## *The following document is used to train research personnel on risk management procedures.*

## Risk Management Procedures

## 1. How is someone identified or flagged for suicide risk?

Each assessment or therapy session has different questions that when endorsed, individually or together, notify us that a participant has suicidal ideation and prompts the study staff that the risk management protocol needs to be initiated. **These specific items MUST BE CHECKED BY THE STUDY STAFF MEMBER at the time of the assessment or session BEFORE the participant leaves.** While these specific questions will trigger a risk assessment, clinical judgment, including combining information gathered during the assessment regarding current risk factors (e.g. active substance use/abuse, available firearm, severe depression, positive suicide attempt history) should also be used to make a decision regarding risk. When in doubt, you can always ask additional questions just to be sure or call the supervisor or clinician on call for a consultation.

## Criteria for suicide flag (by assessment) EXAMPLE:

\*Replace the measure below with items being used to measure risk in the project.

* SCREENING criteria: **BSS-SR**
	+ A score of ‘**2**’ on **ANY** **2 items** on the measure

**AND / OR**

* + A score of **5 OR GREATER** on the entire measure (*criteria for study enrollment*)
		- Anyone who receives these scores, regardless of eligibility for the full study, should receive a risk assessment.
* BASELINE criteria (in-person and telephone): **C-SSRS**
	+ A ‘**YES**’ to **Question 4** (*Have you had these thoughts and had some intention of acting on them?)*

**AND / OR**

**Question 5** (*Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?)*

 **Risk assessment should be done after every baseline.**

* FOLLOW UP ASSESSMENT criteria (in-person and telephone):BSS-SR and C-SSRS
	+ - A score of ‘**2**’ on **ANY** **2 items** on the measure

**AND / OR**

* + - A score of **5 OR GREATER** on the entire measure (*criteria for study enrollment*)
	+ **IF YES:**
		- A ‘**YES**’ to **Question 4** (*Have you had these thoughts and had some intention of acting on them?)*

**AND**

**Question 5** (*Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?)*

## 2. Risk assessment procedures

Research staff will review all self-report or interview measures for indications of elevated risk for suicide based on the above criteria before the participant leaves the assessment or therapy session to ensure participant safety. For those who report suicidal ideation on any of the above scales, determination of high risk for suicide will be based on a combination of the information gathered during the assessment (both self-report and verbal interview) and the interaction between the study staff member and the participant.

**In-person and over the phone**:

* Study staff will check the self-report measures completed by the participant as part of the screening packet for the risk criteria.
	+ If the participant DOES NOT meet the above criteria **AND** DOES NOT exhibit any concerning language or behaviors, the study staff member will continue with assessment procedures (payment, etc.).
	+ If the participant DOES meet the above criteria **OR** exhibits any concerning language or behaviors, the study staff member will let the participant know that their answers indicated an elevated risk and they would like to ask them some additional questions.
		- Example: *“Sometimes when someone gets very upset, they may have thoughts of wanting to hurt themselves or wanting to end their life. I noticed that you marked having some feelings of depression or thoughts of hurting yourself recently, so I’d like to make sure that everything is okay before we go on. Ok?”*
	+ Study staff will then ask the following question: **“Have you had these thoughts and had some intention of acting on them?”**
		- If the participant says **NO**, the study staff member will do the following:
			* Let the participant know that should they experience a change in their thoughts or if they feel like they need help, there are resources available for them to contact (e.g. their therapist at the VA, the Emergency Department, the crisis line).
			* Provide the participant with the study resource brochure.
			* Continue with the assessment procedures
			* Complete the Incident Report Form documenting the risk assessment and interaction.
		- If **‘YES’** to the above question, study staff will ask the following question: **“Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?”**
		- If the participant says **NO**, the study staff member will do the following:
			* Let the participant know that should they experience a change in their thoughts or if they feel like they need help, there are resources available for them to contact (e.g. their therapist at the VA, the Emergency Department, the crisis line).
			* Provide the participant with the study resource brochure.
			* Continue with the baseline recruitment pitch (presuming the participant meets all eligibility criteria).
			* Complete the Incident Report Form documenting the risk assessment and interaction.
			* *NOTE:* if you feel during the assessment that the information provided by the participant is ambiguous, or if you would like a consultation, you can call the supervisor or clinician on call.
* If ‘**YES**’ to the above question, study staff will conduct a formal risk assessment, where they will ask additional questions to obtain enough information for a clinical consultation (e.g. obtain additional information regarding thoughts, intention, plan, past attempt history, risk and protective factors.)
	+ Study staff will use the Risk Assessment Form as a guide to help structure their questions and make sure they are gathering all of the information needed.
	+ Once completed, the study staff will notify the participant that they are concerned about their safety, and that they need to contact their supervisor. Study staff may ask the participant about who they might be comfortable talking to about their current suicidal thoughts and plans.
		- Example: *“I would like you to talk with someone today about your thoughts of hurting yourself. You can meet with a nurse on the unit (screener/baseline) someone in the ED (if in the VA for follow up), or you can call the Suicide Prevention Hotline. We can also try and get in touch with your outpatient clinician or therapist (follow up). Which would you like to do?”*
		- If the person is reluctant to talk with anyone, try to identify and address their concerns. Explain to the participant that it may be helpful to talk to someone even if they think it is only somewhat likely that they will harm themselves.
	+ Study staff will call their supervisor or clinician on call while the participant is still at the assessment. Study staff OR participant will explain the situation to the supervisor/clinician on call and provide them with the information gathered on the Risk Assessment Form.
	+ The supervisor or clinician on call will evaluate the risk level and decide what steps need to be taken to ensure the participant’s safety. If necessary, they may speak to the participant.
	+ Study staff will then follow the actions recommended by the supervisor or clinician on call. These may include:
		- Providing a resource brochure.
		- Notification of the participant’s clinician, doctor, or Suicide Prevention Coordinator.
		- Warm handoff to the crisis line.
		- Warm handoff to the ED
	+ In cases in which confidentiality must be broken, we always encourage participants to disclose their suicidal thoughts to the professional (i.e., their therapist, suicide prevention coordinator, psychiatrist on call, etc). vs. study staff disclosing this information. This helps to empower the participant and maintain study confidentiality.
	+ If the participant **IS** willing to speak to a professional regarding their suicidal thoughts, the study staff member must stay with the participant and/or take the participant to the clinical professional in order to provide the warm handoff. Once the handoff is complete, the study staff member will complete the Risk Assessment Form, documenting what actions were taken to ensure the participant’s safety.
	+ If the patient **REFUSES** to speak to someone, with consultation of the study clinician, it may be necessary to inform other professionals about the participant’s high risk.
		- Participants should be reminded about the limits of confidentiality that were discussed in the consent form, and should be notified that we are required to share the information with a clinical professional in order to keep them safe.
		- It is important to notify the participant that only information that is pertinent to the situation (gaining appropriate help for the participant) will be relayed to the professional- no other information collected from the participant during the assessment will be disclosed.
		- If the participant leaves the assessment or hangs up the phone/will not answer calls before professional contact can be made, study staff will notify the police that the participant is a danger to themselves.
		- Once the contact with the professional has been made, the study staff member will complete the Risk Assessment Form, documenting what actions were taken to ensure the participant’s safety.
		- If confidentiality is broken by study staff (the participant refuses to disclose the risk on their own to a professional), documentation of a SAE must be submitted to the IRB within 5 business days.
	+ After the assessment is complete, study staff will ensure that all forms (Incident Report Form or Risk Assessment Form) are completed, signed, and entered into the Risk Assessment database. Forms will then be given to the supervisor for review. Information from these reports may also be included as part of the Data and Safety Monitoring Board report.

## 3. Additional telephone assessment procedures

For telephone assessments, study staff will need to have some additional information available to them:

* Study staff should always have an additional phone available in case they need to make a call to a supervisor or clinician on call for a clinical consultation during the phone assessment. You should never place on hold or hang up on a high-risk participant to call a supervisor.
* If conducting an assessment by phone, the participant’s current location should be confirmed at the start of the call, in case any rescue help needs to be sent to them. Study staff should follow the prompts listed on the telephone assessment to collect the address and phone number where the participant can currently be reached.
* Study staff should be aware of how to make 3 way calls on whatever type of phone they are using to conduct the assessment (i.e. office phone, cell phone, etc.) in case an outside contact is needed as part of the risk assessment (e.g. calling the participant’s clinician or psychiatrist on call, connecting the participant to the crisis hotline). See warm hand off telephone directions below.

## 6. VA National Suicide Prevention Hotline and VA Office of Research & Development

### Warm Transfer Telephone Instructions

**If someone calls in crisis, or crisis status becomes evident during a call…**

OBTAIN INFORMATION- Get the patient’s

* 1. Name
	2. Callback number
	3. Location/Address
	4. Social status- Are they alone or is someone with them?
	5. Last 4 digits of SSN
1. WARM TRANSFER IF NEEDED – If appropriate, do a warm transfer to the National VA Crisis Line using the instructions in this document.

IF PATIENT IS IMMINENTLY SUICIDAL, have someone else call the crisis line with the patient’s contact information so that they can call the patient directly as a call waiting. Avoid putting the patient on hold. Then confirm that the crisis line indeed has a connection with the patient. Alternatively, if there is a clinician nearby in the office, hand the patient over to the clinician directly.

* 1. If warm transfer fails, or the patient otherwise becomes disconnected, attempt to call patient back. If they cannot be reached, notify site coordinator.
1. RECORD/REPORT- All crises are considered SAEs\*. Record in the site’s SAE-AE log and notify the site coordinator (PI) and RA that SAE has occurred. Recommend that they update the patient’s PCP and Suicide Prevention Coordinator and put a note in CPRS.

If patient is not in crisis, but clinician input is needed, call or text Mark Ilgen (734-845-3646 [office] or 734-680-5893 [cell]) or Paul Pfeiffer (734-222-7447 [office] or 734-223-0618 [cell])

#### Warm Transfer to a Crisis Line – DESK PHONE

1. Be empathetic with the patient, use reflective listening. Validate their experience:
	1. “It sounds very hard, and like you’re feeling pretty hopeless right now.”
	2. “We have individuals trained to help veterans experiencing these types of thoughts and feelings who are standing by and can speak with you over the phone. I’d like to connect you with them, would that be alright?”
2. Get the patient’s:
	1. Name
	2. Phone number
	3. Location/Address – Are they alone or with someone?
	4. Last 4 digits of SSN
3. Tell patient to stay on the line, they will hear music. If you get disconnected you will call them back. With call in progress, press TRANSFER.
4. Dial crisis line number, wait for them to answer.

**NATIONAL VA CRISIS LINE: 9-1-800-273-8255** **press** **1**

National Call Center For Homeless Veterans: 9-1-877-424-3838

1. Introduce yourself. Tell crisis line worker, “I’d like to bring you into a conversation with a Veteran who is struggling with \_\_\_\_\_. His/her name is \_\_\_\_\_, phone number is \_\_\_\_\_\_\_, and location is \_\_\_\_\_\_\_. Last 4 digits of SSN are\_\_\_\_\_.”
2. Press CONF. 3-way conference is established.

-If you try to conference call and get the person’s voicemail, DO NOT HANG UP. Press \*\*\* Transfer to disconnect voicemail and retrieve patient. Be sure to push transfer right away after the \*\*\*.

1. Say, “(Patient), this is (Crisis Line Worker). He/she will be able to help you with what’s going on.” Then hang up. Connection between the patient and crisis line worker will be maintained.

#### Warm Transfer to a Crisis Line – POLYCOM PHONE, 1 EXTERNAL LINE, 1 VA EXTENSION

1. Be empathetic with the patient, use reflective listening. Validate their experience:
	1. “It sounds very hard, and like you’re feeling pretty hopeless right now.”
	2. “We have individuals trained to help veterans experiencing these types of thoughts and feelings who are standing by and can speak with you over the phone. I’d like to connect you with them, would that be alright?”
2. Get the patient’s:
	1. Name
	2. Phone number
	3. Location/Address – Are they alone or with someone?
	4. Last 4 digits of SSN
3. Tell patient to stay on the line, they will hear music. If you get disconnected you will call them back. With call in progress, press TRANSFER.
4. Dial VA Extension, wait for them to answer.

**NATIONAL VA CRISIS LINE: 9-1-800-273-8255** **press** **1**

National Call Center. For Homeless Veterans: 9-1-877-424-3838

1. Introduce yourself. Tell crisis line worker, “I’d like to bring you into a conversation with a veteran who is struggling with \_\_\_\_\_. His/her name is \_\_\_\_\_ , phone number is \_\_\_\_\_\_\_, location is \_\_\_\_\_\_\_. Last 4 digits of SSN are\_\_\_\_\_.”
2. Press MORE, then CONF. 3-way conference is established.
3. Say, “(Patient), this is (Crisis Line Worker). He/she will be able to help you with what’s going on.” Then hang up. Connection between the patient and crisis line worker will be maintained.

#### Warm Transfer to a Crisis Line – POLYCOM PHONE, 2 EXTERNAL LINES

1. Be empathetic with the patient, use reflective listening. Validate their experience:
	1. “It sounds very hard, and like you’re feeling pretty hopeless right now.”
	2. “We have individuals trained to help veterans experiencing these types of thoughts and feelings who are standing by and can speak with you over the phone. I’d like to connect you with them, would that be alright?”
2. Get the patient’s:
	1. Name
	2. Phone number
	3. Location/Address – Are they alone or with someone?
	4. Last 4 digits of SSN
3. With call in progress, press TRANSFER.
4. Dial crisis number, wait for them to answer.

**NATIONAL VA CRISIS LINE: 9-1-800-273-8255** **press** **1**

National Call Center For Homeless Veterans: 9-1-877-424-3838

1. Introduce yourself. Tell crisis line worker, “I’d like to bring you into a conversation with a veteran who is struggling with \_\_\_\_\_. His/her name is \_\_\_\_\_, phone number is \_\_\_\_\_\_\_, and location is \_\_\_\_\_\_\_. Last 4 digits of SSN are\_\_\_\_\_.”
2. Press MORE, then CONF, then CONF again, and then CANCEL. 3-way conference is established.
3. Say, “(Patient), this is (Crisis Line Worker). He/she will be able to help you with what’s going on.” Then hang up. Connection between the patient and crisis line worker will be maintained.

# **7. MENTAL HEALTH CRISIS TELEPHONE CALLS FLOW CHART**

Call received from Veteran in an emotional crisis.

Responder obtains initial information from caller including:

**name of Veteran, last 4 of SSN, address, phone number and reason for call.**

Responder keeps caller on phone & informs caller they will be doing a warm transfer to the Veterans Crisis Line.

Responder does a warm transfer to the Veteran’s Crisis Line (using conference call) at:
**9-1-800-273-8255,**

**press 1**

**conference call is completed As follows:**

**with call in progress press transfer key. dial hotline number (9-1-800-273-8255, press 1).**

**upon hotline answering announce desire to conference and press conf key**.

**three-way conference is established.**

Responder will provide the Veterans Crisis Line staff with the Veteran’s information: **name of Veteran, last 4 of ssn, address, phone number and problem veteran is having.**

Responder will document initial contact with veteran and warm hand-off to the Veterans Crisis Line in CPRS IF it is not documented by the clinician or crisis line contact.

Veterans Crisis Line staff will assess Veteran & facilitate appropriate disposition.

Veterans Crisis Line staff will contact the Suicide Prevention Coordinator to assure appropriate follow-up care for the Veteran.

# **Risk Assessment Template**

This form should be used to collect additional information from a participant of MODERATE or HIGH risk to help the supervisor and/or clinician make a determination of any action steps that may need to be taken to keep a participant safe.

1) Current suicidal ideation or intent during the past 2 weeks?  Yes  No

Describe frequency, duration, controllability, etc.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2) Current plan?  Yes  No

Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Current or easy access to plan/method/means to end their life?  Yes  No

- Current access to a firearm?  Yes  No

3) Past suicide attempt?  Yes  No

Describe type of attempt, how long ago, etc.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4) Current emotional/physical problems (e.g. mood changes, trouble sleeping, feeling anxious?)  Yes  No

Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Currently seeing or hearing things that others cannot?  Yes  No

- Currently on any medications?  Yes  No

-Recently stopped any medications?  Yes  No

5) Any increased alcohol or drug use in past 2 weeks?  Yes  No

Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6) Current supportive systems (family, friends, recovery community, doctors, therapists, etc.)?  Yes  No

Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Action Step 2

a. Was the participant informed of the need to consult supervisor?  Yes  No  N/A

b. Was the supervisor or designated senior clinician contacted immediately?  Yes  No

c. Was a recommendation made for urgent evaluation (clinician, hotline, ED?)  Yes  No

 - Did the participant agree with the recommendation plan for evaluation?  Yes  No

 - Did the participant take steps to follow through with the evaluation?  Yes  No

Preferred Action Steps:

1. Was the participant’s doctor or clinician contacted?  Yes  No

2. Was the participant connected to the Veteran’s Crisis line?  Yes  No

3. Was the participant taken to the ED, PES, or other service?  Yes  No

4. Were the police contacted?  Yes  No

d. Did someone remain with the participant until the supervisor or designated

senior clinician indicated it was safe?  Yes  No

NOTES/OUTCOM/REASONS FOR DECISIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Risk Assessor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor/Clinician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_