one business day, and close out referrals from the Veterans Crisis Line in a timely manner, in some cases consulting with MHTC to determine the most appropriate action to take.
 - (2) The suicide prevention staff, or a designee, will connect Veterans, referred by the Veterans Crisis Line, to services as appropriate, according to their needs and desires.
- j. Mental Health Residential Rehabilitation Treatment Programs (MHRRTP) programs will implement additional measures to ensure a culture of safety is maintained in the SARRTP program, to include enhanced annual training for staff, Operation SAVE training for residents, and routine suicide risk assessment (and as indicted safety planning) for residents, consistent with the national Memorandum entitled, "Improving the Culture of Safety in Mental Health Residential Rehabilitation Treatment Programs."
- k. Behavioral health clinicians who become involved with patients who are ineligible for VA care and who present with suicide risk to behavioral health, whether at the medical center or in the community based outpatient clinics, will be evaluated for level of risk utilizing the behavioral health suicide risk assessment. Suicide prevention staff should be consulted to provide assistance as needed.

- (1) Those individuals who are found to have acute risk for suicide shall be sent to the nearest emergency room, including the VAMC ED when presenting at the VAMC.
- (2) In cases where acute risk is not identified, the individual seeking care should be referred to an outside provider based on insurance coverage, or in the absence of any insurance coverage, they should be referred to their local county mental health facility. For assistance with locating an appropriate provider, contact the NYS Office of Mental Health Director, Bureau of Community Outreach and Public Education, at (518) 474-7585.
- 1. All behavioral health staff must use the nationally scripted outgoing voicemail message indicating how to address a mental health emergency, as well as how to reach the Veterans Crisis Line (VCL). All calls coming into the main auto-attendant at the VA medical center will include a prompt to press a number that will directly transfer that call to the Veterans Crisis Line. All transfers made by medical center staff to the VCL must use a "warm transfer" process, wherein a conference call is used to introduce the Veteran to the VCL responder.
- m. The facility SPC, SPCM and/or designees with conduct outreach in the form of materials distribution, SAVE, other gatekeeper trainings, and other Veteran-specific and approved suicide prevention training at an average rate of five per month.
- n. The suicide prevention team will add all patients identified as being at high risk for suicide to the national Suicide Prevention Application Network (SPAN) database by to satisfy national reporting requirements. In addition, those events of self-directed violence acts, preparations and death with suicide intent (or undetermined intent) will be added to the events screen in the (SPAN) database.
- o. The Suicide Prevention Coordinator and the facility Patient Safety Officer will lead routine inspections (no less than quarterly) of the inpatient psychiatry unit with the interdisciplinary inspection team (ISIT); identify, categorize and prioritize hazards for any/all environmental patient safety issues; and, mitigate identified issues as expeditiously as possible. All mitigations will be reported semiannually to the National Suicide Prevention Office using the Patient Safety Assessment Tool (PSAT) submission process. In addition, the inpatient psychiatry team and others who access the inpatient unit will complete annual training in TMS on environment of care safety. In addition, the inpatient psychiatry staff and the ED staff will be reminded routinely (i.e., no less than once each year) by the SPC about common and uncommon potential environmental hazards to be aware of in their settings. Ad hoc safety alerts will also be brought to the attention of the inpatient psychiatry team when they are received for just-in-time training.

- p. All non-behavioral-health hospital staff members who receive a phone call from a Veteran who is suicidal should follow the guidance described in Attachment F, "Responding to Suicide Ideation: Phone Calls."
- q. Primary care, specialty care and CBOC clinical teams, including prescribers, nurses and LPNs, are to follow the guidance in Attachment G, "Decision Trees…" pertaining to Veterans presenting with suicidal behavior.
- 4. <u>REFERENCES</u>: VHA Memorandum 10/17/12, "National Patient Record Flag for High Risk for Suicide;" Joint Commission 2018 National Patient Safety Goals (15.01.01); VHA Directive 1071, Mandatory Suicide Risk and Intervention Training for VHA Employees 12/22/17; VHA Memorandum 7/13/10, Safety Plans for High Risk Veterans; VHA Memorandum, Improving the Culture of Safety in Mental Health Residential Rehabilitation Treatment Programs, 11/15/12; VHA Handbook, 1160.06 Inpatient Mental Health Services, 9/16/13; VHA Directive 1167, Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients, 5/12/17; and, the 10N Guide to Issue Briefs, 7/24/17.
- 5. **<u>RECISSIONS</u>**: SOP SL 01-213 dated February 5, 2013.
- 6. <u>FOLLOW-UP RESPONSIBILITY</u>: Joseph Hunter, PhD, LCSW, Suicide Prevention Coordinator
- 7. **<u>REVIEW</u>**: This SOP is scheduled to be reviewed on February 2, 2021.

8. CONCURRENCE:

Director Associate Director Chief of Staff Suicide Prevention Service Chief

ATTACHMENTS

- A Behavioral Health Suicide Risk Assessment
- B Suicide Risk Screen
- C Suicide Behavior Report
- D VA Safety Plan
- E Suicide Prevention Welfare Check Template
- F Responding to Suicide Ideation: Phone Calls
- G Decision Trees for Specialty Care Clinical Staff regarding Suicide Behavior

U.S. Department of Veterans Affairs New York/New Jersey VA Health Care Network Albany VA Medical Center

Attachment A
Behavioral Health Suicide Risk Assessment

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is. Is patient currently or has patient recently experienced	
suicidal ideations? • Yes C No C Refused (If yes, describe dates, types, level of intent, and precipitants of the	
(if yes, describe dates, types, level of intent, and precipitants of the suicidal crises)	
1b. Has patient experienced suicidal ideations in the past? 🗠 Yes 🗅 No 🗋 Refused	1
2. Any history of preparations or events of self-directed violence with	
suicidel intent? (Refer to Reports Tab, Health Summary, Buicide Documentation Review)	
C N0	
	1
C REFUSED	
3. Warning Signs/Other Risk Indicators:	
(Discuss each area with patient)	
*C Yes C No C Refused Significant enwiety	
*C Yes C No C Refused Sleep disturbance	
* Yes C No C Refused Current or chronic pain issues	
*□ Yes □ No □ Refused Active alcohol or other substance abuse	
*□ Yes □ No □ Refused Engaging in sisky behaviors	
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*C Yes C No C Refused Psychosocial stressors *C Yes C No C Refused Increased avoidance or isolation	
*C Yes C No C Refused Increased avoidance or isolation *C Yes C No C Refused Has not sought out help during times of crisis	
"C Yes C No C Refused Currently talks of death, dying or suicide	
"C Yes C Ho C Refused Perceives self as a burden to others	
*C Yes C No C Refused lacks a sense of belongingness or lacks social supports	
*○ Yes ○ No ○ Defused Lacks life meaning or purpose	
*C Yes C No C Refused Sense of hopelessness	
*C Yes C No C Refused Crisis related anniversaries	
*C Yes C No C Refused Infrequent adherence to prescribed psychotropic medications	
If yes, please explain below:	
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7. Clinical impression of suicide lavel of risk:	
DESCRIPTION OF NICH RISK LEVEL	
Consider immediate emergency intervention and/or psychiatric admission,	
particularly when safety planning is refused by patient. The suicide	
prevention team should be directly notified. A Suicide Prevention Safety Flam note	
must be completed with the patient and in CPRS, as soon as possible. If imminent	
risk-do NOT LEAVE PATHEFT ALONE.	
DESCRIPTION OF INTERMEDIATE RISK LEVEL	
A Suicide Prevention Safety Plan should be considered, especially if there is a history of suicide	
attempt or suicide ideation in the past 30 days. The Suicide Prevention Safety Flan note should be	
completed with the patient and in CDDS. The mulcide prevention team is to be added as an additional	
signer to this Suicide Disk Assessment note.	
DESCRIPTION OF LOW RISK LEVEL	
Fatient may have a mental illness diagnosis or substance abuse problem with	
relative abundance of coping strengths and resources. Ho history of suicidal self-	
diemetmd violemen, chronic muicidal ideation or history of impulsivity.	
C Righ	
La andecementative .	
a Low Risk Level justification: *	
ing ingeligence	
Fatient was not willing or was unable to answer one or more questions, so the	
final risk determination is based on incomplete information.	
(If any answers above are listed as refused-please list reasons below)	
 Level of care recommendations, based on current suicide risk level. 	
•	
6 No treatment indicated at present time	
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Attachment B Suicide Risk Screen

🖉 Reminder Resolution: *REVISED Depression Screening FY09	×
Click here to follow up on Positive PHQ-2s.	-
(Can be done by an MD, NP, DO, PhD or PsyD Psychologist, LCSW, APN, PA	
for intervention and treatment.)	
SUICIDE RISK ASSESSMENT SCREEN: (**REQUIRED**)	
Are you feeling hopeless about the present or future?	
O No	
C Yes	
Have you had thoughts about taking your life?	
C No	
C Yes	
Have you ever had a suicide attempt?	
C No	
C Yes	
Is Patient demonstrating suicidal ideations/behaviors/risks?	
C No	
C Yes	
	J
Clear Clinical <u>M</u> aint <u>Vi</u> sit Info < Back Next > Finish Cancel	
	-
*REVISED Depression Screening FY09 : SUICIDE RISK ASSESSMENT SCREEN: (**REQUIRED**)	-
	-
Health Factors: DEPRESSION ASSESS COMPLETE, SUICIDE RISK ASSESSMENT DONE	
* Indicates a Required Field	

/ Rem	ninder	Resol	ution: *Denressi	on Screening FYO9)			×
				SCREEN: (**REQU				
						futurol		
	Are you feeling hopeless about the present or future?							
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		Com	ment:					
	Have	you	had thoughts	about taking	your life?			
	0	No						
	© Yes							
		_	did you have erday	these though	ts? *		_	
		-		n to take you:	r life?			
		C	No					
		۲	Yes Comment:					
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			High Risk fo		Description			
			Immediace	Intervention	Required			
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	ear		Clinical <u>M</u> aint		< Back	Next >	Finish	Cancel
*De	press	sion	Screening FY0	19 :				-
Health	Facto	rs: DE	PRESSION AS	SESS COMPLE	TE, HOPELE	SSNESS PR	ESENT/FUT	URE,
SUICI	DAL	тнос	IGHTS, SUICID	E PLAN, SUICID	E RISK ASS	ESSMENT D	ONE	
* Indica	ates a	Requi	red Field					
Remir	nder F	Resolu	tion: *Depressio	n Screening FYO9				×
Н	lave	you e	ever had a su	icide attempt	?			
	O N	lo						
	• 2	les.						
	I	escr	iption\Dates:	:				
I	s Pa	tient	: demonstrati	ng suicidal i	deations/b	ehaviors/ri	.sks?	
	O N	Io						
	• 5	les.						
	·	omme:	nt:					
			, 					
				LAN (**REQUIE and/or PHQ-9		reviewed ar	nd the pati	ent
ass	esse	d ind	luding asses	sment of suic	ide risk. 1	Based on th	ie assessme	nt the
fol	following disposition plan will be implemented:							
Clea	ar	C	linical <u>M</u> aint	⊻isit Info	< Back	Next >	Finish	Cancel
*Dep								
								-
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RIOR	SUIC	JDE /	PRESSION AS	SESS COMPLE CIDAL THOUG				TURE,

DOWTO DD 100		+>=====				
	ESSMENT AND PLAN (* of the PHQ-2 have b	····•	no notiont occo	ssed includin	y accacement (of
	k. Based on the ass		-			
-Plan and	disposition					
🗆 No ment	tal health condition	n requiring furthe	r intervention.			
	y receiving needed (ency services provid		t information a	nd instructio	ns for access:	ing
	t to obtain treatmen sing emergency serv:		. Contact infor	mation and in	structions for	r
Medicat provi	tion ordered. Cont: ded.	act information and	1 instructions	for accessing	emergency set	rvices
Patien	t to be evaluated b [,]	v Mental Health				
		services provided.				
-9 Question		isorder				
			< Back	Next >	Finish	Cancel
-9 Question	naire Clinical <u>M</u> aint	isorder ∐yisit Info	< Back	Next >	Finish	Cancel
-9 Question Clear REVISED Depr	naire	<u>1sorder</u> <u>V</u> isit Info	Kack	Next >	Finish	Cancel
I-9 Question Clear REVISED Depr SUICIDE R	naire Clinical <u>M</u> aint ression Screening FY LISK RSSESSMENT SCRE	isorder Visit Info (09 : IEN: (**REQUIRED**)	, <u> </u>		Finish	Cancel
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he results of the PHQ-2 have been reviewed and the patient assessed including assessment of suicide risk. Based on the assessment the following disposition plan will be implemented: Plan and disposition No mental health condition requiring further intervention.						
Comment:						
Already receiving needed treatment. Contact information and instructions for accessing emergency services provided.						
Comment:						
Patient to obtain treatment outside this VA. Contact information and instructions for accessing emergency services provided.						
Comment:						
Location:						
Hedication ordered. Contact information and instructions for accessing emergency services provided. Comment:						
Patient to be evaluated by Mental Health						
C Immediate Mental Health evaluation needed: care arranged						
Urgent Mental Health evaluation (within 24 hours) needed: Referral made, contact information for Mental Health and instructions for accessing emergency services provided						
C Mental Health Evaluation (non-urgent, within 14 days) needed. Referral made, contact information for Mental Health and instructions for accessing emergency services provided.						
Further intervention recommended but patient refused. Contact information and instructions ; for accessing emergency services provided.						
Comment:						

ZReminder Resolution: *REVISED Depression Screening FY09						
Is Patient demonstrating suicidal ideations/behaviors/risks?						
O No						
C Yes						
PROVIDER ASSESSMENT AND PLAN (**REQUIRED**) The results of the PHQ-2 have been reviewed and the patient assessed including assessment of						
suicide risk. Based on the assessment the following disposition plan will be implemented:						
Plan and disposition						
No mental health condition requiring further intervention.						
Already receiving needed treatment. Contact information and instructions for accessing emergency services provided.						
Patient to obtain treatment outside this VA. Contact information and instructions for accessing emergency services provided.						
Medication ordered. Contact information and instructions for accessing emergency services provided.						
Comment:						
Patient to be evaluated by Mental Health						
Further intervention recommended but patient refused. Contact information and instructions						
for accessing emergency services provided.						
VA/DOD CPG for Major Depressive Disorder						
PHQ-9 Questionnaire						
**OPTIONAL: PHQ-9 QUESTIONS						
Clear Clinical <u>M</u> aint <u>V</u> isit Info < Back Next > Finish Cancel						
*REVISED Depression Screening FY09 :						
SUICIDE RISK ASSESSMENT SCREEN: (**REQUIRED**)						
Health Factors: ANTI-DEPRESSANT TREATMENT, DEPRESSION ASSESS COMPLETE, SUICIDE RISK ASSESSMENT DONE Orders: Outpatient Medications						
Indicates a Required Field						

Reminder Resolution: *Depression Screening FY09 × . instructions for accessing emergency services provided. Patient to obtain treatment outside this VA. Contact information and instructions for accessing emergency services provided. Medication ordered. Contact information and instructions for accessing emergency services provided. Patient to be evaluated by Mental Health O Immediate Mental Health evaluation needed: care arranged O Urgent Mental Health evaluation (within 24 hours) needed: Referral made, contact information for Mental Health and instructions for accessing emergency services provided O Mental Health Evaluation (non-urgent, within 14 days) needed. Referral made, contact information for Mental Health and instructions for accessing emergency services provided. Further intervention recommended but patient refused. Contact information and instructions for accessing emergency services provided. < Back Clear Clinical <u>M</u>aint ⊻isit Info Next > Finish Cancel -*Depression Screening FY09 : SUICIDE RISK ASSESSMENT SCREEN: (**REQUIRED**) PROVIDER ASSESSMENT The results of the PHQ-2 and/or PHQ-9 have been -Health Factors: DEPRESSION ASSESS COMPLETE, SUICIDE RISK ASSESSMENT DONE Orders: MENTAL HEALTH CONSULT ORDERS FOR DEPRESSION * Indicates a Required Field

Rer	Reminder Resolution: *Depression Screening FY09							
		Urgent Mental Health evaluation (within 24 hours) needed: R						
	made, contact information for Mental Health and instructions for accessing emergency services provided							
	O Mental Health Evaluation (non-urgent, within 14 days) needed.							
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C	lear	Clinical <u>M</u> aint <u>V</u> isit Info < Back Next > Finish	Cancel					
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* 00	*Depression Screening FY09 : SUICIDE RISK ASSESSMENT SCREEN:(**REQUIRED**)							
	PROVIDER ASSESSMENT The results of the PHQ-2 and/or PHQ-9 have been							
	Health Factors: DEPRESSION ASSESS COMPLETE, REFUSES MH REFERRAL FOR DEPRESSION. SUICIDE RISK ASSESSMENT DONE							
		NTAL HEALTH CONSULT ORDERS FOR DEPRESSION						
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Template: SUICIDE BEHAVIOR REPORT-ALBANY	le Behavior Report
	_ <u>8 ×</u>
CPRS BIGHTY FIVE FIVE ZZTEST	<u> </u>
100 TEST STREET BUFFALO, NEW YORK14215	
Home Phone: 7163562728	
SSN: 000-00-1449	
DOB: MAY 14,1949 (62)	
(If exact time is unknown please appr	roximate)
Date/Time of event: *	approximate)
Location of event: * O On station O Off station	-
Patient status at time of event: * O Outpatient O Inpatie	ent
Outcome of event: *	
T died	
hospitalized: indicate where in the box below	
Source of information: *O Face-to-Face O Telephone O Wri	itten, *
O Patient self-report O Family member	
C Outside agent	
O VA staff	
O Other:	
Name & Phone # of source:	
Reported: Patient Level of Intent of this event was: *	
C High C Hedium	
C Low	
O Unknown	
🖸 Not Applicable	
(ASK: What did you think the outcome would be?)	
Last Pain Score: 99 (03/13/2012 16:00)	
Did the patient have access to firearms? * Yes 🔿 No 🔿 U	Unknown 👻
All None * Indicates a Required Field Preview	OK Cancel
Template: SUICIDE BEHAVIOR REPORT-ALBANY	_ 6 ×
Did the patient have access to firearms? * Yes O No O U	
Per report, the support available at time of the event in	
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* O None.	
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 * None. At least one supportive relationship. Some supportive relationships. Good social and/or family support. Unknown or unable to obtain. Other: Per report, the treatment plan changes at the time of the * No changes Bedication changes: describe: Therapy changes: describe: Discharge from inpatient/residential treatment within Unknown or unable to obtain Other: Description of event: * Past 10 Clinic Visits: 03/05/2012 09:51 AL-CI TC-X 03/06/2012 151 SCH-THST CPBS 1 NC 03/15/2012 09:51 AL-CI TC-X 03/06/2012 14:10 EM-POCT SYM HOM TOP HOSPI 11/15/2012 14:36 BH-POCT SYM HOM TOP HOSPI 11/15/2011 14:36 AL-PORM TOR CENSULT-X	ncluded: e event included: 30 days UNSCHEDULED UNSCHEDULED UNSCHEDULED CANCELLED BY CLINIC UNSCHEDULED UNSCHEDULED
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 * None. C At least one supportive relationship. C Scome supportive relationships. C Good social and/or family support. C Winknown or unable to obtain. C Other: Per report, the treatment plan changes at the time of the * No changes Medication changes: describe: Therapy changes: describe: D theringer for inpatient/residential treatment within Unknown or unable to obtain Other: Description of event: * Past 10 Clinic Visits: 03/15/2012 09:51 LN-TEST CPRS 1 NC 03/15/2012 09:51 LN-TEST CPRS 1 NC 03/15/2012 09:51 LA-TEST CPRS 1 NC 03/15/2012 14:10 EN-MON MYDRIATIC CAMERA 01/24/2012 14:48 EN-PEARM NOC E-CONSULT-X 11/02/201 09:14 AD-ENDER WISHING TEEL -X 	ncluded: • event included: 30 days UNSCHEDULED UNSCHEDULED UNSCHEDULED UNSCHEDULED UNSCHEDULED

Attachment C Suicide Behavior Report

* Indicates a Required Field Preview OK Cancel

Per report, patient's area(s) of treatment prior to the event include:

- H-----

All None

Template: SUICIDE BEHAVIOR REPORT-ALBANY			_ B ×
Per report, patient's area(s) of treatment prior to t	he event :	include:	
<u>*</u>			
Mental Health			
Substance Abuse			
MHICM			
T PTSD			
PRRC/Day Treatment			
HCHV			
Non-VA Mental Health Care			
Primary Care			
Свос			
Unknown or unable to obtain			
Specialty clinic or other:			
Per report, the patient's Primary Care Provider is:			
Ter report, one protent 5 trimming oure trovider 15.			
Per report, the patient's Case Manager/Therapist is:			
Per report, the prescribing Physician is :			
Ter report, one preserioing injuterial is .			
Active Problem List:			
	Active Pro		
	LAST MOD	PROVIDER	
Encounter for palliative care * (ICD-9-CM V66.7) Arthritis, Gouty, Onset 09/01/2011		2 DIETERLE, DEBORA 1 EMERY, NICHOLAS	
Patient reports similar symptoms of gout	09/01/201.	I BEEKI,NICHOLES	
in right foot.			
Inguinal hernia, without mention of obstruction	07/22/2013	1 GOLLA,HARI	
or gangrene (ICD-9-CM 550.90)			
HTN with CHF	01/27/201.	1 SORIN, SERGEY	
Acute suppurative otitis media without	01/18/201	1 IBEWIRO, HELEN	
spontaneous rupture of ear drum, Onset			
01/18/2011			
Start antibiotics today follow up for			-
All None * Indicates a Required Field Pre	view	OK Cancel	

Template: SUICIDE BEHAVIOR REPORT-ALBANY			X
Acute Renal Insufficiency	08/28/2008	MATHIS, TIMOTHY	<u>-</u>
End Stage Renal Disease (ESRD)	08/28/2008	MATHIS, TIMOTHY	
Hypercholesterolemia, Pure	07/01/2008	ISAACS,SETH J	
Carbuncle/Furuncle	07/01/2008	WANG, WALLACE	
Actinic Keratosis	07/01/2008	WANG, WALLACE	
(If patient was an inpatient at time of e	vent)		
INPATIENT UNIT:			
Inpatient status at time of event: O On Pass			
O Unauthorized Absence			
O On unit.			
O Off unit			
Reported response following the event:			
*			
None necessary - Patient died			
Limit the means			
Developed crisis management plan			
Inmediate planning for the future			
Decrease isolation			
Decrease anxiety and agitation			
Medication management			
Taken to ER (specify hospital below)			
Admitted to a medical unit (specify hospi —			
Admitted to inpatient psychiatric care (s	pecify hospital belo	ພ)	
Refer for Mental Health treatment			
Provide emergency phone contact numbers			
Assure followup appointment is made Inform/involve someone close to patient			
Inform/involve someone close to patient Increase contact frequency			
Increase contact frequency Help patient through the crisis			
Other - indicate below			
, other indicate below			
All None * Indicates a Required Field	Preview	OK Cancel	
Indicates a required rieu			

VA Safety Plan						
SAFETY PLAN: VA VERSION						
Step 1: Warning signs:						
1.						
2.						
3.						
_	2: Internal coping strategies - Things I can	do to take my mind off my problems				
without cont	acting another person:					
1.						
2.						
3.						
Step 3	3: People and social settings that provide d					
1.	Name	Phone				
2.	Name					
3.	Place 4. Pla					
Step 4	: People whom I can ask for help:					
1.	Name	Phone				
2.	Name	Phone				
3.	Name	Phone				
Step 5	5:Professionals or agencies I can contact d	uring a crisis:				
1.	Clinician Name	Phone				
	Clinician Pager or Emergency Contact #					
2.	Clinician Name	Phone				
	Clinician Pager or Emergency Contact #					
3.	Local Urgent Care Services					
	Urgent Care Services Address					
	Urgent Care Services Phone					
4.	VA Suicide Prevention Resource Coordina	tor Name				
	VA Suicide Prevention Resource Coordina	tor Phone				
5.	5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a					
	VA mental health clinician					

Attachment D

Step 6	: Making the environment safe:
1.	
2.	
Safety	Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

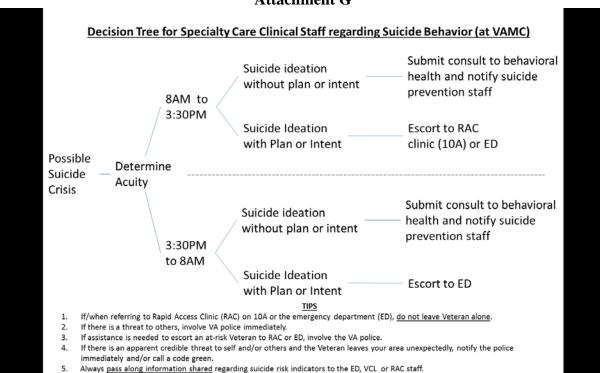
Attachment E			
Suicide Prevention Welfare Check Template			

Tale: SUICIDE PREVENTION WELFARE CHECK		
Date and Time Welfare Check requested: *		
Reason Welfare Check has been initiated: *		
□ report of suspected patient self-directed viole		
	mber/concerned friend revealed patient is in crisis	
[patient's latest clinical presentation suggests		
□ othes		
Threat details: *		
Contact Details:		
Police contect: *		
Police Department responding: *		
Address or location of Veteran: * Phone number of Veteran, if known:		
FROMe number of veteran, if known:		
Consider sharing this information with the police .	in a need-to-know basis:	
T Access to weapons (*notification to police requ	red when there is known access to wespons)	
□ Specific concern about threat of harm to self of	others	
E Recent suicide attempt		
☐ Indication of intoxication or being under the 1	fluence of substances	
☐ Indication of impulsive behavior, extreme anger		
T History of violence or threats spainst law enfo	cement or others	
C Others in the home (including children or anima		
C Other relevant safety information shared on a m		
Disposition: *		
Disgnosis: *		
Notifications: *		
Directly notified Suicide Prevention Staff (DEC Directly notified police per facility protocol	IRD)	
Directly notified Mental Health Treatment Coord		
I Directly notified Hental Health Treatment Goord Directly notified supervisor	ARDE	
AFTER SIGNING THIS NOTE, ENSURE YOU HAVE A AS AN ADDITIONAL SIGNER		
IF & SUICIDE ATTEMPT HAS OCCURRED, & *SUIC COMPLETED FOR YOUR FACILITY-REQUIRED	DE BERAVIOR BEDORT" NOTE MIST BE	
COMPLETED FOR YOUR FACILITY-REQUIRED.		
* Indicates a Required Field	Preview OK Cancel	
a decision of a field week a set		

Attachment F RESPONDING TO SUICIDE IDEATION: PHONE CALLS

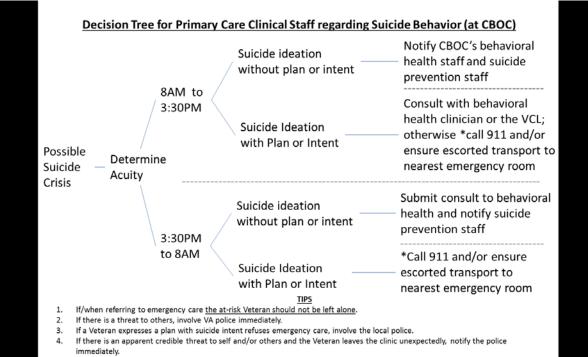
Remain calm, gather information casually, listen, act with confidence, offer		
	ve comments	
Step 1. Obtain and write-down the followir	ng information:	
Name		
Address/location (where are you	u calling from?)	
Phone number calling from		
Last 4 of Social Security Number	•	
Reason for the call		
Keep the caller on the line until s/he is in contact with professionals or		
emergency personnel		
Step 2. Tell the individual that you will connect them with someone who can help and		
that if for some reason the call is lost they will be called right back.		
Step 3. Place the call on Mute and get a second employee to help		
If they don't want to be transferred ask the following:		
Method (s) of suicide considered		
Access to that method	t de la constante de	
When plan would be a	arried out	
•	o transfer the call to someone who can help.)	
When suicide risk is imminent or may be imminent – for example, when the vet has		
a weapon, has already taken steps to harm self, has plan with means available, sounds		
desperate, OR seems irrational, ask another employee to call 62911 (VA Police		
Emergency) to contact and send local police to the address. (If necessary, press		
the mute button and yell for help!) Notify Supervisor and the Suicide Prevention		
Coordinator.		
Calls during business hours	Afterhours calls:	
(M-F, 7:30AM-4:00PM)	evenings, nights, weekends, holidays	

Step 4: Ask another employee to	Step 4: Ask another employee to contact the	
contact behavioral health triage: 626-	Suicide Prevention Hotline (9-1-800-273	
5311 and provide information gathered.	8255- press 1 for veterans) and provide	
 *Once triage worker is located, 	the information gathered	
confirm what ext. the call is to be	 Inform caller that transfer will be 	
transferred to, inform caller that	made to a professional, but if call is	
transfer will be made to a	lost, that hotline personnel will call	
professional but if call is lost, that	him/her right back	
triage will call right back.	 To Transfer call, push conference 	
• To Transfer call, push conference	button, dial the 800 number and	
button, dial ext. 65311 and push	push the conference button again	
the conference button again (for	(for 3-way call); then introduce the	
3-way call); then introduce the	patient to the crisis line worker	
patient to the triage worker	before hanging up.	
before hanging up.	 Verify call was received on the 	
Verify call was received with clinic	administrative line: 9-1-585-393-	
staff: 626-5339	7937	
*If triage staff can't be reached, utilize		
the afterhours call procedure.		
Regardless of outcome, consult with and otherwise seek support from your supervisor,		
behavioral health staff and colleagues. Notify Suicide Prevention Coordinator: 6-5329.		



When notifying suicide prevention (SP), always do so - in person, by phone or by voicemail (65515, 65329); never only by view alert. 6.

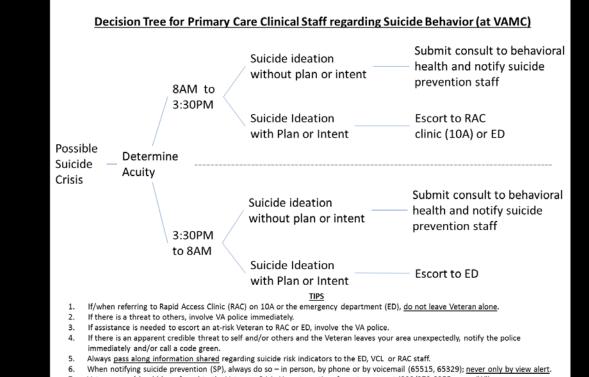
Veterans can/should be referred to the Veterans Crisis Line at any time for extra support (800/273-8255, press "1"). 7.



Always pass along information shared regarding suicide risk indicators to the ED, Veterans Crisis Line (VCL) or Rapid Access Clinic (RAC) 5.

6. When notifying suicide prevention (SP), always do so - in person, by phone or by voicemail (65515, 65329); never only by view alert.

Veterans can/should be referred to the Veterans Crisis Line at any time for extra support (800/273-8255, press "1"). 7.



7. Veterans can/should be referred to the Veterans Crisis Line at any time for extra support (800/273-8255, press "1").