**University of Toledo Medical Center**

**Department of Psychiatry Service Guidelines**

**Title**: Suicide Risk Screen

**Purpose**: This guideline outlines the procedures and documentation for Suicide Screen for patients ages 12 years and older

**Related Polices**: 3364-100-45-23 Involuntary Civil Commitment; Patients Lacking Decision Making Capacity
3364-100-60-60 Adult Patients Requiring Psychiatric Interventions
3364-101-02-01 Ambulatory Medical Record
3364-160-CR-110 Suicide Risk Assessment

**Accountability**: It is the clinical team's responsibility to conduct suicide risk screens and implement plans of treatment under guidance of a licensed provider, based on the clinical needs of the patient.

**Procedure:**

1. As part of each **pharmacological management appointment**, the Medical Assistant (MA) will ask the patient all suicide screening questions of the Patient Health Questionnaire-9 (PHQ-9) screening tool and document responses in the clinical record.
    a. If the patient responds, "Not at all" to question #9, "Thoughts that you would be better off dead or of hurting yourself in some way (past 2 weeks)," no further action is needed by the MA.
    b. If the answer to question #9, "Thoughts that you would be better off dead or of hurting yourself in some way (past 2 weeks)," is any answer other than "Not at all", the screening is considered positive. The following actions should be taken:
        i. The MA will document this information in the medical record and notify the provider immediately that the patient PHQ-9 screening was positive. Patient will be staffed 1:1* until provider retrieves the patient and will complete documentation on the Suicide Precaution Checklist.
        ii. When patient is with the clinician, the clinician will:
            1. Ensure the patient is staffed 1:1* until safety planning is complete and disposition determined;
            2. Conduct a Suicide Risk Assessment and determine appropriate level of care based on assessment;
            3. Add an objective on the treatment plan that will address suicidal ideation for on-going monitoring as part of the session and delivery of care;
            4. Conduct safety planning in collaboration with the patient and guardian if applicable, to include coping skills and resources for reducing risks (National Suicide Prevention Lifeline and other local resources).

2. As part of the **Initial therapy appointment**, the provider will conduct the PHQ-9 suicide screen and document responses in the clinical record.

    a. If the patient responds, "Not at all" to question #9, "Thoughts of hurting yourself in some way (past 2 weeks)," no further assessment is required.
    b. If the answer to question #9, "Thoughts of hurting yourself in some way (past 2 weeks)," is any answer other than "Not at all", the screening is considered positive and the clinical provider will:

   i. Ensure the patient is staffed 1:1* until safety planning is complete and disposition determined;
   ii. Conduct a Suicide Risk Assessment and determine appropriate level of care based on assessment;
   iii. Add an objective on the treatment plan that will address suicidal ideation for on-going monitoring as part of the session and delivery of care;
   iv. Conduct safety planning in collaboration with the patient and guardian if applicable, to include coping skills and resources for reducing risks (National Suicide Prevention Lifeline and other local resources).

3. Emergency Hospitalization Considerations:
   a. In the case where the patient is not agreeable for inpatient treatment and does not meet criteria for emergency involuntary civil commitment, requests will be made of the patient to contact friends, family, or other outpatient treatment providers. (If necessary, HIPAA permits providers to make these contacts when the provider believes the patient may be a danger to self or others)
   b. For patients who are deemed appropriate for emergency involuntary civil commitment ("pink slip"):
      i. Provider will complete the involuntary civil commitment documentation which will accompany the patient.
      ii. Patient will be escorted to the Emergency Department by 2 staff persons, preferably patient transport or hospital security and a physician. The psych consult team can also assist with transport if needed.

4. Telehealth Considerations:
   a. The staff member should confirm at the start of every telehealth encounter:
      i. The patient's physical location
      ii. A telephone number to contact should they lose connection
      iii. An emergency contact and their phone number should the staff member need to contact to assist in maintaining patient safety (e.g., while waiting for emergency services/911 to arrive)
   b. If a patient expresses a psychiatric emergency during a telehealth appointment:
      i. The staff member is to attempt to remain on the phone with the patient
      ii. The staff member is to contact 911/emergency services to request a well-check
      iii. Document the disclosure on the PHI disclosure log

*Staffed 1:1 means one individual assigned to one patient who will maintain visual contact and be located in the same room of the assigned individual at all times.

**Resources:**

*Screening for Depression and Adolescents: U.S. Preventive Services Task Force Recommendation Statement* Annals of Internal Medicine Vol 164 No. 5 1 March 2016

*Child Suicide Screening Methods: Are We Asking the Right Questions? A review of the Literature and Recommendations for Practice* The Journal for Nurse Practitioner – JNP Volume 12, Issue 6, June 2016

*Practice Parameter for the Assessment and Treatment of Child and Adolescents with Suicidal Behavior* Child and Adolescent Psychiatry 40:7 July 2001

*The Suicidal Behaviors Questionnaire – Revised (SBQ-R): Validation With Clinical and Non-Clinical Samples* Psychological Assessment 2001 Volume 8, Number 4 443-454

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