D.10 SUICIDE PREVENTION

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

SUICIDE PREVENTION

1. **PURPOSE**: 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. **RESPONSIBILITIES**:
   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. PROCEDURES:

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).

(1) 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.

l. 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. **REFERENCES**: 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. **RECISSIONS**: SOP SL 01-213 dated February 5, 2013.

6. **FOLLOW-UP RESPONSIBILITY**: Joseph Hunter, PhD, LCSW, Suicide Prevention Coordinator

7. **REVIEW**: 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

Attachment A
Behavioral Health Suicide Risk Assessment

Template: BEHAVIORAL HEALTH SUICIDE RISK ASSESSMENT

BEHAVIORAL HEALTH SUICIDE RISK ASSESSMENT

1a. Is patient currently or has patient recently experienced suicidal ideations? * Yes No Refused
(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

2. Any history of preparations or events of self-directed violence with suicidal intent? (Refer to Reports Tab, Health Summary, Suicide Documentation Review)
- NO
- YES
- REFUSED

3. Warning Signs/Other Risk Indicators:
(Discuss each area with patient)

- * Yes No Refused Significant anxiety
- * Yes No Refused Sleep disturbance
- * Yes No Refused Current or chronic pain issues
- * Yes No Refused Active alcohol or other substance abuse
- * Yes No Refused Engaging in risky behaviors
- * Yes No Refused New or worsening medical/mental health diagnoses
- * Yes No Refused Psychosocial stressors
- * Yes No Refused Increased avoidance or isolation
- * Yes No Refused Has not sought out help during times of crisis
- * Yes No Refused Currently talks of death, dying or suicide
- * Yes No Refused Perceives self as a burden to others
- * Yes No Refused Lacks a sense of belongingness or lacks social supports
- * Yes No Refused Lacks life meaning or purpose
- * Yes No Refused Sense of hopelessness
- * Yes No Refused Crisis related anniversaries
- * Yes No Refused Infrequent adherence to prescribed psychotropic medications

If yes, please explain below:

4. Protective factors: CHECK ALL THAT APPLY:
*

All | None | * Indicates a Required Field | Preview | OK | Cancel

Template: BEHAVIORAL HEALTH SUICIDE RISK ASSESSMENT

4. Protective factors: CHECK ALL THAT APPLY:
*
- Positive social supports
- Positive therapeutic support
- Cultural/religious/spiritual beliefs
- Sense of responsibility to family/others
- Hope for the future
- Knows how to access support
- Life satisfaction
- Positive coping skills/problem solving skills
- Fear of death or moral objection to suicide
- Restricted access to lethal means
- None reported
- Other

5. Psychosocial risk factors: CHECK ALL THAT APPLY:
*
- Relationship difficulties
- Recent transition from military to civilian life
- Military/civilian trauma exposure
- Legal issues
- Financial/work or housing stressors
- History of physical/sexual abuse
- Family history of mental illness
- Chronic pain
- Chronic medical condition
- Lack of support
- Repeated exposure to death, dying and/or suicide
- Suicide of close family member or friend
- None reported
- Other

6. Does the patient have access to?
(If yes, describe below and explain staff actions to restrict means)
- * Yes No Refused Firearms (If yes, document gun safety lock offered below)
- * Yes No Refused Stockpiled medication with suicidal intent
- * Yes No Refused Other means

7. Clinical impression of suicide level of risk:
DESCRIPTION OF HIGH 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 Plan note

All | None | * Indicates a Required Field | Preview | OK | Cancel

Template: BEHAVIORAL HEALTH SUICIDE RISK ASSESSMENT

7. Clinical impression of suicide level of risk:

DESCRIPTION OF HIGH 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 Plan note must be completed with the patient and in CPRS, as soon as possible. If imminent risk-DO NOT LEAVE PATIENT 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 90 days. The Suicide Prevention Safety Plan note should be completed with the patient and in CPRS. The suicide prevention team is to be added as an additional signer to this Suicide Risk Assessment note.

DESCRIPTION OF LOW RISK LEVEL

Patient may have a mental illness diagnosis or substance abuse problem with relative abundance of coping strengths and resources. No history of suicidal self-directed violence, chronic suicidal ideation or history of impulsivity.

*

- ○ High
- ○ Intermediate
- ○ Low

Risk level justification: *

☐ Patient 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)

☐ 8. Level of care recommendations, based on current suicide risk level:

*

- ○ No treatment indicated at present time
- ○ Outpatient
- ○ Inpatient (medical unit/psychiatric unit)
- ○ Triage/Emergency Room
- ○ Day treatment
- ○ Residential treatment

9. Immediate Action Steps

*

- ☐ Not applicable
- ☐ Further suicide risk assessment
- ☐ Complete the Suicide Prevention Safety Plan note and give a copy to the patient
- ☐ Provide Veterans Crisis Line information
- ☐ Directly notify suicide prevention team (for high risk patients)
- ☐ Add suicide prevention team as additional signers (for INTERMEDIATE risk patients only)

10. Family/Friends provided with:

*

- ☐ Not applicable
- ☐ Clinic and hotline contact information
- ☐ Appointment card and next step details
- ☐ Managing risks/seeking help information and literature

All | None | * Indicates a Required Field | Preview | OK | Cancel

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?
- ○ No
- ○ Yes

Have you had thoughts about taking your life?
- ○ No
- ○ Yes

Have you ever had a suicide attempt?
- ○ No
- ○ Yes

Is Patient demonstrating suicidal ideations/behaviors/risks?
- ○ No
- ○ Yes

Clear | Clinical Maint | Visit 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

Reminder Resolution: *Depression Screening FY09

SUICIDE RISK ASSESSMENT SCREEN: (**REQUIRED**)

Are you feeling hopeless about the present or future?

- No
- Yes

Comment:

Have you had thoughts about taking your life?

- No
- Yes

When did you have these thoughts? *

yesterday

Do you have a plan to take your life?

- No
- Yes Comment:

****
High Risk for Suicide
Immediate Intervention Required

****

Clear | Clinical Maint | Visit Info | < Back | Next > | Finish | Cancel

*Depression Screening FY09 :

Health Factors: DEPRESSION ASSESS COMPLETE, HOPELESSNESS PRESENT/FUTURE, SUICIDAL THOUGHTS, SUICIDE PLAN, SUICIDE RISK ASSESSMENT DONE

* Indicates a Required Field

Reminder Resolution: *Depression Screening FY09

Have you ever had a suicide attempt?

- No
- Yes

Description\Dates:

Is Patient demonstrating suicidal ideations/behaviors/risks?

- No
- Yes

Comment:

PROVIDER ASSESSMENT AND PLAN (**REQUIRED**)
The results of the PHQ-2 and/or PHQ-9 have been reviewed and the patient assessed including assessment of suicide risk. Based on the assessment the following disposition plan will be implemented:

Clear | Clinical Maint | Visit Info | < Back | Next > | Finish | Cancel

*Depression Screening FY09 :

Health Factors: DEPRESSION ASSESS COMPLETE, HOPELESSNESS PRESENT/FUTURE, PRIOR SUICIDE ATTEMPT, SUICIDAL THOUGHTS, SUICIDE DEMO BEHAVIORS-YES, SUICIDE PLAN, SUICIDE RISK ASSESSMENT DONE

* Indicates a Required Field

Reminder Resolution: *REVISED Depression Screening FY09

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.
- [ ] 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

Clear | Clinical Maint | Visit 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

Reminder Resolution: *REVISED Depression Screening FY09

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

- [x] No mental health condition requiring further intervention.
  Comment:
- [x] Already receiving needed treatment. Contact information and instructions for accessing emergency services provided.
  Comment:
- [x] Patient to obtain treatment outside this VA. Contact information and instructions for accessing emergency services provided.
  Comment:
  Location:
- [x] Medication ordered. Contact information and instructions for accessing emergency services provided.
  Comment:
- [x] Patient to be evaluated by Mental Health
  - ( ) 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
  - ( ) Mental Health Evaluation (non-urgent, within 14 days) needed. Referral made, contact information for Mental Health and instructions for accessing emergency services provided.
- [x] Further intervention recommended but patient refused. Contact information and instructions for accessing emergency services provided.
  Comment:

Reminder Resolution: *REVISED Depression Screening FY09

Is Patient demonstrating suicidal ideations/behaviors/risks?

- ○ No
- ○ 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 Maint | Visit 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

○ 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

○ 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.

Clear | Clinical Maint | Visit Info | < Back | 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

Reminder Resolution: *Depression Screening FY09

○ Urgent Mental Health evaluation (within 24 hours) needed: Referral made, contact information for Mental Health and instructions for accessing emergency services provided

○ 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:

VA/DOD CPG for Major Depressive Disorder

PHQ-9 Questionnaire

☐ **OPTIONAL: PHQ-9 QUESTIONS

Clear | Clinical Maint | Visit Info | < Back | 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, REFUSES MH REFERRAL FOR DEPRESSION, SUICIDE RISK ASSESSMENT DONE
Orders: MENTAL HEALTH CONSULT ORDERS FOR DEPRESSION

* Indicates a Required Field

Attachment C
Suicide Behavior Report

Template: SUICIDE BEHAVIOR REPORT-ALBANY

☑ CPRS EIGHTY FIVE FIVE ZZTEST
100 TEST STREET
BUFFALO, NEW YORK14215
Home Phone: 7163562728

SSN: 000-00-1449
DOB: MAY 14,1949 (62)

☑ (If exact time is unknown please approximate)
Date/Time of event: * ☐ (Time is approximate)
Location of event: * ○ On station ○ Off station
Patient status at time of event: * ○ Outpatient ○ Inpatient
Outcome of event: *
☐ remained outpt
☐ died
☐ hospitalized: indicate where in the box below

☑ Source of information: * ○ Face-to-Face ○ Telephone ○ Written , *
○ Patient self-report
○ Family member
○ Outside agent
○ VA staff
○ Other:

Name & Phone # of source:

☑ Reported: Patient Level of Intent of this event was: *
○ High
○ Medium
○ Low
○ 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 ○ Unknown

All | None | * Indicates a Required Field | Preview | OK | Cancel

Template: SUICIDE BEHAVIOR REPORT-ALBANY

Did the patient have access to firearms? * ○ Yes ○ No ○ Unknown

Per report, the support available at time of the event included:
*
○ 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 event included:
*
☐ No changes
☐ Medication changes: describe:
☐ Therapy changes: describe:
☐ Discharge from inpatient/residential treatment within 30 days
☐ Unknown or unable to obtain
☐ Other:

Description of event: *

Past 10 Clinic Visits:

03/15/2012 09:51	CN-TEST CPRS 1 NC	UNSCHEDULED
03/15/2012 09:51	AL-GI TC-X	UNSCHEDULED
03/06/2012 16:19	CN-TEST CPRS 1 NC	UNSCHEDULED
02/15/2012 14:10	BH-NON MYDRIATIC CAMERA	CANCELLED BY CLINIC
01/24/2012 14:48	BH-PCCT SYM MGMT MD HOSPI	UNSCHEDULED
11/15/2011 14:36	AL-PHARM ONC E-CONSULT-X	UNSCHEDULED
11/02/2011 08:14	OL-BLUE NURSING TELE -X	UNSCHEDULED
08/18/2011 09:47	BU-SWS DIALYSIS	UNSCHEDULED
08/11/2011 09:04	AL-CCHT IVR AS TX PLAN TC	UNSCHEDULED
07/22/2011 15:10	AL-GEN SURG ER	UNSCHEDULED

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

All | None | * Indicates a Required Field | Preview | OK | Cancel

Template: SUICIDE BEHAVIOR REPORT-ALBANY

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

- ☐ Mental Health
- ☐ Substance Abuse
- ☐ MHICM
- ☐ PTSD
- ☐ PRRC/Day Treatment
- ☐ HCHV
- ☐ Non-VA Mental Health Care
- ☐ Primary Care
- ☐ CBOC
- ☐ Unknown or unable to obtain
- ☐ Specialty clinic or other:

Per report, the patient's Primary Care Provider is:

Per report, the patient's Case Manager/Therapist is:

Per report, the prescribing Physician is :

Active Problem List:

15 Active Problems

PROBLEM	LAST MOD	PROVIDER
Encounter for palliative care * (ICD-9-CM V66.7)	01/24/2012	DIETERLE,DEBORA
Arthritis, Gouty, Onset 09/01/2011 Patient reports similar symptoms of gout in right foot.	09/01/2011	EMERY,NICHOLAS
Inguinal hernia, without mention of obstruction or gangrene (ICD-9-CM 550.90)	07/22/2011	GOLLA,HARI
HTN with CHF	01/27/2011	SORIN,SERGEY
Acute suppurative otitis media without spontaneous rupture of ear drum, Onset 01/18/2011 Start antibiotics today follow up for	01/18/2011	IBEWIRO,HELEN

All | None | * Indicates a Required Field | Preview | OK | Cancel

Template: SUICIDE BEHAVIOR REPORT-ALBANY

PROBLEM	LAST MOD	PROVIDER
Acute Renal Insufficiency	08/28/2008	MATHIS,TIMOTHY
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 event)
INPATIENT UNIT:
Inpatient status at time of event:

- ○ On Pass
- ○ Unauthorized Absence
- ○ On unit
- ○ Off unit

☑ Reported response following the event:
*

- ☐ None necessary - Patient died
- ☐ Limit the means
- ☐ Developed crisis management plan
- ☐ Immediate planning for the future
- ☐ Decrease isolation
- ☐ Decrease anxiety and agitation
- ☐ Medication management
- ☐ Taken to ER (specify hospital below)
- ☐ Admitted to a medical unit (specify hospital below)
- ☐ Admitted to inpatient psychiatric care (specify hospital below)
- ☐ Refer for Mental Health treatment
- ☐ Provide emergency phone contact numbers
- ☐ Assure followup appointment is made
- ☐ Inform/involve someone close to patient
- ☐ Increase contact frequency
- ☐ Help patient through the crisis
- ☐ Other - indicate below

All | None | * Indicates a Required Field | Preview | OK | Cancel

Attachment D
VA Safety Plan

SAFETY PLAN: VA VERSION

Step 1: Warning signs:

1. ____
2. ____
3. ____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. ____
2. ____
3. ____

Step 3: People and social settings that provide distraction:

1. Name______________________________ Phone____________________
2. Name______________________________ Phone____________________
3. Place______________________ 4. Place ________________________

Step 4: People whom I can ask for help:

1. Name______________________________ Phone____________________
2. Name______________________________ Phone____________________
3. Name______________________________ Phone____________________

Step 5:Professionals or agencies I can contact during 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 Coordinator Name______________________
   VA Suicide Prevention Resource Coordinator Phone______________________
5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

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

Title: SUICIDE PREVENTION WELFARE CHECK

Date and Time Welfare Check requested: *

Reason Welfare Check has been initiated: *
- [ ] report of suspected patient self-directed violence
- [ ] contact with patient/significant other/family member/concerned friend revealed patient is in crisis
- [ ] patient's latest clinical presentation suggests potential for harm
- [ ] other

Threat details: *

Contact Details:
Police contact: *
Police Department responding: *
Address or location of Veteran: *
Phone number of Veteran, if known:

Consider sharing this information with the police on a need-to-know basis:
*
- [ ] Access to weapons (*notification to police required when there is known access to weapons)
- [ ] Specific concern about threat of harm to self or others
- [ ] Recent suicide attempt
- [ ] Indication of intoxication or being under the influence of substances
- [ ] Indication of impulsive behavior, extreme anger and/or extreme anxiety
- [ ] History of violence or threats against law enforcement or others
- [ ] Others in the home (including children or animals)
- [ ] Other relevant safety information shared on a need-to-know basis

Disposition: *

Diagnosis: *

Notifications: *
- [ ] Directly notified Suicide Prevention Staff (REQUIRED)
- [ ] Directly notified police per facility protocol
- [ ] Directly notified Mental Health Treatment Coordinator
- [ ] Directly notified supervisor

AFTER SIGNING THIS NOTE, ENSURE YOU HAVE ASSIGNED YOUR SUICIDE PREVENTION STAFF AS AN ADDITIONAL SIGNER
IF A SUICIDE ATTEMPT HAS OCCURRED, A "SUICIDE BEHAVIOR REPORT" NOTE MUST BE COMPLETED FOR YOUR FACILITY-REQUIRED

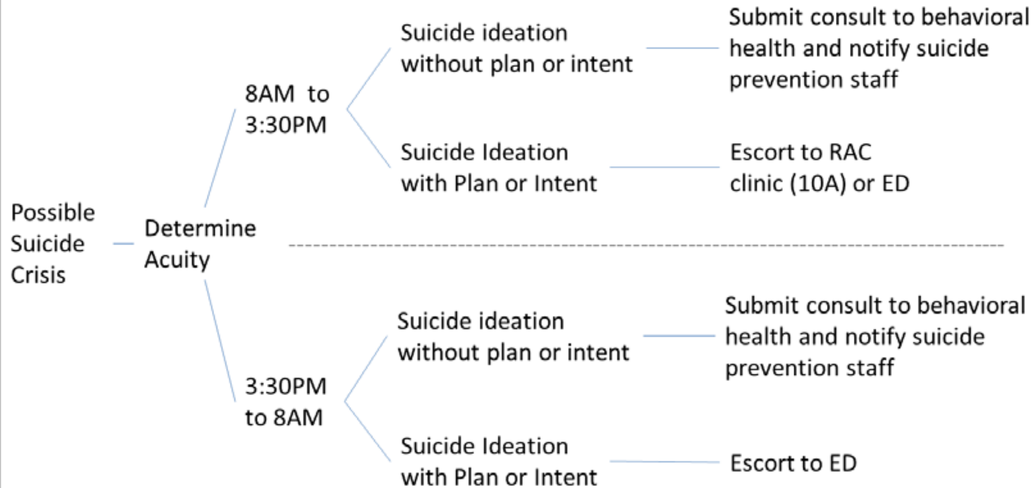
* Indicates a Required Field Preview OK Cancel

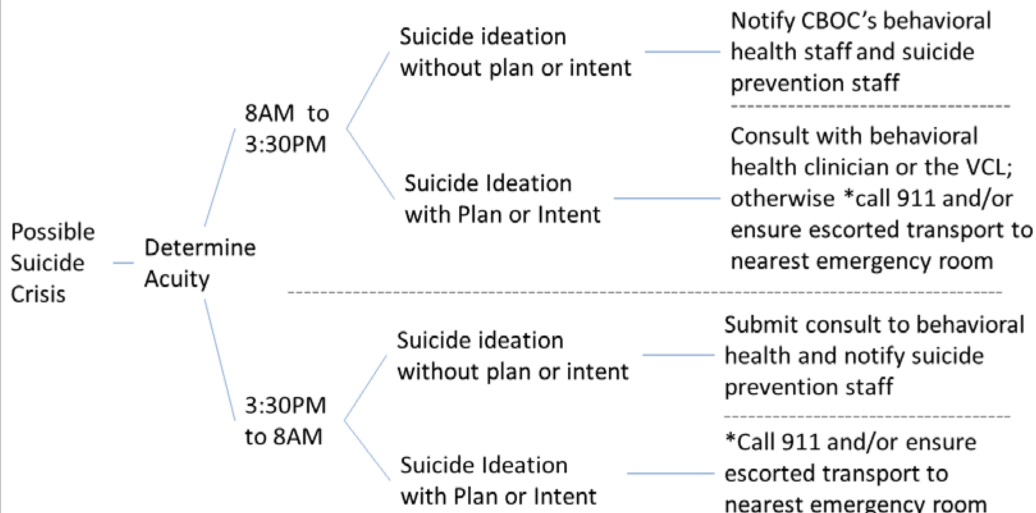
Attachment F
RESPONDING TO SUICIDE IDEATION: PHONE CALLS

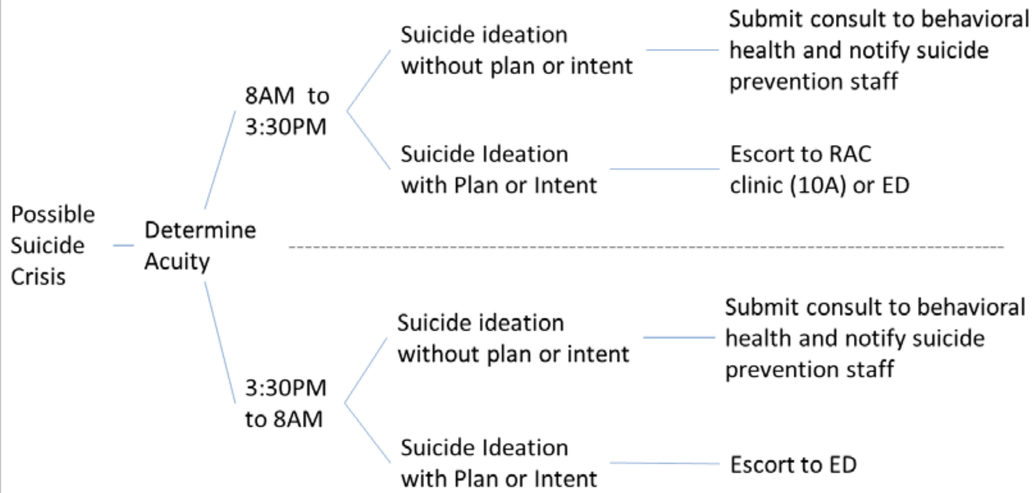
<table>
<tr><td colspan="2">Remain calm, gather information casually, listen, act with confidence, offer supportive comments</td></tr>
<tr><td colspan="2">Step 1. Obtain and write-down the following information:
Name
Address/location (where are you calling from?)
Phone number calling from
Last 4 of Social Security Number
Reason for the call</td></tr>
<tr><td colspan="2">Keep the caller on the line until s/he is in contact with professionals or emergency personnel</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td colspan="2">Step 3. Place the call on Mute and get a second employee to help</td></tr>
<tr><td colspan="2">If they don't want to be transferred ask the following:
• Method (s) of suicide considered
• Access to that method
• When plan would be carried out
(Try to redirect and repeat you would like to transfer the call to someone who can help.)</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td><u>Calls during business hours
(M-F, 7:30AM-4:00PM)</u></td><td><u>Afterhours calls:
evenings, nights, weekends, holidays</u></td></tr>
</table>

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

Attachment G






Decision Tree for Primary Care Clinical Staff regarding Suicide Behavior (at VAMC)
Possible Suicide Crisis
Determine Acuity
8AM to 3:30PM
Suicide ideation without plan or intent
Submit consult to behavioral health and notify suicide prevention staff
Suicide Ideation with Plan or Intent
Escort to RAC clinic (10A) or ED
3:30PM to 8AM
Suicide ideation without plan or intent
Submit consult to behavioral health and notify suicide prevention staff
Suicide Ideation with Plan or Intent
Escort to ED
TIPS
1. If/when referring to Rapid Access Clinic (RAC) on 10A or the emergency department (ED), do not leave Veteran alone.
2. If there is a threat to others, involve VA police immediately.
3. If assistance is needed to escort an at-risk Veteran to RAC or ED, involve the VA police.
4. If there is an apparent credible threat to self and/or others and the Veteran leaves your area unexpectedly, notify the police immediately and/or call a code green.
5. Always pass along information shared regarding suicide risk indicators to the ED, VCL or RAC staff.
6. When notifying suicide prevention (SP), always do so – in person, by phone or by voicemail (65515, 65329); never only by view alert.
7. Veterans can/should be referred to the Veterans Crisis Line at any time for extra support (800/273-8255, press "1").