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## Improving Suicide Screening and Safety Plan Documentation Rates in Behavioral Health Clinics

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IMPROVING SUICIDE SCREENING AND SAFETY PLAN DOCUMENTATION RATES IN  
BEHAVIORAL HEALTH CLINICS

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Brandi Hrasdzira

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### **Abstract**

Suicide is the 10th leading cause of death in the United States with over 47,000 people dying in 2017 from suicide alone (National Institute of Mental Health [NIMH], 2019). In the United States, one in three people who die by suicide were seen by a behavioral health provider within the same year (McCabe et al., 2018). The purpose of this project was to determine if suicide screenings and safety plans are being completed and documented properly; how many patients are refusing to complete the patient health questionnaire (PHQ-9) and is there a pattern present in these patients. Objectives are to improve the rates of suicide risk screening, safety plan documentation, decrease patient refusals, and determine if a pattern is present. The aims of this project are to determine the rate of suicide screenings and suicide safety plan documentation and increase rate to 95%; determine rate of patient questionnaire refusals and decrease by 10%; and implement alert system for 100% of patients at risk for suicide. The project was implemented over a 10-week period of which two psychiatric nurse practitioners participated. Results indicate that there was a 15% decrease in screening and safety plan documentation; 100% of patients at risk for suicide had an alert placed; PHQ-9 refusals decreased by 27%, however, 25% of patients were not asked to complete the PHQ-9 once providers switched to tele-visits. A pattern was observed in patients who refused to complete the PHQ-9.

*Keywords:* suicide screening, Zero Suicide, suicide prevention

## **Improving Suicide Screening and Safety Plan Documentation Rates in Behavioral Health Clinics**

Suicide is the 10th leading cause of death in the United States with over 47,000 people dying in 2017 from suicide alone (NIMH, 2019). It is the second leading cause of death for individuals age 10-34 and fourth leading cause of death for individuals 35-54 (NIMH, 2019). In the United States in 2017, there were over 1.4 million suicide attempts with an average of 129 suicides per day and among the 1.4 million attempts, 1.2 million made suicide plans; 10.6 million reported serious thoughts about suicide (NIMH, 2019). Suicide prevention interventions have been proven to decrease suicide attempts and completed suicides although 91% of patients are shown not to be screened for suicide in clinic sites (Stuck et al., 2017). Research has found that most suicides occur within 30 days of being seen by a provider (Stuck et al., 2017). Individuals seen in the behavioral health clinics are not immune to these statistics. Providers need to be trained and periodically assessed on their suicide screening and suicide safety plan methods, rates, and documentation to verify that patients are getting the best care possible regarding suicide prevention.

According to the National Committee for Quality Assurance (n.d.), follow-up visits within 7 days after discharge from the emergency department was less than 48% while the follow-up visit 30 days after discharge was less than 70% as reported by commercial insurance companies, Medicaid, and Medicare. To improve outcomes for suicidal patients it is necessary to address suicidality specifically with the treatment and discharge plans (The Joint Commission, 2016). The Joint Commission National Patient Safety Goal 15.01.01 indicates that facilities are required to identify individuals at risk for suicide (King et al., 2017). Their expectations are that the suicide risk assessment identifies specific risk factors that may increase or decrease the risk,



the individual's immediate safety needs are addressed, and the National Suicide Prevention Lifeline number is given to the individuals and their families (King et al., 2017).

Evidence indicates there are gaps in care ranging from primary care through inpatient stays to behavioral health clinics. These gaps include unidentified suicide risk, not effectively providing safe suicide care, and not providing supportive contacts (National Action Alliance, 2018). Behavioral health clinics should assess individuals for suicide risk using a standardized screening tool, complete a suicide safety plan during the same visit that a risk is identified and at each visit that the suicide risk remains high, and provide the National Suicide Prevention Lifeline (National Action Alliance, 2018). Part of the safety plan, see Appendices E and F, is asking about lethal means and availability to the patient; confirm removal or reduction of lethal means if feasible, such as calling family or friends to have items removed (Department of Veterans Affairs/Department of Defense [VA/DoD], 2013). If an appointment is missed then initiate caring contacts whether it is a call, text, or visit as these interventions have been proven to reduce self-harm and suicide (National Action Alliance, 2018). Providers can decrease suicide risks in the most vulnerable populations by providing high-quality suicide care which includes receiving training on comprehensive suicide prevention. Rather than treating the underlying symptom, suicide risk needs to be treated directly, that is performing safer suicide care (Suicide Prevention Resource, n.d.).

### **Statement of the Problem**

#### **Background**

The Centers for Disease Control and Prevention (CDC, 2018) indicate an increase in suicides by more than 30% since 1999 in more than half the states in the United States. Suicide is often linked to mental health and substance use disorders. Behavioral health providers are at the

center of detecting and treating suicide and behavioral health problems (Suicide Prevention Resource, n.d.). Considering the rates of individuals not being screened for suicide in the clinic setting and dying from suicide within a month of being seen for primary care providers or within a year for behavioral health providers, providers need to be cognizant of the care these individuals need. An area for improvement found was providers not asking patients about their screening questionnaires, safety plans, nor verifying they have the National Suicide Prevention Lifeline number. Also found were the ability of the patients to refuse the screenings, therefore, no screening or safety plan would be completed. The completion of the screenings cannot be made mandatory as the patients have the right to refuse. This prompted the topics of suicide screenings, suicide safety plan documentation, and patient refusals of questionnaires as the quality improvement initiative for this project.

More than 800,000 people worldwide die by suicide each year resulting from multiple internal and external factors (Zalsman et al., 2016). Another issue is many individuals with suicidal ideations and attempts are unable to continue treatment due to financial difficulties meaning that during any visit with these patients leads to an opportunity for brief therapeutic interventions. Brief interventions include assessing suicidal thoughts and plans, two-way communication between the patient and the provider, and focused prevention interventions (McCabe et al., 2018). Family members, or other people the patient wants involved in care, should be included in interventions such as safety planning. Besides being included in the interventions, they should have a copy of the safety plan and provide a working number in case of emergency for the patient and providers.

**Significance**

The most common fallout that the Joint Commission found was inadequate psychiatric assessments for suicide (The Joint Commission, 2016). Providers may need more training on suicide risk assessment and interventions or training on better documentation of the assessment done, findings, and interventions implemented. Most behavioral health providers do not get routine training in providing a comprehensive approach to individuals at risk for suicide. Statistics show that one in every two psychiatrists experience patient suicide while psychologists are one in five. There are no data on psychiatric nurse practitioners, but with the number of patients they see it is inevitable that they experience a patient's suicide (American Foundation, 2017).

Evidence indicates that comprehensive suicide training programs for professionals increases their confidence and provides them with the most up to date and current evidence-based practice interventions. Providers who attended training reported changing the way they practice and facility policies to provide effective life-saving treatment (American Foundation, 2017). The goal put in place by the Research Prioritization Task Force of the National Action Alliance for Suicide Prevention Research is to reduce suicide deaths by 40% by 2024 (Stuck et al., 2017). To help reach this goal multiple strategies have been recommended to implement in all health care settings including behavioral health clinics such as crisis response plans, safety planning interventions, and initiatives such as Zero Suicide. Zero Suicide is a continuous quality improvement process with a leadership-driven approach. It consists of staff training, the use of evidence-based treatments, and care pathways. The Zero Suicide initiative has exceptional results in reducing suicides in facilities that have implemented this framework (Canady, 2019)

The universal screening method of using the PHQ-9 followed by the Columbia-Suicide Severity Rating Scale (C-SSRS) has had extensive research done to verify the accuracy, efficacy, validity, and reliability of the tests themselves and if using them is an appropriate intervention. Evidence indicates that using these tests together is the best way to screen for suicide as the PHQ-9 can have false positive results and the C-SSRS is considered the gold standard for detecting suicidal behavior and ideation, see Appendices B, C, and D (Na et al., 2018). The C-SSRS was shown to have near perfect scores compared to three other screening tools in sensitivity and specificity (Erford et al., 2017). Sensitivity for both tests were 95% while specificity of the PHQ-9 item 9 was 76.8% while the C-SSRS was 95.3% (Viguera et al., 2015). Patients reported that the electronic version gives them the ability to be honest in their answers specifically to sensitive questions and with providers who are not well known or trusted (Viguera et al., 2015). Evidence shows that most patients (92.0%) appreciated suicide risk being part of their mental health assessment; 41.0% were more likely to report suicidal ideations in electronic format; 49% admitted that their provider never went over the results with them (Viguera et al., 2015).

Universal screening reaches many individuals that normally may be missed since many people do not talk about suicide or suicidal ideations as well as the providers who are afraid to ask patients about suicide. Other ways to improve suicide risk screening is to include social and adaptive functioning including employment, partner loss, and housing (King et al., 2017). Assessing the severity of suicidal ideations, including suicidal intent, has been shown to be accurate in predicting suicide attempts. Denial of suicidal ideations should not be a reason to quit the suicide risk assessment because some individuals deny ideations and still engage in suicidal behavior.

**Assessment**

Upon check-in, patients are given the opportunity to complete the screening questionnaires at which time they have the right to refuse. Patients usually refuse due to not understanding why they must complete the screenings at every visit, or they feel they do not get the help they need when they do complete the screening questionnaires. Currently, there are no flags or alerts in the system to bring attention to patients who have a history of intermediate or high-risk suicide scores. Suicide screening is implemented using the C-SSRS after the patient verbalizes intent or ideations, reports a positive score on item 9 of the PHQ-9 questionnaire, a total score of 20 or higher on the PHQ-9, or has a diagnosis of major depressive disorder. At that time, the patients speak to care managers who review the answers, document the scores, and complete the suicide safety plans. The care managers then bring the charts to the providers, mostly psychiatric mental health nurse practitioners, and go over what the patient spoke about regarding suicide. The providers then speak to the patient, go over medications, and determine the severity of the suicide risk during assessment. They should then verify risk score, safety plan documentation, and verify the patient has received the National Suicide Prevention Lifeline number which is not always done.

Once care management or a provider determines the patient to be at an intermediate or high risk of suicide, an alert or flag should be permanently placed on the patients record easily visible for future visits. These alerts have helped both the Veterans Affairs clinics (Berg et al., 2018) and primary care clinics to recognize patients at risk for suicide easier than without the alerts (Calman & Little, n.d.). Implementing an alert system to notify staff and providers of suicide risk may be a challenge as it will be a new process and an additional task for providers to complete daily. There are challenges to implementing changes in how individuals are assessed or

the universal screening process, but the solutions are to change provider behavior, modify the culture of the system as a whole, provide guidelines to follow, and make training available on how to implement the guidelines (King et al., 2017). Challenges to obtaining data on suicide prevention activities in the electronic health record in most facilities are reconciling suicide risk and assessments, determining whether a suicide safety plan was done, and verifying safety plans are reviewed at each visit while the risk is high (Yarborough et al., 2019).

The data regarding the suicide screening rate for the macrosystem for 2019 was 67% and the patient refusal rates are unknown as this is not something they normally measure. This information can initiate changes to improve quality outcomes for patients and verify that facility metrics are being met. The data collected for this project would be used to verify goals of the National Action Alliance for Suicide Prevention suicide standard of care guidelines are being met. These two goals specifically are to have suicide prevention as a core component of health care visits and to implement best practices for assessing and treating at risk suicidal behaviors (Yarborough et al., 2019). The organization and the stakeholders are ready for change indicated by their willingness to help identify areas for improvement, make resources available, and allow implementation of the project in their facility.

### **Project Identification**

#### **Purpose**

The purpose of this project is to determine whether patients who are at an intermediate or high risk for suicide are being screened properly, their safety plans are being created during the initial visit, and determine the number of patients refusing to complete the PHQ-9 questionnaire. Suicide screening should be done for every patient meeting the requirements using a standardized screening tool. The questionnaires are to be reviewed before the patient leaves the

appointment and the suicide safety plans should be reviewed every visit while the patient is still at intermediate to high-risk of suicide (The Joint Commission, 2016). The first and second aims of this project are to determine the rates of suicide screening and safety plan documentation in patients who are at an intermediate or high risk of suicide. The third aim of this project is to determine the rate of patients refusing to complete the PHQ-9 questionnaire and decrease those numbers by 10%. Lastly, the fourth aim is to determine if there is a pattern in the patients who are refusing to complete the questionnaire.

### **Objectives**

Objectives of this quality improvement project are to increase the rates of suicide risk screenings and safety plan documentation while decreasing the rate of patient refusals of the PHQ-9 questionnaire. Evidence provided by the National Strategy for Suicide Prevention indicates that potential causes for the increase in suicide rates are due to inadequate suicide risk detection, evidence-based interventions are not utilized, and intensity of care is not increased when suicide risk is high (Labouliere et al., 2018). However, there are still gaps between knowing these interventions need to be improved and the care individuals receive. This field has moved to a prevention-oriented approach where individuals with a high risk of suicide are given a comprehensive suicide risk assessment yet many providers are not trained to provide the correct interventions or how to build strong relationships with suicidal patients (Labouliere et al., 2018).

### **Summary and Strength of the Evidence**

Brief interventions including suicide screening, safety planning, and follow up have been determined to help decrease the rates of suicide. A systematic review of 252,932 participants indicate suicide screening is best done using the PHQ-9 followed by the C-SSRS with risk

assessment as it has been found to provide more accurate results (Viguera et al., 2015). In a cohort study of 841 participants validating Viguera's study the C-SSRS with risk assessment was found to be considered the gold standard for assessing suicide risk (Na et al., 2018) and is highly regarded as a comprehensive tool that is quick and easy to use (Erford et al., 2017). Erford et al. (2017), found in a meta-analysis of five different suicide screening tools that the C-SSRS had close to perfect sensitivity and specificity making it superior to the other tests. In a systematic review of four controlled studies, both randomized and non-randomized mixed, McCabe et al. (2018), found that patients treated with these interventions may experience suicidal ideations but are unlikely to act on them and die by suicide. Brief interventions are believed to decrease suicide rates by providing social support to individuals who have limited support and financial or human resources (McCabe et al., 2018). These interventions are found to provide a better therapeutic relationship when utilized within a few days of an attempt or visit to the emergency department (McCabe et al., 2018).

In behavioral health clinics, suicide prevention interventions for individuals who have attempted suicide have been shown to be the best for decreasing suicide attempt rates (Hofstra et al., 2019). However, behavioral health clinics had worse completed suicide rates than other settings and the control (Hofstra et al., 2019). The best interventions for prevention of suicide attempts are multilevel, shown by a correlation between the effect size and number of levels; as the levels increase so does the effect size (Hofstra et al., 2019). The Zero Suicide Initiative is an evidence-based, best practice in suicide, multilevel approach that was a concept of the National Strategy for Suicide Prevention (Labouliere et al., 2018). This initiative was put in place to prevent further individuals from getting lost in the system (Labouliere et al., 2018). Multilevel interventions mean interventions are done by multiple different providers all of which are in



different areas of expertise (Hofstra et al., 2019). For example, primary care providers, care management, and mental health providers all working together to recognize individuals who may be at risk for suicide.

Providing suicide safe care in behavioral health clinics, whether it is a mental health clinic, intensive outpatient program, partial hospital programs, or private practice, should be a core responsibility. These types of facilities should have providers with the confidence and competence in working with individuals at risk for suicide who can provide evidence-based treatment (National Action Alliance, 2018). Providers in behavioral health clinics can use the AIM model to ensure they are performing suicide risk screenings, safety plan interventions, and safety plan reviews. AIM stands for (A) assess, which means to utilize best practices to detect suicide risk in patients by suicide risk screenings; (I) intervene, which uses evidence-based practices and tools to prevent suicide using suicide specific interventions such as implementing the safety plan intervention; and (M) monitoring, which means using enhanced monitoring during high risk suicide periods by reviewing safety plans, follow-up phone calls, brief assessment of suicide risk, and assessing upcoming barriers to care (Suicide Prevention, n.d.).

### **Project Intervention**

First, baseline data were collected consisting of January and February's information for the two providers participating in the project regarding total patients seen, completion of the C-SSRS, PHQ-9 completion and scores, PHQ-9 refusal total, and safety plan documentation. Audit and feedback were used to notify staff of areas for improvement. Education for providers on how to initiate and acknowledge the broadcast alert for patients at risk for suicide including instructions in the alert to other staff that only the prescribing provider can acknowledge the alert. Implementation of the PHQ-9 and the C-SSRS was not needed as the staff are already

using these tools which are evidence based best practice. The staff should be completing suicide screenings using the C-SSRS on every patient who has major depressive disorder, scores positive on question 9 of the PHQ-9 depression screening tool, or has a score 20 or higher per facility policy.

However, it has been brought to attention that some patients refuse to complete the screening tools. Those patients would receive a handout explaining the importance of why they are asked to complete the PHQ-9 at every visit and importance of notifying their providers of suicidal thoughts and behaviors along with the National Suicide Prevention Lifeline number. The explanation sheet would be handed out with the PHQ-9 in both English and Spanish.

Suicide screening goals for the funding metric are set by the government. Patient refusals to complete the screenings could affect reaching the set goal, however, if the facility is aware of how many people on average are refusing, they could notify the government to update the set requirement. Patient refusals are documented by the nurses and will be collected to determine on average the number of patients who do not complete the screenings. These rates are important in determining if it is affecting the metric and if it will affect the goal for this project. The handout explaining the PHQ-9 process may decrease the number of refusals indicating a need to also get pre- and post-data for the number of patient refusals.

Another intervention is an alert that was implemented in the electronic medical record (EMR) to indicate when a patient is at a risk for suicide. This alert is called a broadcast alert that immediately pops up when the patient's record is entered. The provider initiated and acknowledged the alert as they are the sole determinant on their patient's suicide risk level. This intervention would help all staff when they are rotating through the clinics as well as working in their home clinic. When providers are seeing unfamiliar patients, they will easily see the

broadcast alert and know the patient is at risk for suicide and can take the appropriate steps even though they may have never seen that patient before.

Lastly, the Caring Contacts intervention is where patients who are at risk for suicide are contacted by phone or letters in a non-demanding manner letting them know they are cared for, thought about, and can call the clinic if they need anything. This intervention would be led by the clinic's peers who are past patients themselves who no longer need services of the clinic. They now help other patients grow, reach the goals they set for themselves, and act as mentors. The evidence shows that when Caring Contacts are used it reduces self-harm and suicide (National Action Alliance, 2018). Other findings indicate that patients find Caring Contacts to be helpful and show they are cared about (Reger et al., 2018). There are over 40 years of research on Caring Contacts with consistent evidence showing it is cost-effective, able to reach numerous patients, and effective in reducing rates of self-harm and suicide (Reger et al., 2017).

### **Setting**

The project took place in a behavioral health clinic in an area that consists of multiple hospitals and clinics with a large homeless and poverty-stricken population. Most of the patients in the clinic have no insurance, get their medication through the medication assistance program, and have transportation issues. The adult behavioral health clinic sees over 32,000 patients annually. The primary care office has a psychologist who is a behavioral health consultant and will refer patients to the adult behavioral health services when needed. In behavioral health services there are numerous care managers, four LVNs, three psychiatric nurse practitioners, and two psychiatrists.

## Population

The clinic sees adult patients ages 18 and up with all mental health diagnoses. The population that was included in the data collection were patients 18-85 years old. Within the included population variables that were measured were safety plan documentation; PHQ-9 refusal; diagnosis, demographics, provider, and time of appointment for refusal pattern determination; and suicide risk broadcast alert initiation and acknowledgement. Demographic characteristics are presented in Table 1.

**Table 1**

*Patient Demographics and Characteristics*

Characteristics	<i>n</i> = 768	%
Sex		
Male	288	37.5
Female	480	62.5
Age		
18-25	59	7.7
26-45	335	43.6
46-65	338	44.0
66-85	36	4.7
Diagnosis		
Schizophrenia	135	17.6
Schizoaffective Bipolar	119	15.5
Type		
Schizoaffective Depressive	52	6.8
Type		
Major Depressive Disorder	175	22.8
Bipolar I	234	30.5
Bipolar II	35	4.6
Unspecified Depressive	2	0.3
Disorder		
Unspecified Bipolar	16	2.1
Disorder		
Provider		
A	359	46.7
B	409	53.3

**Organizational Barriers/Facilitators**

The barriers experienced are the difficulty and length of time it takes to have reports generated for the C-SSRS and PHQ-9 due to the age of the software and amount of IT staff available to assist with reports; safety plans cannot be generated in reports, they must be looked up manually; the age of the software made it impossible to implement the wanted alerts in the record; multiple entities to get project and intervention approval from; and inability to utilize any resources until the letter of approval is obtained from the HIPPA compliance officer.

The Caring Contacts intervention was going to be approved contingent on the amount of work it was going to entail for the staff completing the letters. The Treatment and Care Council requested information on an estimate of how many patients a week these letters would be sent to. They also would need to get approval from the Forms Committee regarding the letters and figure out the best method of sending them. There were too many obstacles for this intervention to be implemented and the time constraint of this project did not allow enough time to gather the needed information and approval in time to implement this intervention.

Shortly after the project started, Coronavirus regulations were initiated regarding social distancing and students were no longer allowed in the clinic. Most visits were tele-visits which providers started doing exclusively starting March 23, and patient encounters were low. The PHQ-9 was no longer asked for all patients willing to complete it and the C-SSRS was no longer asked on all patients with Major Depressive Disorder. During tele-psych visits, the PHQ-9, C-SSRS, and safety plans were no longer completed. This change in practice influenced the outcomes for all objectives of this project. The PHQ-9 and Suicide Prevention information handout was never approved by the Forms Committee because during the time they were supposed to review it, everything with the Coronavirus needed to be taken care of first.

Therefore, this intervention never received final approval and was not used during the implementation period.

Facilitators of the project include the nurse practitioners and nurses who were willing to participate in the project, provide information handouts, and complete the data collection form. Additional facilitators of the project were the project mentor and the academic coordinator along with other staff who implemented the policy to have students' complete doctoral projects in the facility which was not previously done. Approval for this project was determined by the chief medical officer, Treatment and Care Council, and the HIPAA compliance officer.

### **Ethical Considerations**

An IRB review was completed and indicated this project was deemed not to be regulated research. A review was also completed by the facility's HIPAA compliance officer who gave a final letter of support, see Appendix A. Considering the suicide screening, providers may face ethical dilemmas when they have to require a patient be put under emergency detention as explained in the VA/DoD (2013) guidelines since this action causes the provider to have to breach patient confidentiality. Providers may also face ethical concerns when trying to determine whether to warn a third party of imminent danger. According to the Texas Health and Safety Code §611.004 (2005), providers are not mandated with the duty to warn. It is up to the provider to notify medical or law enforcement if there is imminent physical danger to the patient or others.

## **Results**

### **Screening and Safety Plan Documentation**

Objective one, as seen in Table 2, was to increase the rate of suicide screenings and safety plan documentation to 95%. Suicide screenings using the C-SSRS was 48.5% which

decreased to 7.2% after implantation phase. Safety plan documentation was 2.5% and decreased to 0.4%. Post-intervention data indicated a decrease in both the C-SSRS and safety plan documentation rates which could be a result of provider only tele-visits with no care management involvement. Care management performs C-SSRS screening and completes safety plans at this facility. The goal of increasing the rate to 95% was not met as shown by the 15% decrease in post-intervention data. Patients with major depressive disorder were no longer screened once tele-visits started. During post-intervention chart audits, tele-visit patients were asked about suicidal and homicidal ideations in which there was a documented patient response. According to the documentation, patients denied suicidal ideation, but providers advised patients to call 911 if they felt suicidal or had thoughts of suicide. The National Suicide Prevention Lifeline was not given to any patients.

**Table 2**

*Columbia Suicide Severity Rating Scale and Safety Plan Documentation Rates*

Characteristics	C-SSRS				Safety Plan			
	Pre		Post		Pre		Post	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Sex								
Male	82	28	21	38.2	4	26.7	1	33.3
Female	210	72	34	61.8	11	73.3	2	66.7
Age								
18-25	28	9.5	6	10.9	1	6.7	1	33.3
26-45	145	49.3	17	30.9	6	40.0	2	66.6
46-65	111	37.8	29	52.7	8	53.3		
66-85			3	5.5				
Completion	292	48.5	55	7.2	15	2.5	3	0.4

Note. Pre-implementation data based on  $n = 292$ ; Post-implementation data based on  $n = 768$ .

### Patient Health Questionnaire

Objective two, see Table 3, was to decrease the rate of patient questionnaire refusals by 10%. Post-implementation data indicated that of the 575 patients who were screened, or had a recent PHQ-9 on file, 37 refused, decreasing the rate of refusal by 27%. Of the total 768 patients, 25% were not asked to complete the PHQ-9 including patients who have a diagnosis of major depressive disorder. All the patients not asked to complete the PHQ-9 had a tele-visit.

### Refusal Pattern

Patterns were seen in patients who refused to complete the PHQ-9 as seen in Table 3. Most of the patients who refuse are 26-45 years old (56.8%), with a diagnosis of schizophrenia (35.1%) who have appointments in the afternoon (54.1%) and are seen by provider B (67.6). This data will be used by the facility to develop a process so that these patients can be screened properly with both the PHQ-9 and the C-SSRS. The facility's goal in having this data collected was to improve the facilities screening process and increase the rates of patients screened.

**Table 3**

*PHQ-9 Refusal Rates and Patterns*

Characteristics	Pre-implementation		Post-implementation	
	<i>n</i>	%	<i>n</i>	%
Sex				
Male	46	30.7	18	48.6
Female	104	69.3	19	51.4
Age				
18-25	9	6	1	2.7
26-45	68	45.3	21	56.8
46-65	64	42.7	14	37.8
66-85	9	6	1	2.7
Diagnosis				
Schizophrenia	32	21.3	13	35.1
Schizoaffective	18	12	10	27
Bipolar Type				



Characteristics	Pre-implementation		Post-implementation	
	<i>n</i>	%	<i>n</i>	%
Schizoaffective Depressive Type	13	8.7	3	8.1
Major Depressive Disorder	13	8.8	2	5.4
Bipolar I	42	23.3	9	24.3
Bipolar II	3	2.0		
Appointment Time				
AM			17	45.9
PM			20	54.1
Provider				
A			12	32.4
B			25	67.6
Total Not Asked	0	0	193	25
Total Refusals	150	23.7	37	6.4

Note. Pre-implementation total patients  $n = 632$ ; Post-implementation total patients  $n = 768$ .

### Suicide Risk Alerts

Objective 3 was to implement an alert system for 100% of patients at risk for suicide as seen in Table 4. Post-implementation data indicates the goal of 100% was met. A total of four patients were deemed to be at risk for suicide during the office visit time-period with all four having alerts placed on the chart. Provider A was the only provider who placed suicide risk alerts on the chart. During chart audits of tele-visits, documentation indicated that all the patients denied suicidal ideation or previously had thoughts but no longer had suicidal thoughts. During office visits, the care managers screen the patients and complete the safety plans along with advising providers when someone is at risk for suicide. Since 71% of visits were tele-visits it is possible that patients were deemed not at risk for suicide so that the providers did not have to complete the screening or safety plans. Verification of when the alerts were acknowledged could not be determined because it is not clearly indicated on the charts. After multiple requests on

how to verify by who and when an alert was acknowledged with no responses, this information was not collected.

**Table 4**

*Suicide Risk Alert Placement*

Characteristics	Suicide Risk	
	<i>n</i>	%
Sex		
Male	2	50
Female	2	50
Age		
18-25		
26-45	2	50
46-65	2	50
66-85		
Diagnosis		
Schizophrenia		
Schizoaffective Bipolar Type		
Schizoaffective Depressive Type		
Major Depressive Disorder	3	75
Bipolar I	1	25
Bipolar II		
Provider		
A	4	100
B		
Alert		
Placed	4	100
Not Placed		

## Discussion

A successful part of this project is seeing that safety plan documentation was completed on three out of the four patients deemed at risk for suicide with alerts placed during those visits. This indicates the alerts may be beneficial in reminding care management and providers to verify a safety plan is documented. Anyone who had an alert in place and did not go directly to the

crisis intervention center, were given appointments for a week out. This is an improvement from the normal 3 month waiting time. Another success was determining how many patients refuse to complete the screening process and identifying a pattern of those who refuse. The pattern information and refusal data can provide insight for the facility to develop a new screening process for those patients. The new process can potentially decrease refusal rates and increase screening rates which could lead to better suicide screening by providers.

Difficulties seen with this project include a lack of knowledge regarding how to implement and use the alert system built into the EMR and a lack of knowledge regarding assessing for suicide and the importance of determining if someone is at risk. As seen in other studies, including one by Berg et al. (2018), some difficulty seen with this project as well, arises with having multiple providers. Determining suicide risk is subjective even when using the universal screening tools such as the C-SSRS, which leads to issues initiating an alert on the chart and some providers do not see the benefit in using suicide risk alerts. During this project, the alerts that were placed were supposed to be acknowledged by the prescribing physician after input from care management regarding their assessment. However, according to provider A, his alerts could possibly be acknowledged by the providers at the crisis intervention center since they usually see the patients for at least 3 days in a row. The alert, once it is acknowledged, can not be easily found to see who acknowledged it and when. Since the EMR used at this facility is older, the alert system in its entirety was difficult to manage as they would not print out with the schedule of the day, unable to be seen unless you brought up the patient chart, unable to be printed in reports, and could be acknowledged by anyone since there is no way to lock it for prescribing provider only.

Strengths of the project were providers realization that the suicide alerts would be beneficial when floating to other clinics. They could also help remind the providers of what is going on with the patient as soon as they opened the chart. The alerts could also help care management when assessing the patient to know their suicide risk and remind them to complete or update the safety plan. Information obtained regarding patient refusals provide data that the facility can use to verify they will reach the goals for their funding. Part of the funding is based on the number of suicide screenings and PHQ-9 screenings which are set by the government, but with this information they can advise the government that they have a certain amount of refusals to consider. Sustainability of this project moving forward is a strength in that the alert intervention can be used in all the clinics in the macrosystem and the new policy for screening patients who normally refuse can also be used across the macrosystem as well.

**Limitations**

The outdated EMR software made it impossible to implement the intended alert of changing a symbol on the patient's chart a certain color to indicate the patient is at risk for suicide. The only option was to use the broadcast alert, which is used for all alerts, can be initiated by anyone, and can be acknowledged by anyone which removes it from the patient's chart. Provider B did not know how to initiate the broadcast alert but was taught how to do so and when to initiate and remove the alert. Provider B also indicated a lack of knowledge on how to identify a patient at risk for suicide. Before implementation of the project one provider out of the three decided not to participate. After the restrictions put in place for in office visits, most visits were by video or phone. This impacted how the screening and documentation of safety plans was implemented.

**Recommendations**

The Caring Contacts intervention should be further considered as the evidence in previous studies indicate it helps in decreasing suicide risk, keeping patients engaged in their care, and causes patients who have been discharged to re-engage in their care. EMR alerts for suicide risk patients should be continued as this helps providers realize immediately the patient is at risk. Nurse practitioners and physicians who must float to other clinics benefit from these alerts especially because they are unfamiliar with these patients. The suicide risk alert notifies them of the extra care that must be given to these patients during their visit. The PHQ-9 and Suicide Prevention informational handout should be given to patients when they check in so that they know why they are being asked to complete the questionnaire ahead of time. This may help decrease the refusal rate as nursing staff verbalized the patient not understanding why they had to complete it as the most used reason for not completing the questionnaire.

Education regarding suicide screening, identifying someone at risk for suicide, and implementation of new screening protocols for tele-visits would be beneficial for this facility and the patients. There would be better patient care and documentation with educating providers on how to screen patients for suicide and what to look, or listen, for with patients. The providers who are psychiatric nurse practitioners are taught how to complete both the PHQ-9 and C-SSRS along with safety plans before graduation. New protocols indicating they are to screen patients during tele-visits and complete the safety plan would ensure these are being performed and increase screening rates. Yearly facility educational requirements to complete training for suicide screening and identification would also increase these rates. The facility could also collaborate with the Zero Suicide initiative to provide a comprehensive training program for all staff.

**Implications for Practice**

Implementation of an EMR alert system would be beneficial to the clinic macrosystem as there are numerous clinics and providers involved in the care of patients. These providers along with the staff are often asked to provide their services at other clinics and are not familiar with the patients at those locations. The alert system, if utilized and utilized correctly, could potentially help save lives. Pattern information for patients who refused the PHQ-9 provides the facility with needed data to initiate a new screening protocol for these patients to provide better care, fewer refusals, and an increase in screening for both depression and suicide.

The Doctor of Nursing Practice prepared nurse practitioner brings the knowledge and skills to any facility to improve the quality of care patients are receiving. They can also assess for quality improvement needs and implement changes to provide better outcomes for patients. However, the facility administration and staff must be willing to embrace the process and changes needed to improve care for their patients. This project is sustainable if the facility requires that alerts be placed on all charts of patients at risk for suicide, otherwise the providers will not continue to implement it. The providers involved in this project understand the importance of the suicide risk alert and its benefits.

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**Appendix A**  
**Letter of Support**

[REDACTED]

[REDACTED]

Mental Health & Substance Abuse Solutions

[REDACTED]

January 11, 2020

To Whom It May Concern:

Ms. Brandi Hrasdzira, University of the Incarnate Word doctoral nursing student, has presented a proposal to [REDACTED] to complete a quality improvement project to "Improve Provider Suicide Screening and Suicide Safety Planning Rates in Behavioral Health Clinics". This project is not deemed to be research and no identifiable or personal health information will be shared. Required approvals have been met for Ms. Hrasdzira to proceed with the mentioned project.

Sincerely,



[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

## Appendix B

## Patient Health Questionnaire (PHQ-9)

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Over the last 2 weeks, how often have you been  
bothered by any of the following problems?  
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns  +  + 

(Healthcare professional: For interpretation of TOTAL, TOTAL:   
please refer to accompanying scoring card).

10. If you checked off <i>any problems</i> , how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

## Appendix C

## Columbia-Suicide Severity Rating Scale (C-SSRS)

	Past month	
Ask questions that are bolded and <u>underlined</u> .	YES	NO
<b>Ask Questions 1 and 2</b>		
1) <b><u>Have you wished you were dead or wished you could go to sleep and not wake up?</u></b>		
2) <b><u>Have you actually had any thoughts of killing yourself?</u></b>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) <b><u>Have you been thinking about how you might do this?</u></b> E.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."		
4) <b><u>Have you had these thoughts and had some intention of acting on them?</u></b> As opposed to "I have the thoughts but I definitely will not do anything about them."		
5) <b><u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u></b>		
6) <b><u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u></b> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. <b>If YES, ask: <u>Was this within the past three months?</u></b>		

- Low Risk  
 Moderate Risk  
 High Risk

## Appendix D

## C-SSRS Risk Assessment

**COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)**

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, &amp; Mann

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**RISK ASSESSMENT**

<b>Instructions:</b> Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.			
<b>Past 3 Months</b>	<b>Suicidal and Self-Injurious Behavior</b>	<b>Lifetime</b>	<b>Clinical Status (Recent)</b>
<input type="checkbox"/>	Actual suicide attempt <input type="checkbox"/> Lifetime	<input type="checkbox"/>	<input type="checkbox"/> Hopelessness
<input type="checkbox"/>	Interrupted attempt <input type="checkbox"/> Lifetime	<input type="checkbox"/>	<input type="checkbox"/> Major depressive episode
<input type="checkbox"/>	Aborted or Self-Interrupted attempt <input type="checkbox"/> Lifetime	<input type="checkbox"/>	<input type="checkbox"/> Mixed affective episode (e.g. Bipolar)
<input type="checkbox"/>	Other preparatory acts to kill self <input type="checkbox"/> Lifetime	<input type="checkbox"/>	<input type="checkbox"/> Command hallucinations to hurt self
<input type="checkbox"/>	Self-injurious behavior <i>without</i> suicidal intent	<input type="checkbox"/>	<input type="checkbox"/> Highly impulsive behavior
<b>Suicidal Ideation</b> <b>Check Most Severe in Past Month</b>			<input type="checkbox"/> Substance abuse or dependence
<input type="checkbox"/>	Wish to be dead		<input type="checkbox"/> Agitation or severe anxiety
<input type="checkbox"/>	Suicidal thoughts		<input type="checkbox"/> Perceived burden on family or others
<input type="checkbox"/>	Suicidal thoughts with method (but without specific plan or intent to act)		<input type="checkbox"/> Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
<input type="checkbox"/>	Suicidal intent (without specific plan)		<input type="checkbox"/> Homicidal ideation
<input type="checkbox"/>	Suicidal intent with specific plan		<input type="checkbox"/> Aggressive behavior towards others
<b>Activating Events (Recent)</b>			<input type="checkbox"/> Method for suicide available (gun, pills, etc.)
<input type="checkbox"/>	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)		<input type="checkbox"/> Refuses or feels unable to agree to safety plan
Describe:			<input type="checkbox"/> Sexual abuse (lifetime)
			<input type="checkbox"/> Family history of suicide (lifetime)
<input type="checkbox"/>	Pending incarceration or homelessness		<b>Protective Factors (Recent)</b>
<input type="checkbox"/>	Current or pending isolation or feeling alone		<input type="checkbox"/> Identifies reasons for living
<b>Treatment History</b>			<input type="checkbox"/> Responsibility to family or others; living with family
<input type="checkbox"/>	Previous psychiatric diagnoses and treatments		<input type="checkbox"/> Supportive social network or family
<input type="checkbox"/>	Hopeless or dissatisfied with treatment		<input type="checkbox"/> Fear of death or dying due to pain and suffering
<input type="checkbox"/>	Non-compliant with treatment		<input type="checkbox"/> Belief that suicide is immoral; high spirituality
<input type="checkbox"/>	Not receiving treatment		<input type="checkbox"/> Engaged in work or school
<b>Other Risk Factors</b>			<b>Other Protective Factors</b>
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	

## Appendix E

### Safety Plan

**SAFETY PLAN**

What brought on the crisis?

\_\_\_\_\_

Step 1: What are my crisis warning signs (thoughts, feelings, situations, behaviors, etc.):

\_\_\_\_\_

Step 2: What helps me feel calm (activities, coping skills, relaxation techniques, etc.):

\_\_\_\_\_

Step 3: I feel comfortable talking to:

1. Name	Phone:
2. Name	Phone:

Step 4: Places I can go to feel safe are:

\_\_\_\_\_

Step 5: Professionals or agencies I can contact during a crisis:

1. In case of Emergency, call 911
2. ....
3. .... Hours of Operation: 8 AM - 8 PM
4. .... Hours of Operation: 8:30 AM - 5:30 PM
5. Crisis Line
6. Local Hospital Emergency Room  
Local Hospital Name:  
Local Hospital Address:  
Local Hospital Phone:
7. National Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: I can create a safe environment by:

\_\_\_\_\_

Step 7: Two responsible parties that can be contacted by ..... if you cannot be reached by phone:



## Appendix F

### Safety Plan-continued

1. Name \_\_\_\_\_ Phone: \_\_\_\_\_  
 2. Name \_\_\_\_\_ Phone: \_\_\_\_\_

Step 8: The one thing that I look forward to and is most important to me is:

#### Calming Activities:

##### 1. Play Music:

Play music that creates an emotion that is the opposite of the one you are struggling. For example, if you are very sad, play happy and upbeat music. If you are feeling anxious, play slow and relaxing music.

##### 2. Do Something:

Participate in a highly engaging activity. Television or computer activities do not count here as these are too passive. Instead, take a walk, dance, clean your house, or do some other activity that gets you engaged and distracts you from your current emotions.

##### 3. Call Someone:

Reaching out to others can really help when you are struggling with strong emotions. Call a supportive friend or family member that you are comfortable talking with. If you don't have someone in mind that is supportive, call a helpline (for example: in the U.S. you can call the National Suicide Prevention Lifeline).

##### 4. Ride it out:

The peak of most strong emotional reactions (and the urges to engage in harmful activities, like self-harming or drinking, that can go along with these reactions) last for a few minutes and then begin to subside. Grab an egg timer from the kitchen, and set it for 10 minutes. Wait the 10 minutes, & practice riding out the emotion.

##### 5. Be mindful:

Practice mindfulness of your emotions. Notice the emotion you are having, and let yourself experience it as a wave, without trying to block it, suppress it, or hold on to it. Try to accept the emotion for what it is.

##### 6. Breathe Deeply:

Sit or lie somewhere quiet and bring your attention to your breathing. Breathe evenly, slowly, and deeply. Watch your stomach rise and fall with each breath.

##### 7. Take a Warm Bath or Shower:

Try to lose yourself in the sensations of the warm water, the smell of the soap, etc. Allow the sensations to distract you from the situation you are upset about.

##### 8. Ground Yourself:

When emotions seem to be taking you out of the current mood (e.g. you are starting to feel "zoned out" or can't see anything else going on at the moment), do something to ground yourself. Grab an ice cube and hold it in your hand for a few moments, snap a rubber band against your wrist, "snap yourself back" into the moment.

##### 9. Help Someone Else:

Do something nice for someone else. It doesn't have to be something big; you can walk to the nearest store, buy a pack of gum, and give the cashier a smile and say, "Have a great day." It may sound silly, but small gestures like this can really reduce emotional pain.

...#10, 642 (Rev 10/11/17)

**Appendix G****Data Tracking Form**

MRN \_\_\_\_\_ Tele: \_\_\_\_\_

PHQ-9 Refused: Yes \_\_\_\_\_ No \_\_\_\_\_ PHQ-9 Not Asked: \_\_\_\_\_

Columbia: Yes \_\_\_\_\_ No \_\_\_\_\_ Safety Plan: Yes \_\_\_\_\_ No \_\_\_\_\_

Suicide Risk: Yes \_\_\_\_\_ No \_\_\_\_\_

Alert: Initiated during today's visit \_\_\_\_\_

Initiated prior to today's visit \_\_\_\_\_

Alert Acknowledgement: During today's visit \_\_\_\_\_

Prior to today's visit \_\_\_\_\_

During crisis visit \_\_\_\_\_

Not acknowledged \_\_\_\_\_

Diagnosis \_\_\_\_\_

M/F Age \_\_\_\_\_ Time \_\_\_\_\_ Date \_\_\_\_\_