Protocall Documentation Principles and Guidelines

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Background and Purpose

Protocall counselors document each interaction answered in accordance with the standards included in this document. These Principles and Guidelines are designed to ensure the following:

- Usefulness and understanding of what transpired during the interaction for our customers, supporting their ability to follow up with the client
- Meet Protocall’s accreditation and licensure requirements
- Demonstrate services provided were consistent with best practice standards
- Summarize counselor interactions with the caller/visitor for internal quality assurance and compliance purposes

Protocall’s Documentation Principles and Guidelines are organized by and include:

- Stages of the interaction
- All types of interactions
- All types of forms used by Counselors
- Applicable to all counselors

Interaction Documentation is made available to Protocall Customers no more than 24 hours after the document has been completed and “finalized.” Most of the time they are transmitted immediately.

Definition of Terms

Defined Terms used frequently throughout Protocall’s Documentation Principles and Guidelines:
Call Taker(s): Any staff person answering inbound calls
Chext: Chat and text modality of service
Clinical Assessment Section: A section used in Proteus that is embedded as part of a Service Request Form (see Service Request Type).
Clinical Call Taker: Either a Clinical Specialist or a Crisis and Access Specialist in a call taking role.
Clinical Specialist (CS): Masters-level licensed (or provisionally licensed) counselor; Performs crisis assessment and intervention on all accounts.
Counselor(s): Crisis and Access Specialists and Clinical Specialists

Crisis and Access Specialist (CAS): Bachelor-level counselor; Performs crisis assessment and intervention on most accounts; Otherwise performs screening with callers to determine if escalation to a Clinical Specialist is needed

Details Field: Information that may be pertinent to a specific question or juncture of a call designed to assist call handling and/or documentation; Automatically appears on the right-hand side of the Proteus application while processing a call.
Field: A single question within a section. May be referred to as "field" or "question"
Imported Global Section (+ Section)*:* A section manually imported from a list of available sections based upon the uniqueness of an account or call. Examples: Abuse notification; Interpreter Services.
Least Invasive Intervention (LII): Utilizing a person centered collaborative approach to meet the consumer's needs before implementing ascending levels of interventions, up to and including requesting emergency services.
Macros (Imbedded): A structured set of documentation prompts that aid the call taker in addressing all components of an assessment. These automatically populate when current risk is selected for each assessment item. Documentation is completed next to the macro line and does not need to be in complete sentences.
Memo Field: A blank supplemental narrative tool in Proteus; used as needed by call takers to take brief notes prior to determining the nature of a call (i.e., selecting the proper Form). Once the call type is determined notes are to be taken in the proper section.
Message: A type of Section used in Proteus to document non-clinically related calls that may need follow up from the Protocall Customer.
Non-Transactional: A Chext Interaction where the Consumer never responded to the counselor after the counselor sent the initial greeting message.
Person in Charge (PIC): An individual in the call center designated with providing consultation and support to counselors.
Proteus: The call handling application used by counselors to document and process interactions with consumers and display account procedures.
Section: A template used to document a specific type of interaction or subsection of an interaction. New sections will be presented as options at the end of your current section.
Service Request: A type of Proteus Section used to document the nature of the services the consumer needs from the Protocall customer; enables the Protocall counselor to gather required information and facilitates accurate handling of the interaction.
Standard Counseling Request (SCR): A type of Proteus Section used by counselors to document requests for behavioral health services from consumers who are making a routine request without presented risk. The presentation of the consumer is absent of distress, assessed not to have current or recent thoughts of suicide, has not taken action to harm themselves, and does not have thoughts of harming someone else.
Service Request Summary (SRS): A type of Proteus Section used at the direction of the Person in Charge when call center conditions warrant use based upon the number of consumers waiting in the telephone queue. This Section is used when the request is routine in nature and the caller did not present with distress, was assessed not to have current or recent thoughts of suicide, had not taken action to harm themselves, and does not have thoughts of harming someone else.
Visitor: A person who reaches out via chat or text rather than by phone.

Documentation Principles

Principle One: The Document is Readable

Protocall's documentation is used by Protocall customers to enable follow up. Fellow counselors may review the report and utilize pertinent content. Prior to finalization, the documentation is reviewed within the following framework:

- The reader be able to quickly ascertain the nature of the interaction
- The reader will know what to do next to support the consumer and/or situation
- The reader will clearly understand the reason behind actions taken
- The reader will understand the disposition of the interaction

Principle Two: The Document is Concise

Documentation of the interaction contains information that is relevant to the consumer's request, the counselor's actions and what, if any, further actions are needed to serve the consumer.

Principle Three: The Document Contains Minimal Redundancy

Redundancy is the repetition of ideas, words or phrases which do not add depth or insight to the written summary. At times, repetition as part of a clinical justification and rationale may be necessary in order to adequately summarize interventions and actions taken or not taken.

Example of Unnecessary Redundancy:

Copying a phrase such as: "I was unable to assess due to the emergent nature of the situation", in all the assessment narrative fields, when we can simply select unable to assess in the radio buttons and write one justification/rationale that includes this reasoning.

Principle Four: The Document Provides Clarity

Documentation is written in simple, direct and transparent language. It should be accurate and easily understood.

Clear Documentation includes:

- Professional grammar and spelling
- Clear and unambiguous use of pronouns
- When referring to multiple parties, use of names should be used rather than "caller," "visitor" or "person of concern"
- Use of clinically descriptive language ("Caller"/"Visitor" appears...as evidenced by…")
- Is consistent across all fields (i.e., Level of distress matches level of care)

Clear Documentation does **not** include:

- Technical/professional jargon (SI, HI, ISI)
- Protocall specific terminology (PIC, SCA, SCAS, SCS, Mentor, etc.)

- Abbreviations
  - Examples include: abbreviations for substances, shorthand for treatment, history, prescription (Tx, Hx, Rx and others), and writing shorthand for Declined (Dec), Did not ask (DNA) and Unknown (Unkn).

Principle Five: The Document is Free of Jargon

Jargon is technical shorthand, which is understood by a specific profession, but others may not or do not interpret the concepts the same way.

Examples of "jargon":

"**DESCRIBE THOUGHTS**: "Endorses baseline suicidal ideation with a plan and no intent."

This sentence contains jargon which might not be understood by all readers. Jargon is particularly problematic when used to describe risk to an individual in one of the narrative assessment fields.

Instead, use descriptions in lay persons terms:

DESCRIBE THOUGHTS: thinks about death frequently (versus jargon - "has suicidal ideation" or "passive thoughts of suicide")
ACTIONS ALREADY TAKEN: none
METHOD/HOW: considers jumping from balcony thinks about leaning over the balcony edge until he almost falls (versus jargon - "with a plan")
DESIRE/COMMITMENT TO ACT: says he would never jump from the balcony (versus jargon - "no intent")

Principle Six: The Document References Account-Specific Procedures

Documentation demonstrates that account procedures are followed and specifically:

- when providing referrals
- transferring to a secondary service
- rationale when procedures are not followed

Principle Seven: The Document Includes Work Done During the Interaction

We include documentation of all of the relevant work completed on the call. We do not document work that we have not completed yet, such as documenting responses to assessment questions before they are asked, documenting a consultation before it happened or checking an intervention box for *Reviewed Coping Strategies* before doing so with the caller.

Documentation is driven by the work the counselor performed, as opposed to length of time on a call. A longer than average call does not always mean more documentation, nor does a shorter than average call always means less documentation.

Principle Eight: The Document is Written from the Call Taker's Perspective

Documentation is based on the counselor's assessment and determination, not transcribing what the caller said. For example, the counselor avoids writing "denies" behind macro assessment items and instead provides evidence that an assessment was conducted such as "**ACCESS TO LETHAL MEANS**: does

not have access to firearms, does not have pills." The counselor does not transcribe the specific order of what was said. The only time order may be important is in the Intervention section when we are demonstrating an escalation of least invasive interventions.

Examples of documentation transcription:

Chronological

Documentation that is written as a play by play narrative, rather than a summary of the interaction.

- For example: "Caller reports thinking about suicide and has access to a firearm. I advised the caller to put the firearm in another location, or to give it to a family member while we speak. The caller did not agree to do so and I told him I would need to request a welfare check." **This documentation mixes intervention information with the assessment documentation. The assessment information should be part of the suicide assessment macro and the interventions in the additional interventions field.**
- Another example: "The call abruptly ends and I placed an outbound call to finish the assessment. The caller was suicidal planning to shoot himself in three days." **This information should be in the appropriate assessment fields and not in one narrative paragraph.**

Overuse of Caller Quotations

Quoting the caller should be reserved for capturing a unique caller presentation or disposition. It is rare to need to quote a caller. Typically a concisely written summary will suffice.

- For example: "Caller reports 'thinking about suicide'. Caller reports having a plan 'to overdose on Tylenol'. Caller states that 'work problems and financial issues' are contributing to their thoughts of suicide." **In this example, the quotations do not add credibility to the documentation, and make it lack conciseness. Nothing is lost by dropping the quotations and summarizing: "**Caller is thinking about overdosing on Tylenol because of stress at work and financial concerns."
- Proper use of caller quotation- "Partner threatened to "finish the job" yesterday, which they threatened in the past and is interpreted by the caller as a death threat." **In this example quoting the 'finish the job' is more descriptive than only a summary/explanation would be.**

Overuse of Caller Narrative

Over use of caller narrative without quotations, or caller report language- This is a transcription of call content without using quotation marks. This style fails to comply with the principle of concise writing and can reflect inadequate assessment. Use of the phrases "Caller reports" or "Caller states" should be used sparingly.

- Improper use of "caller reports" example:
  Type of Substance(s): Caller reports using alcohol
  Frequency: Caller reports daily
  Amount Used: Caller reports a case of beer

Duration of Use: Caller reports being uncertain of how long she has been using at this level
Last Use: Caller reports drinking half a case so far today.
Current Symptoms: Caller reports they are not yet feeling intoxicated.

- Proper use of "caller reports" example:

  Type of Substance(s): alcohol
  Frequency: daily
  Amount Used: case of beer
  Duration of Use: uncertain how long she has been using at this level
  Last Use: today, half of a case so far
  Current Symptoms: caller reports not feeling intoxicated, but their speech is slurred

Principle Nine: The Document is Recovery Oriented and Includes the Minimum Necessary

All narrative sections are to be recovery focused, non-judgmental, and as objective as possible. Use of person-first language is essential. Recovery documentation highlights the strengths, abilities, and personal resources of the caller.

Extraneous information is not included, particularly when it comes to a medical diagnosis. Particular care is taken not to document a diagnosis of HIV/AIDS due to the stigma society sometimes places on the illness as well as legal protection around disclosure of the diagnosis. There are other issues that could have legal repercussions in some states such as accessing an abortion and providing gender affirming medical care to transgender minors.

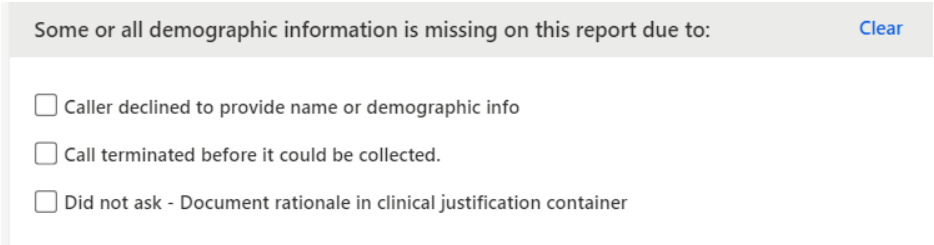
Examples of documenting medical concern: "Caller is seeking support due to a surprising medical diagnosis" and "Caller is seeking support following a stressful medical procedure."

Guidelines for Proteus

Fields and Sections

Name Conventions in the Name Field	• Documentation of names is based on the name the caller/visitor provides for themselves or for the identified person of concern • If an individual provides a professional title, it is acceptable to document that and use appropriate abbreviations. For example, Dr. Ortiz; Officer Lilo; Deputy Hagerty • If a name prefix is provided, document it before the first name in the Prefix field. For example, **Mx**. Amara; **Prof**. Keanu; **Rev**. Tala. • If a name suffix is provided, document it after the last name in the Suffix field. For example, Mbatha **Jr**; Wang **III**; Shah **MD**. • Legal names are not required • Descriptors are not included in the name field, such as "pulled from history", or "charge nurse", "On call" etc. These may be documented elsewhere in narrative fields

	● When **gender is confirmed by caller/visitor but name is declined**, the following format of name conventions will be used (this is not a comprehensive lis)t: ○ "Declined Male" ○ "Declined Female" ○ "Declined Nonbinary" ○ "Declined Trans Feminine" ○ "Declined Trans Masculine" ○ "Declined Declined" or "Declined Unknown" (see below) ● If the caller/visitor wishes to decline their name, best practice is to ask "Is there a name you would like me to call you during this call/interaction?" We can also ask "is there anything else you'd like to share with me, like your gender/pronouns?" ● A caller offering a slur or profanity as their name is considered to have declined their name. Do not document the slur. You can explain in a narrative field that the caller gave a slur or profanity as their name. ● When there was no opportunity to ask the caller/visitor's name or gender use: ○ "Unknown Unknown" ○ Sufficient explanation is provided when information is unknown in narrative fields ● In general, if a name is declined, do not document the person you suspect they "might" be in the name field ○ Presentation alone will **not** be used to determine and document someone's identity. ● If a caller/visitor's name is unknown at the start of the call but is later *given by the caller/visitor* it is corrected and updated in the Caller Name field. It may be necessary to explain the cause for the name change in a Narrative field if it seems relevant to the interaction with the caller/visitor. ● If a declined caller/visitor has a person alert or account alert *and* their identity is able to be confirmed using *at least two* other pieces of demographic information (phone number checked against the account contact list, DOB, address, etc.), their name is documented in the Name Field. Use a Narrative field to explain the name was declined. ● A caller/visitor (without a person alert or account alert) who declines their name should be documented as Declined. If identifying information is obtained by another party such as law enforcement when mitigating risk, document the name in a narrative field. ● Confirming Name and Number Policy
Alternative Name Field	● This field is used only for caller/visitor's expression of alternative names or an alternate name identified in an account alert/person repository ● When a declined person's presentation is consistent with a noteworthy caller this information is noted in any narrative field and is

	not included as an alternative name.
Pronoun Use	• Use the pronouns shared by the caller throughout the document • If pronouns are unknown, default to using they/them pronouns
Multiple Individuals	• Documentation involving multiple individuals (including providers or other professionals) is clear and understandable throughout the document. The reader is easily able to track which data corresponds to which person. • For the purpose of clarity when documenting calls/chats/texts involving multiple individuals, preference will be given to referring to each party by name, or role, such as therapist, case manager, neighbor, etc. • If used, the term "Caller" or "Visitor" will refer to the person whose name is documented on the Caller Survey/Chat and Text Person Information. • "Person of Concern" will refer to the individual whose name is third party documented as the "Person of Concern" in the New Call Survey. The Person of Concern may be the caller/visitor or a third party. This term is used, even if the third party individual is spoken to directly.
Phone Number Field	• Number should be documented as provided by the caller/visitor • If number is unknown or declined, phone number field should be left blank. • Phone number can be used to verify a caller/visitor's identity for comparison to an Account Alert or Person Alert. • **When a clinical situation supported by consultation warrants** use of the caller/visitor's phone number through call ID or phone system look up, phone number should be documented in phone number field AND and a rationale given in Additional Interventions Options. ○ Number **must be compared with account contact list** to ensure the phone number is not the account's number prior to documentation • Confirming Name and Number Policy
Caller Information Fields	• When large amounts of information are declined or unknown and an applicable check box option is available, preference will be given to checking the applicable box at the end of the clinical section (see screenshot below), rather than filling in each field or line.  ○ Exception- The Name fields on the New Call Survey will be

	filled in according to Name Conventions. ● Sufficient explanations are provided in Interventions or Clinical Justification and Rationale when information is unavailable, ambiguous or not gathered. ● When applicable, fields are filled in with: ○ Declined* ○ Unknown* ○ Did not Ask* *Note- Abbreviations should not be used.
Call History/Person Alerts	When applicable, documentation indicates that client information is gathered from or verified against call history or Person Alerts. Preference is given to using a relevant check box option rather than narrative summary, unless no check box option is available.
Interpreter Services	Documentation of interpreter use occurs in the + Section called Interpreter Services.
Consultation	Documentation demonstrates consultation occurred in conjunction with any action that may breach client confidentiality, when considering a higher level of care, or when account procedures are not followed. Documentation includes the details and outcome (what was considered/discussed? what was decided?) of the consultation and note the name, job title, as well as degree and/or relevant license status of the person(s) consulted. **When documenting consultations regarding abuse reporting, specific criteria from state statues considered are included.** **General Example:** I consulted Senior Crisis and Access Specialist, José Esperanza, and we agreed to connecting the caller to 911 given the caller's thoughts of suicide and the caller's inability to safety plan paired with assessed intent. **Abuse Consult:** I consulted Supervisor Maria Vanderspargen, LMSW about whether to make an abuse report given the caller's report of having been hit by her caregiver resulting in bruising, and we agreed this met the definition of physical abuse for the caller's state. Consider clinical descriptiveness when writing consultations about risk mitigation: **Not descriptive**: "I consulted with Supervisor Fabuki Sho, and we agreed that caller could be safety planned with." **Clinically Descriptive**: I consulted with Supervisor Fabuki Sho, and we agreed that safety planning was appropriate as the caller did not have intent and was willing to limit access to means by having her mother hold onto her pills for her." Protocall specific references should *not* be used. (For example, PIC, Person in

	Charge, Protocall Supervisor). ● Appropriate Job Title documentation conventions ○ Crisis and Access Specialist ○ Clinical Specialist ○ Senior Care Associate ○ Senior Crisis and Access Specialist ○ Senior Clinical Specialist ○ Supervisor ○ Other Relevant Job Title ○ Except for degree and license information, abbreviations are not used.
Outbound Calls	Compassionate Care Outreach Form Updates The Outbound Call section is used when available. Documentation of outbound calls includes: time of the call (if no Outbound Call section), reason for the call, phone number called (as applicable), and identifying information of the person answering (as applicable) For outbound calls where we will make a clinical determination (ex: request welfare check) documentation must include consultation that describes the reason for the outbound call and a decision about which steps should be taken if we are unable to reach the person.
General Definitions: Declined Denied Unable to Assess Did not ask	**Declined** is a convention used when information has been requested from a caller and they choose not to provide the requested information. In most cases this is applicable to callers who choose to remain anonymous or limit the amount of personal information they provide. In rare instances a caller may refuse to participate in a clinical assessment. **Denied** is the convention used to document when a caller affirms something to be untrue including the existence of any symptoms, thoughts or behaviors related to an assessment item. This could be in response to direct questioning, or via self-report and congruent with observation. *Denies language is not used independently after macros.* If utilized, additional language from the assessor is provided. For example, **DESCRIBE THOUGHTS/ACTIONS**: initially denied, but later disclosed they took 10 Xanax just before the call. **Unable to Assess** is a convention used when clinical assessment information is unavailable to the call taker. This could be because: ● the call is about a person of concern and not the caller directly when the caller does not have sufficient information to fully assess ● of a medical emergency requiring immediate medical attention, the caller's ability to engage is limited by impairment ● this is part of a deliberate clinical strategy as opposed to thinking an item is not relevant or forgetting to follow standard operating procedure by not asking. **Did not ask** is a convention used when information is not asked. This may be

	most applicable to use on surveys used for information gathering (Caller Information). *The terms in bold should be written out rather than using abbreviations.
Requests for Multiple Parties (Third Party Calls with two or more Assessments)	When taking multiple requests for counseling services from one person on a single call, it is typically sufficient to document these requests in the same call report. If there is no assessment (such as an SCR or SRS) or only assessment information for the person of concern, this information can also remain in one report. If you speak directly to multiple adult individuals seeking separate services on the same call, they will each need their own document. For the sake of clarity, *if risk or sensitive information about **two or more** people is documented*, this will require two or more separate documents. Each document will have the same Caller listed, but a different Person of Concern. Facility calls for multiple people require a separate report for each Person of Concern if they are all completed during the same phone call.
Message Narrative Field	This field is intended to relay messages to account staff, and to quickly capture the general type of call and context of a request particularly if there are no appropriate sections or procedures guiding our call handling. The Narrative field of the Message Section should not contain references to calls which would require clinical triage. Appropriate situations to document a request in the message field: ● When procedures indicate a request should be documented as a message ● When a Person Alert or Account Alert indicates a request should be documented as a Message ● When a medication request has been identified as a regular refill request and there is no Medication Section available ● When a caller is calling back regarding a previous recent call (ex: reporting they arrived at the hospital, calling back due to being disconnected, etc.). Link these types of calls to the previous call as a case.
Pick one outcome from the drop-down list…	Select from the drop-down menu the highest level of intervention used for the call. This information is used for gathering statistical information about call outcomes.
Work Life Narrative Field	When an available check box option does not fully describe the service request, a one sentence description of the request should be documented.

	Legal, Financial as well as Concierge/Information requests are the most typical examples which would benefit from more clarity. The following template, called "This for That" should be used: Caller is seeking ... for ... Example: Caller is seeking a legal consultation for divorce. Attention should be paid to documenting when Protocall's standard operating procedures conflict account procedures, for example: A request for legal consultation in an employment related matter, AND procedures direct us to connect that caller with a vendor. (*Reference Policy- EAP Workplace Legal Issues).*
Info and Referral Section	This section is used to document non-clinical requests for information or referral to non-clinical resources. Such as: ● Housing assistance, Homelessness shelters ● assistance paying rent, or utilities ● food boxes ● transportation ● legal resources ● anything we would refer to 211 Any request which requires clinical triage, should not be documented using this section. A clinical assessment section is used when the request is specifically for resources related to (but not limited to) the following: ● accessing behavioral health services (SCR may also be used) ● when suicide or self-injury are discussed ● requests for substance use treatment ● shelter resources for Interpersonal Violence ● medication related requests (when not routine)
On Call Section	Documentation includes all of the following: ● Reason for consulting with account staff (specifically when the reason for consultation is not procedurally clear) ● What is expected of the on-call staff ● Outbound call and Response times ● Who was contacted ● Outcome of contact ● Any other information account procedures direct you to document
Abuse Notification Section	Mandated Report (Vulnerable Populations): Documentation includes: ● Completing relevant sections ● Consultation regarding all Abuse/Neglect situations ● Contacting On-Call for Imminent Abuse reporting ● Details regarding reporting to authorities ● Completing any required forms by the state in which we reported

	This section should not be used to document the details of the assessment, but rather for documenting the content of the reportable material.
Memo Section	This section is NOT seen by the customer and should be reviewed for any pertinent information that should be elsewhere in the document before finalizing. This section is for internal communication processes when screening, individual note taking, or providing documentation feedback. This section is visible to internal staff and is saved in our internal reports.
Screened Call Section	This is an internal tool for the call triage process. Information in this section is not visible in the report sent to the customer. This section should not be used in place of the Screened Hang-up Alert, which does go to the customer.
Screened Hang-up Alert Section	This is added when it is identified that the caller hung up after being screened to the 1XXX queue. It is not appropriate to utilize this alert when a caller was screened to the 2XXX queue or an emergent warm transfer was attempted and hung up.
Service Request Summary (SRS) Section	***To be used only at the direction of the Person In Charge/Supervisor***. To be used when: ● The caller and/or client has mild or no distressThe clinical situation would have a **routine** level of care ● The caller is requesting to set up **new** clinical or work-life services ● Caller has **declined** immediate support ● There are **no** current safety concerns The following questions are required on all calls being considered for Service Request Summaries: 1. Have you taken any action to harm yourself today? 2. Are you having thoughts of suicide today or recently? 3. Are you having thoughts to hurt others? A call is **NOT eligible** as a Services Request Summary **if it fits any of the following criteria:** ● For calls such as facility calls, authorization requests, CISD, or Law Enforcement calls, or in situations in which we will need to consult on call staff regardless of level of care. ● Caller is requesting in the moment support. ● The caller has shared concerns about Suicide, Homicide, Substance Use, Vulnerable Person Abuse/Neglect, or Interpersonal Violence or medical emergency.
Standard Counseling Request (SCR) Section	The following questions are required on all Standard Counseling Requests: 4. Have you taken any action to harm yourself today? 5. Are you having thoughts of suicide today or recently?

	6. Are you having thoughts to hurt others? A caller is **NOT eligible** for the Standard Counseling Request process if **any of the following are true**: ● Caller has taken any action to harm themself today ● Caller is having any thoughts of suicide today or in the last two months ● Caller is having any thoughts to harm others ● The caller presents in distress ● Other risk assessment areas are implied or endorsed (self-injury, substance use, interpersonal violence, abuse/neglect related concerns, medication changes, or cognitive concerns) If any areas of assessment are implied or endorsed (suicide, self-injury, threat of violence towards others, substance use, interpersonal violence, abuse related concerns, medication concerns, or cognitive concerns) then a full clinical assessment should be completed. Some calls may be clinical in nature but end before any meaningful clinical information can be gathered and before assessment questions can be asked. For example, a caller who does not present with risk or distress and who disconnects. Document using "This for That" format: Caller is seeking ... for …
Standard Counseling Request: Brief Clinical Interaction - Without Risk or Distress	Some calls may be clinical in nature but end before any meaningful clinical information can be gathered and before assessment questions can be asked These interactions should be documented in the Standard Counseling Request form under "Brief Clinical Interaction - Without Risk or Distress" If any substantive clinical information, particularly any information about clinical risk, is disclosed by the caller, this call should be documented in the clinical form instead.

Quick Exits

Do Not Finalize	Use when a report is accidentally created such as a duplicate report, wrong account or one that was intended to be in demo mode for learning purposes. Not to be used for any actual call as this does not send to accounts.
Fax Signal	A fax signal

Hang Up	A hang up is a call where no one speaks to or engages with you on the phone. A call where no one speaks to you is a hang up even if you hear a person, or background sound as in an accidental dialed call, or a recorded message.
Line Transfer	A line transfer happens when an account places a call to confirm the transfer of their lines to us.
Phone Line Test	This option is best used when Account staff or phone company staff are testing phone lines.
Test, Internal	This option is best used when Protocall staff is testing phone lines.
Wrong Number	A wrong number occurs when someone is attempting to reach an agency or company or individual not affiliated with the account the call rang in on.

Amending a Document

The purpose of amending a document is to add or clarify information after a document has already been finalized. Amending a document does not change the original document. Instead it creates a duplicate document with the additional text that is sent to the customer. Because of this, amending a document should only be done when necessary or at the request of the account. Amending a document will typically be done with the approval of a supervisor. Examples of reasons to amend a document include making additional attempts to report abuse or neglect, when we are given important demographic information after a call has been finalized, …If multiple amendments are needed, it is important to amend the most recent amendment.

Clinical Assessment Section

Lead Sentence

"The Lead" sentence is used in the Presenting Problem/Overview field of the clinical assessment section and provides a summary of the caller's request. The Lead provides a brief summary of the call content and what to expect in the rest of the document.

Demographic descriptors are usually not needed in The Lead, however, if it supports clarity for the reader the following may be included: Age, Gender, Marital/partnered/relationship status, Other additional descriptors identifying role, relationship or client type. Examples include, but are not limited to: "noteworthy caller"; "current client"

Examples of a well written Lead which summarizes the clinical interaction:

- Caller presents with anxiety secondary to continued conflict with her estranged husband.
- Adult male seeks support for frustration over continued conflict with his estranged wife.
- Caller is seeking immediate support reporting thoughts of suicide precipitated by a recent job loss and financial stresses.
- Jane is requesting a referral for services on behalf of her 29-year-old son, John, to address his alcohol use after he received a DUI.

Examples of poorly written Lead:

- Caller is seeking counseling.
- Caller wants to talk.
- Caller is a 47-year-old female, identifying as single but living with a partner, with 5 children, homeless for 10 months, seeking counseling services to address depression.
- Caller is seeking immediate support for anxiety related to his academic performance. Caller has a therapist but has not been to appointments in three months because he is busy. Caller is also depressed. Caller's dog died last week.

Documenting Medication Information

All psychiatric medications should be listed, including any current side effects, and whether or not the person is taking the medication as prescribed. A list of medications is in the Tool and can be used to check spelling. This section should also include supplements or other substances that are prescribed by a doctor for mental health purposes. Examples include St. John's Wort, Medical Cannabis, and Hormone Replacement Therapy.

Interventions

Overview

An intervention is a process carried out to de-escalate, stabilize, or to assist a person in moving through their personal crisis and to facilitate access to mental health services in a timely manner. Interventions are the work the call taker does to stabilize the crisis.

General Principles for Documenting Interventions

- Demonstrates application of a Solution Focused, the Here and Now, model
- Reflective of Protocall Services Policies and Standard Operating Procedures
- Supports the Level of Care assessment
- Exhibits the principles of Lesser Invasive Options/Interventions
- Indicates account procedures were followed
- Reflects an understanding of our Liaison Role particularly as related to different account types
- Intentionality in using appropriate interventions based on level of care

Level of Care

Protocall Services requires documentation of the Level of Care assessment for each call with clinical risk and/or request for immediate support. The clinical assessment section will be used to standardize this documentation. In general, documentation of a Level of Care assessment will be done for the following situations:

- When a caller requests mental health and/or substance use services and is seeking immediate support.
- Any time a request is made for "resources" which relate to one of our standard assessment points: Suicide, self-injury, threat of violence, substance use, interpersonal relationship violence or Abuse, and psychiatric medications.
- When account procedures indicate a Level of Care assessment is to be completed.

Intervention Field

The Interventions fields of the clinical assessment section is comprised of two fields:

- The “Interventions” field is a checklist of common interventions frequently used
- The “Additional Intervention Details” is a narrative field.

“Interventions” Field

This list of check box options is not intended to be an exhaustive list of applicable or acceptable interventions, it is simply a list of the most commonly used interventions. Additionally, the presence of an intervention option, does not mean it is procedurally relevant to the account. Use of these interventions should be clinically relevant, within our role, and support the account’s procedures.
For example, one of the standard options is called, “Provided local resource information to caller”. This option is only relevant if we have a procedure for providing local resources. *If no such procedure exists, then conducting an independent Internet search to find requested resources is outside of our role and is not procedurally supported.*

Use the check boxes, as applicable, instead of writing a narrative or inserting personal macros. If more information is needed, then further detail can be provided in the Additional Intervention Details Field.
IMPORTANT: A box will only be checked ***after*** the intervention has been used.

“Additional Intervention Details” Field

This narrative field is designed for documenting interventions used that are not addressed with the check box options or when additional detail is needed for clarity. It is appropriate to also document the following:

- Outbound calls, whether to emergency services, the caller, or to a third party
- When psycho-educational information is provided, as well as the substance of that information
- Information related to risk mitigation- such as clinical call taker attempts at means elimination, or harm reduction or clinical call takers’ efforts at safety planning in an attempt to explore lesser invasive options/interventions.
- Consultation with Protocall staff
- Details of Risk Mitigation steps/actions
- Include details about how the safety plan was developed and personalized for this caller

Clinical Justification and Rationale Standards

What is a “Justification” and “Rationale”

Justification and Rationale are key to providing the reader the context for our clinical thought process and decision making which supports our intervention strategies, Level of Care assessment and call outcome.

A complete Justification/Rationale will include one of these components:

- Rationale for our assessment that less invasive interventions are sufficient and no further action warranted
- Rationale for our assessment that higher levels of interventions were necessary and lesser invasive interventions would not be sufficient or appropriate in this case

There are also times that you will use this box to elaborate on other things that are not otherwise understood in the document that are clinically significant, for example:

- Why we didn't complete the assessment
- Why we did not follow procedures as written
- Why we contacted the on-call under criteria #1
- Why we chose to report or not report abuse/neglect (if this is not already detailed in Additional Interventions)
- Why we chose the level of care (only needed when it is not obvious based on documentation or LOC guidelines)

Example of a Well Written Narrative Justification and Rationale

"No further intervention is warranted as the Caller does not have a plan, means or immediate intention to end his life. Caller agrees to a safety and contingency plan and to follow up with all of the referrals provided for ongoing support."

"This call is assessed as emergent due to the caller engaging in a suicide attempt by standing on a bridge with intention to jump off."

"This call is assessed as urgent due to the caller's noticeable compromise in their ability to care for themselves as evidenced by the significant decline in their hygiene, having very limited food over a long period of time, and mild confusion in the day/time."

"I assessed this call as urgent given the noticeable impairment in the caller's ability to carry out their primary responsibilities as a student as they have been unable to attend class, are failing many of their classes, and are considering withdrawing from school."

"No additional interventions are needed due to the caller not having intentions to end their life or harm anyone else, was able to engage in means reduction by involving a third party, has positive engagement with the counselor, future oriented thinking, engagement in ongoing services, and agreement to a safety and contingency plan."

"This call was considered a routine level of care as the caller's cognitive concerns are consistent with the caller's usual presentation and something they have been coping with for many years."

Example of a Poorly Written Narrative Justification and Rationale

"Call is high risk due to functional status." **This is not complete and is missing specific factors that led to the determination. We would use urgent or emergent rather than high risk to explain the level of risk as high risk alone is subjective.**

"This call is routine due to baseline presentation." **This does not provide the reasons *why* the baseline presentation is assessed as routine and includes jargon language.**

"No further intervention is needed due to the person alert saying abuse has already been reported." **This information may be useful as part of the justification and rationale, but is missing supporting**

information about how there is no new information and whether or not other risk was assessed during the call.

Check Box Justification

On all 988 related accounts (716, 818, 717) On all 988 related accounts (716, 818, 717) we have moved to using a "check box" justification. This style of justification is based on weighing risk factors with protective factors that reduce or help mitigate that risk. This style is used instead of the Narrative Clinical Justification and Rationale described above.

Risk Factors are organized in six areas that summarize the risk of the call

- **Immediate Risk Factors**: critical considerations in crisis intervention, particularly in assessing the potential for harm to self or others. These risk factors can signal an elevated risk of suicide or violence and require immediate action.
- **Desire** ("I want to kill myself") . Factors include expression of psychological pain, feeling intolerably alone, trapped and a burden to others – It is often driven by hopelessness.
- **Impulsivity:** Heightened impulsivity is an aspect of suicidal capability that has the potential to impair or otherwise override usual impulse control or judgment.
- **Environmental and Social Factors:** Considerations that can increase the complexity of risk on a call.
- **Historical Risk Factors:** Historical risk factors are those aspects of an individual's past experiences or behaviors that can increase their likelihood of facing certain challenges, engaging in harmful behaviors in the future, increase capability, and/or affect credibility.
- **Additional Considerations:** Additional risk factors that do not fit into another category

Protective Factors are those factors that either reduce or mitigate risk. This includes

- Factors limiting the risk of the person's thoughts (no intent/no plan/no access to means, etc.)
- Buffers and Resiliency Factors
- Factors related to the caller's plan or an appropriate third party's plan to ensure their safety

A robust check box justification includes **ALL** known risk factors and protective factors.

After documenting known risk and protective factors, counselors will **determine if the protective factors outweigh the risk factors**. This is based on the counselor's clinical judgment and not just the number of risk factors versus the number of protective factors.

For example: Some risk factors such as a current attempt, or command hallucinations without a demonstrated ability to resist command hallucinations, pose such significant risk that the presence of that risk factor alone may be enough to warrant consulting about imminent risk.

Given these risks and protective factors, what is the clinical justification and rationale for the chosen level of intervention?

For most calls, weighing risk factors against protective factors will result in one of the following outcomes which will be selected in this dropdown box.

- Caller's ability to safety and contingency plan mitigates risk
    - This means that the protective factors outweigh the risk and give us confidence in the caller's ability to appropriately safety plan

- Caller could agree to a temporary safety plan but risk might deteriorate therefore Outbound Call is needed
    - This means that the protective factors in place give us confidence in the ability of the caller to manage their safety in the short term, but the identified risk factors are such that we have identified a potential for the situation to further deteriorate
- Caller's presentation and/or risk warrants higher level of care despite protective factors
    - This means that we have identified imminent risk that cannot be sufficiently addressed through the protective factors

In some limited circumstances, there may be additional complexity that can best be addressed in a narrative clinical justification. (For example: The caller initially presented with wavering intent, but they significantly de-escalated during the call, were assessed to no longer have intent to act, were future oriented by the end of the conversation and committed to a safety and contingency plan including eliminating their access to means). In these circumstances select "Other" and provide a written clinical justification.

Macro Use

What is a Macro and how to use it

Macros are utilized when clinical assessment items need elaboration. The macro helps the reader understand the various components of the risk assessment completed. Macros are written from the perspective of the assessor and are not a direct record of how the caller responded to questions asked.

Core Principles of Macro Use Include:

- Do not delete macros as they support us providing complete assessments and plans
- If a macro gets deleted accidentally please replace it with the copy in the details field
- Writing in full sentences is not required
- The writer indicates their assessment, not the direct response from the caller (avoid use of "denies")
- If additional elaboration is needed, the writer may add detail in the space below the macro

Example of <u>Following</u> Principles and Guidelines for Suicide Risk Assessment Macro Use	**Example of <u>NOT</u> Following Principles and Guidelines for Suicide Risk Assessment Macro Use**

DESCRIBE THOUGHTS: overdose on pills ACTIONS ALREADY TAKEN: poured pills into hand METHOD/HOW: swallow all the pills from Costco size bottle of Tylenol ACCESS TO IDENTIFIED METHOD: bathroom cabinet ACCESS TO LETHAL MEANS: no firearms, has access to pills DESIRE/COMMITMENT TO ACT: waves of intense desire PRECIPITATING EVENT: terminated from employment 6 days ago CURRENT PHYSICAL CIRCUMSTANCES: in bedroom at home, alone HISTORY OF ATTEMPTS: 10 years ago bought rope to hang self, went to tree, treated in hospital IMPAIRMENT DUE TO SUBSTANCES OR COGNITIVE: currently sober, drinking has increased in last 3 days REASONS FOR LIVING: expecting grandson to be born in September CREDIBILITY/RELIABILITY CONSIDERATIONS: forthcoming and cooperative presentation	DESCRIBE THOUGHTS: Caller is thinking about overdosing on pills ACTIONS ALREADY TAKEN: yes METHOD/HOW: yes ACCESS TO IDENTIFIED METHOD: yes ACCESS TO LETHAL MEANS: denies DESIRE/COMMITMENT TO ACT: intent PRECIPITATING EVENT: Caller was terminated from employment 6 days ago. CURRENT PHYSICAL CIRCUMSTANCES: home HISTORY OF ATTEMPTS: 1 past attempt IMPAIRMENT DUE TO SUBSTANCES OR COGNITIVE: no REASONS FOR LIVING: yes, several CREDIBILITY/RELIABILITY CONSIDERATIONS: n/a

Clinical Assessment Section Fields

Primary Problem Category	Callers will frequently have more than one problem or issue, pick the *primary* option based on <u>your</u> overall assessment of the call. This information is used primarily for data gathering purposes. If suicidal risk is assessed, choose *Suicide* as the primary problem.
Assessed Initial Level of Distress	The level-of-distress is assessed based upon BOTH: ● The counselor's subjective clinical understanding of how

	the client's circumstances are impacting the client, as well as, ● The client's presentation, overt behavior and affect.
Presenting Problem/Overview	This is where you document the "Lead" sentence.
Assessed Presentation of Person of Concern	Listed possible description of the caller's affect/presentation, which may be different from their assessed or actual level of distress. For example, a caller may have a flat or blunted presentation, and yet be in severe distress. Check the boxes that apply.
Additional Presentation Details	Note relevant presentation details here that are not offered in the presentation container.
Suicide Risk Assessment	Make the appropriate selection from these options: ● Assessment indicates no risk related to suicide ● Current or recent thoughts of suicide with no recent attempts* ● Current or recent suicide attempts* ● History of thoughts and/or attempts, with current impact ruled out ● Unable to assess *Requires additional assessment and documentation using the macro in narrative field
Narrative Suicide Risk Assessment	When risk is indicated, thorough and relevant documentation includes: ● Describe Thoughts - what are they expressing about suicide?/has caller done anything to hurt themselves already today? ● Actions Already Taken: has the caller taken any steps towards acting on their thoughts or to get ready for their plan? (*Is this a suicide attempt in progress?)* ● Method/How - the caller is going to take their life ● Access to Identified Method - described access to means for identified method ● Access to Lethal Means - describe any access to potentially lethal means, even if they are not cited as the identified method, including weapons, medication, sharps, ropes, keys, etc. ● Desire/Commitment to Act - preparations and/or behaviors, timeline of how soon the individual will carry out their plan ● Precipitating event - what brought on the thoughts/actions? ● Present physical circumstances - physical location, if alone or with others, consideration for proximity to means if applicable

	● History of attempts - when was the last attempt? What means were used? ● Impairment due to substances or cognitive - How did these impact their risk for suicide? Use relevant assessment fields below to document the complete assessment respectively. Credibility/Reliability considerations - include any factors in the call that influence how we assess the person's ability or inability to provide accurate information throughout the interaction and adhere to a dependable safety plan. ● Reasons for living - describe any future-focused thinking or things of importance to the caller ● Assess for Intentional Self Injury and document under the ISI question below ● Any other relevant information
Intentional Self-Injury Risk Assessment	Make the appropriate selection from the following options: ● Assessment indicates no risk related to self-injury ● Not relevant ● Current or recent risk related to self-injury* ● History of self-injury reported, with current impact ruled out ● Unable to assess *Requires additional assessment and documentation using the macro in narrative field
Narrative Intentional Self-Injury Risk Assessment	When assessment indicates risk, thorough and relevant documentation includes: ● The thoughts and/or behaviors ● History - the last occurrence of injury ● Purpose - emotion regulation, compulsion, preparation for acting on suicidal thoughts, etc ● Current access to means ● Any evidence of potential lethality or current medical emergency ● Other relevant information if potential lethality is high
Threat of Violence Risk Assessment	Make the appropriate selection from the following options: ● Assessment indicates no risk related to harm to others ● Current or recent thoughts of harming others* ● History reported, but assessment indicates no current risk ● Unable to assess *Requires additional assessment and documentation using the macro in narrative field

Narrative Threat of Violence Risk Assessment	When assessment indicates risk, thorough and relevant documentation includes: ● Describe thoughts - what are they expressing about harm to others? Has the caller taken any action on these thoughts? ● Method/how - with what means is the caller is going to harm/kill another person; include details of access and potential lethality ● Access to Identified Method - described access to means for identified method ● Access to Lethal Means - describe any access to potentially lethal means, even if they are not cited as the identified method, including weapons, medication, sharps, ropes, keys, etc. ● Desire/Commitment to Act - preparations and/or behaviors, timeline of how soon the individual will carry out their plan ● History of violence - include previous acts of violence or impulsive behavior ● Intended victim - include name, address, DOB of intended victim ● Any other relevant information
Substance Use Risk Assessment	Make the appropriate selection from the following options: ● Assessment indicates no risk related to substance use ● Current or recent substance use* ● History reported, with current impact ruled out ● Unable to assess *Requires additional assessment and documentation using the macro in narrative field
Substance Use Risk Assessment	When assessment indicates use, thorough and relevant documentation includes, (for each substance): ● Name of substance(s) used ● Frequency of use - How often? ● Amount used - Typical quantity per use ● Duration of use - What length of the time has the person been using at this rate? ● Last use - Including current ● Current symptoms - i.e., sober, acute intoxication, acute withdrawals, etc. ● How the use impacted this call - Consider reliability and credibility due to level of intoxication
Interpersonal Violence Risk Assessment	Make the appropriate selection from the following options: ● Assessment indicates no risk to interpersonal violence/relationship abuse

	● Current or recent interpersonal violence/relationship abuse* ● History of violence, with current impact ruled out ● Unable to assess *Requires additional assessment and documentation using the macro in narrative field
Narrative Interpersonal Violence/Relationship Abuse Risk Assessment	When not denied, thorough and relevant documentation with respect to Interpersonal Violence includes: ● Describe Violence/Abuse - The nature of the interpersonal risk (physical, verbal, emotional, threats, financial, etc.) ● Current Danger or Need for Medical Attention - Current danger of interpersonal violence; current need for medical attention or emergency services
Abuse Related Risk Assessment	Make the appropriate selection from the following options: ● Assessment indicates no risk related to abuse ● Not relevant - when not brought up during the interaction and/or the POC is determined to not be a vulnerable individual ○ may warrant consultation ○ may warrant documentation under the Interpersonal Violence Risk Assessment ● Current or recent risk related to abuse/neglect* ● History reported with current risk ruled out* ● Unable to assess *Requires additional assessment and documentation using the macro in narrative field
Narrative Abuse Related Risk Assessment	When assessment indicates risk, thorough and relevant documentation with respect to Vulnerable Populations includes: ● Nature of abuse/neglect - describe alleged action/inaction ● Current danger of abuse/neglect - whether or not there is any present danger ● When and where abuse occurred - include location, state, age of survivor, any known date(s), and time-span ● Demographic information of alleged offender and survivor - include any other relevant identifying information not already documented, including DOB ● Current need for medical attention or emergency services - any current injuries or need for medical or other evaluation ● Considerations for reporting/not reporting - based on reporting guidelines, what factors led to our decision to report or not report? Ex. age, relationship, direct information, etc.

Psychiatric Medications	Make the appropriate selection from the following options: ● Not Relevant ● Denies use of psychiatric medication ● Confirms taking listed psychiatric medication(s) as prescribed* ● Does NOT take listed psychiatric medications(s) as prescribed* ● Unable to assess *Requires additional assessment and documentation using the macro in narrative field
Narrative Psychiatric Medications	When psychiatric medications are prescribed, thorough and relevant documentation includes: ● Psychiatric Medication Name(S) - Name of medication(s) ● Describe Concerns/Risk, If Any - Include whether caller or person of concern are not taking medication as prescribed, and the presence and nature of any side effects or physical withdrawal symptoms. Note: For frequent callers, it is sufficient to only address compliance.
Cognitive Concerns Observed	If observed, select from the list that includes ● Hallucinations* ● Delusions* ● Paranoia* ● Inability to care for self* ● Other* If cognitive concerns are not observed, leave this blank.
Narrative Cognitive Concerns Observed	Provide additional descriptive information in the macro: ● Nature of concern - describe, including examples if relevant ● Combined with SI or HI - Detail any cognitive concerns related to harming self or others ● New or ongoing symptoms - Specify if symptoms are new or ongoing, pay attention to the first onset of symptoms ● Impact to Credibility/Reliability - Include any factors in the call that influence how we view the person's ability to credibly safety plan, especially the presence of any command hallucinations. Note the impact of cognitive concerns on Level of Care. ● Impaired Ability to Care for Self - Specify if cognitive concerns impair caller's ability to care for self ● Impact to the Call - How caller's presentation impacted ability to assess and mitigate risk
Clinical Justification	See Narrative Clinical Justification Section Above

Caller's Plan	This field is used to document what the caller and/or person of concern is going to do after the call. **<u>Details by Level of Care (LOC):</u>** Urgent or Emergent LOC: Required to complete **all** sections of the client's plan. Routine LOC: Expected to complete coping strategies, distractions, and personal/professional supports. The final three sections of the plan (warning signs, risk mitigation, and contingency plan) may be marked N/A in routine circumstances where they were not discussed. —If an area of the plan is not completed, a brief explanation must be included in the Client's Plan section of documentation for the relevant macro. This applies to routine, urgent, and emergent levels of care. It is acceptable to document if the client declined, or that documentation was not completed due to the nature of the contact (e.g., EAP client calling on a brief break, provider coordination). Additional elaboration can be provided if needed in the Clarifying Details section (i.e. explaining our attempts to explore that area of the plan) SELF CARE: *How is the caller going to cope with their level of distress/emotions after the call?* These are coping strategies that the *caller* identifies as helpful and taps into their individual advocacy. Includes *when* the caller will put the plan into action. (Examples include but are not limited to: self care coping skills and connecting with others to engage social supports.) Note: Only documenting that a caller will reach out to a referral is not an example of a self-care plan. This should be documented under **follow-up expectations** (see below). RISK MITIGATION: *How is the caller going to protect themselves from the risk factors around them?* The purpose is to remove/reduce the risk/danger. ● When the caller/visitor endorses access to lethal means, documentation must address means elimination and/or restriction. (Examples include but are not limited to: giving means to a trusted person for safe keeping, destroying means, reducing substance use, etc.). ● Not having access to means does not mean there is no risk. When the caller/visitor does not endorse access to means,

	document any plan to address risk, such as following up with their provider or other ways they are addressing risk. CONTINGENCY: *What will the caller do if the plain fails or things get worse or escalate?* Who will they reach out to? (Examples include but are not limited to: calling back (a crisis line), going to the hospital, or calling 911.) N/A: Used on Routine LOC calls when we have not discussed self care/coping strategies. The additional macro items may be marked with N/A in routine circumstances where all or some components of the plan were not discussed.
Follow Up Expectations	Document what the account, or Protocall, needs to know to facilitate follow up for services. It contains a standard list of follow up options, not all of which are applicable to an individual account. Documentation should be consistent with information as listed in account procedures. May also be used to document when a caller is going to follow up with a referral or with another agency/entity for services.
Custom Form: Referral	Referral information should be documented here when account procedures require it. This section will vary across accounts based on what custom information they are needing. It is not present on all accounts.

Clinical Assessment 2.3 and 2.4 Section Fields

Primary Problem Category	Callers will frequently have more than one problem or issue, pick the *primary* option based on <u>your</u> overall assessment of the call. This information is used primarily for data gathering purposes.
Assessed Initial Level of Distress	The level-of-distress is assessed based upon BOTH: ● The clinical call taker's subjective clinical understanding of how the client's circumstances are impacting the client, as well as, ● The client's presentation, overt behavior and affect.
Presenting Problem/Overview	This is where you document the "Lead" sentence.

Assessed Presentation of Person of Concern	Listed possible description of the caller's affect/presentation, which may be different from their assessed or actual level of distress. For example, a caller may have a flat or blunted presentation, and yet be in severe distress. Check the boxes that apply.
Additional Presentation Details	Note relevant presentation details here that are not offered in the presentation container.
Required Suicide Prompt Questions	• Have you had any thoughts of suicide today or recently? • Have you taken any action to harm yourself today? *Both prompt questions are required on all calls. A yes or unclear response to either or both prompt questions necessitates a complete suicide risk assessment. If unable to assess, mark Unable to Assess and document the reason why you were unable to assess. *On third party calls, ask about the POC. *Questions do not have to be asked verbatim or in the exact order written.
Suicide Risk Assessment	Make the appropriate selection from these options: • Assessment indicates no risk related to suicide • Current or recent thoughts of suicide* • History of thoughts and/or attempts, with current impact ruled out • Unable to assess *Requires additional assessment and documentation using the macro in narrative field
Suicide Risk Assessment Narrative	When risk is indicated, thorough and relevant documentation includes: **DESIRE**: *I want to kill myself* – expression of psychological pain, feeling intolerably alone, trapped and a burden to others – It is often driven by hopelessness. Key Concepts to Listen for and Assess: Suicidal Ideation, Hopelessness, Perceived Burden, Feeling Trapped, Self-Hate, Psychological Pain, Feeling Intolerably Alone • **Describe Thoughts** - what are they expressing about suicide? • **Precipitating Event** - what brought on the thoughts/actions? **INTENT**: *I am going to kill myself* – indicates the probability of enactment and encompasses certain factors, including an attempt in

	progress (the clearest indicator), an imminent plan to hurt self/others, preparatory behaviors and intent to die. <u>Key Concepts to Listen for and Assess</u>: Attempt in Progress, Plan/Method, Preparatory Behaviors, Expressed intent to die. ● **Method / How** - by what means is the caller going to take their life? ● **When / Timeline** - describe specified timeline or date ● **Actions Already Taken** - has the caller taken any steps towards acting on their thoughts or to get ready for their plan? ● **Commitment to Act** - describe any ambivalence about ending their life, expressed intent, or readiness to act **<u>CAPABILITY</u>:** *I am <u>able</u> to kill myself* – relates to the fearlessness of taking action, experience with past suicide attempts and/or self-harming behaviors, inability to control impulses and availability of means. <u>Key Concepts to Listen for and Assess:</u> History of Attempts, History of ISI, Availability of means, Emotional Dysregulation, Currently Intoxicated, Use of Substances, Exposure to someone else's death by suicide, Acute Symptoms of Mental Illness, Sleep Disturbance, Increased Anxiety ● **Access to Identified Method** - described access to means for identified method ● **Access to Lethal Means** - describe any access to potentially lethal means, even if they are not cited as the identified method, including weapons, medication, sharps, ropes, keys, etc. ● **Current Physical Circumstances** - physical location, if alone or with others, consideration for proximity to means if applicable ● **History of Attempts** - when was the last attempt? what means were used? ● **Impairment due to substances or cognitive** - How did these impact their risk for suicide. Use relevant assessment fields below to document the complete assessment respectively. ● **Credibility / Reliability considerations** - include any factors in the call that influence how we view the person's ability to credibly safety plan.

	• **Assess for Intentional Self Injury and document under the ISI question below** • **Any other relevant information**
Intentional Self-Injury Risk Assessment	Make the appropriate selection from the following options: • Assessment indicates no risk related to self-injury • Not relevant • Current or recent risk related to self-injury* • History of self-injury reported, with current impact ruled out • Unable to assess *Requires additional assessment and documentation using the macro in narrative field
Narrative Intentional Self-Injury Risk Assessment	When assessment indicates risk, thorough and relevant documentation includes: • The thoughts and/or behaviors • History - the last occurrence of injury • Purpose - emotion regulation, compulsion, preparation for acting on suicidal thoughts, etc • Current access to means • Any evidence of potential lethality or current medical emergency • Other relevant information if potential lethality is high
Threat of Violence Risk Assessment	Make the appropriate selection from the following options: • Assessment indicates no risk related to harm to others • Current or recent thoughts of harming others* • History reported, but assessment indicates no current risk • Unable to assess *Requires additional assessment and documentation using the macro in narrative field
Narrative Threat of Violence Risk Assessment	**When risk is indicated, thorough and relevant documentation includes:** • **Describe Thoughts** - what are they expressing? ***do not include thoughts of self defense if provoked***; include thoughts of seriously injuring or killing • **Method / How** - with what means is the caller is going to injure/kill another person? how will they gain access to the individual? • **Access to Identified Method** - described access to means for identified method • **Access to Lethal Means** - describe any access to potentially lethal means, even if they are not cited as the identified

	method, including weapons, medication, sharps, ropes, keys, etc. ● **Desire / Commitment to Act** - preparations and/or behaviors ● **When / Timeline** - describe specified timeline or date ● **History of Violence** - include previous acts of violence or impulsive behavior ● **Intended Victim Information Including Access**- include name, address, DOB of intended victim, and if they have access to the identified victim ● **Any other relevant information** **When Considering a Duty to Warn** ● Review **state specific guidelines for mental health professionals** in the state you are licensed in and the state where the incident is occurring. ● Consult and consider: ○ Are they threatening to kill or gravely injure the intended victim? ○ Do we have first hand information? ○ Is there a specific victim identified? Or a general statement? ○ Does the caller have access to the identified victim and means to carry out the plan?
Substance Use Risk Assessment	Make the appropriate selection from the following options: ● Assessment indicates no risk related to substance use ● Current or recent substance use* ● History reported, with current impact ruled out ● Unable to assess *Requires additional assessment and documentation using the macro in narrative field
Substance Use Risk Assessment	When assessment indicates use, thorough and relevant documentation includes, (for each substance): ● Name of substance(s) used ● Frequency of use - How often? ● Amount used - Typical quantity per use ● Duration of use - What length of the time has the person been using at this rate? ● Last use - Including current ● Current symptoms - i.e., sober, acute intoxication, acute withdrawals, etc. ● How the use impacted this call - Consider reliability and credibility due to level of intoxication

Interpersonal Violence Risk Assessment	Make the appropriate selection from the following options: ● Assessment indicates no risk to interpersonal violence/relationship abuse ● Current or recent interpersonal violence/relationship abuse* ● History of violence, with current impact ruled out ● Unable to assess *Requires additional assessment and documentation using the macro in narrative field
Narrative Interpersonal Violence/Relationship Abuse Risk Assessment	When risk is indicated, thorough and relevant documentation with respect to interpersonal violence includes: ● **Describe Violence/Abuse** - The nature of the interpersonal risk (physical, verbal, emotional, threats, financial, etc.) ● **Current Danger or Need for Medical Attention** - Current danger of interpersonal violence; current need for medical attention or emergency services Potentially relevant additional assessment points (not required): ● **The Presence of Deadly Weapons in the Home- such as a firearm** ● **Substance use by the alleged abuser that might make conflict more likely to occur** ● **The ability to call for help if needed**
Abuse Related Risk Assessment	Make the appropriate selection from the following options: ● Assessment indicates no risk related to abuse ● Not relevant - when not brought up during the interaction and/or the POC is determined to not be a vulnerable individual ○ may warrant consultation ○ may warrant documentation under the Interpersonal Violence Risk Assessment ● Current or recent risk related to abuse/neglect* ● History reported with current risk ruled out* ● Unable to assess *Requires additional assessment and documentation using the macro in narrative field
Narrative Abuse Related Risk Assessment	When assessment indicates risk, thorough and relevant documentation with respect to Vulnerable Populations includes: ● Nature of abuse/neglect - describe alleged action/inaction ● Current danger of abuse/neglect - whether or not there is any present danger ● When and where abuse occurred - include location, state, age of survivor, any known date(s), and time-span

	• Demographic information of alleged offender and survivor - include any other relevant identifying information not already documented, including DOB • Current need for medical attention or emergency services - any current injuries or need for medical or other evaluation • Considerations for reporting/not reporting - based on reporting guidelines, what factors led to our decision to report or not report? Ex. age, relationship, direct information, etc.
Psychiatric Medications	Make the appropriate selection from the following options: • Not Relevant • Denies use of psychiatric medication • Confirms taking listed psychiatric medication(s) as prescribed* • Does NOT take listed psychiatric medications(s) as prescribed* • Unable to assess *Requires additional assessment and documentation using the macro in narrative field
Narrative Psychiatric Medications	When psychiatric medications are prescribed, thorough and relevant documentation includes: • Psychiatric Medication Name(S) - Name of medication(s) • Describe Concerns/Risk, If Any - Include whether caller or person of concern are not taking medication as prescribed, and the presence and nature of any side effects or physical withdrawal symptoms. Note: For frequent callers, it is sufficient to only address compliance.
Cognitive Concerns Observed	If observed, select from the list that includes • Hallucinations* • Delusions* • Paranoia* • Inability to care for self* • Other* If cognitive concerns are not observed, leave this blank.
Narrative Cognitive Concerns Observed	Provide additional descriptive information in the macro: • **Command Hallucinations** - note if the voices are telling them to harm themselves or others and ask: *have you ever acted on what the voices tell you to do?* • Nature of concern - describe, including examples if relevant

	• Combined with SI or HI - Detail any cognitive concerns related to harming self or others • New or ongoing symptoms - Specify if symptoms are new or ongoing, pay attention to the first onset of symptoms • Impact to Credibility/Reliability - Include any factors in the call that influence how we view the person's ability to credibly safety plan, especially the presence of any command hallucinations. Note the impact of cognitive concerns on Level of Care. • Impaired Ability to Care for Self - Specify if cognitive concerns impair caller's ability to care for self • Impact to the Call - How caller's presentation impacted ability to assess and mitigate risk
Clinical Justification	See Check Box Justification above.
Caller's Plan	This field is used to document what the caller and/or person of concern is going to do after the call. **Details by Level of Care (LOC):** Urgent or Emergent LOC: Required to complete **all** sections of the client's plan. Routine LOC: Expected to complete coping strategies, distractions, and personal/professional supports. The final three sections of the plan (warning signs, risk mitigation, and contingency plan) may be marked N/A in routine circumstances where they were not discussed. —If an area of the plan is not completed, a brief explanation must be included in the Client's Plan section of documentation for the relevant macro. This applies to routine, urgent, and emergent levels of care. It is acceptable to document if the client declined, or that documentation was not completed due to the nature of the contact (e.g., EAP client calling on a brief break, provider coordination). Additional elaboration can be provided if needed in the Clarifying Details section (i.e. explaining our attempts to explore that area of the plan) SELF CARE: *How is the caller going to cope with their level of distress/emotions after the call?* These are coping strategies that the *caller* identifies as helpful and taps into their individual advocacy. Includes *when* the caller will put the plan into action. (Examples include but are not limited to: self care coping skills and connecting with others to engage social supports.)

	Note: Only documenting that a caller will reach out to a referral is not an example of a self-care plan. This should be documented under **follow-up expectations** (see below). RISK MITIGATION: *How is the caller going to protect themselves from the risk factors around them?* The purpose is to remove/reduce the risk/danger. ● When the caller/visitor endorses access to lethal means, documentation must address means elimination and/or restriction. (Examples include but are not limited to: giving means to a trusted person for safe keeping, destroying means, reducing substance use, etc.). ● Not having access to means does not mean there is no risk. When the caller/visitor does not endorse access to means, document any plan to address risk, such as following up with their provider or other ways they are addressing risk. CONTINGENCY: *What will the caller do if the plain fails or things get worse or escalate?* Who will they reach out to? (Examples include but are not limited to: calling back (a crisis line), going to the hospital, or calling 911.) N/A: Used on Routine LOC calls when we have discussed self care/coping strategies. The additional macro items may be marked with N/A in routine circumstances where all or some components of the plan were not discussed.
Follow Up Expectations	Document what the account, or Protocall, needs to know to facilitate follow up for services. It contains a standard list of follow up options, not all of which are applicable to an individual account. Documentation should be consistent with information as listed in account procedures. May also be used to document when a caller is going to follow up with a referral or with another agency/entity for services.
717 Custom Form: Referral	Referral information should be documented here when account procedures require it. This section will vary across accounts based on what custom information they are needing. It is not present on all accounts.

Chat and Text (Chext) Documentation

Differences in Documenting a Chat/Text Interaction

Chat or Text (chext) interactions are documented differently because of the nature of the service. Our chext assessment is primarily based around thoughts of suicide. Other areas of risk are assessed if they arise throughout the course of the interaction or become required due to presence of risk of suicide or homicide.

Chext Section Fields

Non-Transactional Form	**VUP Chat/Text and Twilio Text:** Used to document Non-Transactional interactions. Non-transactional *means the visitor never responded to the counselor after the counselor sent their initial greeting message.* Types of Non-Transactional Interactions: ● Non-Transactional without risk ● Non Transactional without evidence of potentially imminent risk, nothing further needed (counselor has been cleared to not consult on SI without potentially imminent risk) ● Non-Transactional with risk, consultation occurred to determine next steps ○ This should be selected if you are in Stage 1 and there is any risk OR ○ If you are in Stage 2-3 and the risk is potentially imminent OR ○ You consulted for any reason. ■ Document the consultation, rationale and next steps in the *Clarifying Details and Consultation* section. You may also note unanswered outreach attempts here. ■ If the outreach is answered or a higher intervention (such as EMS involvement) is involved, document the interaction in the *Chat and Text*

	Documentation section instead of the Non-Transactional form. ○ As always, counselors can choose to consult and document accordingly as needed and are encouraged to do so if uncertain. See **<u>above</u>** for how to write a consultation.
Available demographics	**VUP Chat/Text and Twilio Text:** Copy and paste any gathered demographic information from the VUP or Twilio into your Proteus document into the corresponding fields.
Transcript of interaction	**VUP Chat/Text:** Copy and paste the *entire chat/text* interaction transcript from the chext platform into Proteus. *The transcript must be pasted for any service request type of VUP Text (non-transactional, SCR, Clinical Documentation, info & referral, etc.)* **Twilio Texts:** Do NOT paste the transcript from interactions taken in Twilio.
Case Details / Contact Record	**VUP Chat/Text:** In this field, paste the entire demographic and pre-chat survey sections from Vibrant's Unified Platform. The Case Details / Contact Record must be pasted for all types of chexts. **Twilio Texts:** Nothing needed inTwilio.

Required Suicide Prompt Questions	**VUP Chat/Text and Twilio Texts:** ● Have you had any thoughts of suicide today or recently? ● Have you taken any action to harm yourself today? Both prompt questions are required on all interactions. A 'yes' or unclear response to either or both prompt questions necessitates a complete suicide risk assessment. For the 2nd Prompt Question (have you taken any action to harm yourself today?), preparatory action(s) should be counted as a 'yes' response. Other answers that suggest movement towards action should also be taken as 'yes'. Even if they respond 'no' but during our assessment but we determine they have taken some preparatory action, mark 'yes' to the question. If unable to assess, mark 'Unable to Assess' and document the reason why you were unable to assess. *On third party interactions, ask about the POC.
Suicide Risk Assessment and Other Risk Assessment Expectations	**VUP Chat/Text and Twilio Texts:** In Chext interactions, **the suicide risk assessment** is **required** on all interactions. The following assessment areas are required if the client endorses current or recent **thoughts of suicide** in a chat/text interaction: ● Full suicide risk assessment ● Assessing buffers ● Intentional self-injury assessment ● Substance use assessment ● Psychiatric medication assessment The following assessment areas are required if the client endorses current or recent **thoughts of homicide** in a chat/text interaction: ● Full threat of violence assessment ● Assessing buffers ● Substance use assessment The visitor's presentation and/or history may make other assessment macros relevant to understanding

	the overall picture of risk in a chat or text interaction. Assessing for other areas of risk is **relevant** when risk is directly endorsed or when a visitor's alert, history, or presentation indicates risk in that assessment area (Intentional Self Injury, Threat of Violence, Substance Use, Interpersonal Violence, Abuse Related Risk, Psychiatric Medication, and Cognitive Concerns Observed).
"Counselor observed nothing prompting an assessment" Radio Button	Document this option for risk assessment areas other than suicide risk when the visitor has not mentioned or disclosed information related to the specific risk area. If the visitor discloses risk or suggests concern related to a risk area, select the corresponding radio button instead.
If phone outreach is determined to be warranted during a chext interaction and we reach the POC	**VUP Chat/Text and Twilio Texts:** In situations in which we need to call a visitor to complete the assessment, the Chat and Text documentation should contain the overall assessment of risk informed by both the chext and call. ● Once the chext turns into a call, a full clinical assessment should be attempted and use of "Counselor observed nothing prompting an assessment" is no longer an appropriate option. ● Details of the rationale for calling the visitor, including consultation as appropriate, and attempts to call the visitor should be documented in the Clarifying Details and Consultation Section.
Clarifying Details and Consultation	**VUP Chat/Text and Twilio Texts:** Document relative information related to: ● Consultation. The same as the **above,** documentation of consultation includes the details and outcome (what was considered/discussed and what was decided) of the consultation and note the name, job title, as well as degree and/or relevant license status of the person(s) consulted. **When documenting consultations regarding abuse**

	reporting, specific criteria from state statues considered are included. ● Attempted Outreach Call(s) ● Visitor connected to crisis line call center support via phone ● Emergent interventions and any intervention details not addressed in the check box options including *attempted* less invasive interventions. ● Visitor presentation details that may be helpful or needed for a person alert ○ Examples: If we learn a visitor is familiar to law enforcement, specific language or phrases they use that is uniquely identifiable, etc. ● While not required, this section is also your opportunity to provide any information that may not be obvious based on a simple reading of the assessment and interventions (for example: explaining why a call is urgent if no thoughts of suicide or homicide are present)
Client's Plan Documentation Requirements	**VUP Chat/Text and Twilio Texts:** This field is used to document the plan made to support a client's safety and coping after our contact with them. Whether documenting the details of the plan, entering "N/A" when appropriate, or providing a rationale for why a section was not completed, <u>each macro must contain documentation on every clinical call and chat/text.</u> <u>Details by Level of Care (LOC):</u> Urgent or Emergent LOC: Required to complete **all** sections of the client's plan. Routine LOC: Expected to complete **coping strategies, distractions, and personal/professional supports**. The final three sections of the plan (warning signs, risk mitigation, and contingency plan) may be marked N/A in routine circumstances where they were not discussed. —If an area of the plan is not completed, a brief explanation must be included in the Client's Plan

	section of documentation for the relevant macro. This applies to routine, urgent, and emergent levels of care. It is acceptable to document if the client declined, or that documentation was not completed due to the nature of the contact (e.g., EAP client calling on a brief break, provider coordination). Additional elaboration can be provided if needed in the Clarifying Details section (i.e. explaining our attempts to explore that area of the plan)
Client's Plan Macros	**VUP Chat/Text and Twilio Texts:** **Internal Coping Strategies:** Coping strategies are things the individual can do on their own to help feel a little better at the moment. *- What can you do, on your own, to help yourself cope with distress?* **Distractions:** Distractions include people or places that may offer comfort or a break from their current situation or environment *- Which people or places help you take your mind off your problems at least for a little while?* *- Who helps you feel better when you socialize with them?* **Personal Supports:** Personal supports are people the individual feels comfortable talking to about what they are going through, and who can provide help. When possible, it can be helpful to talk with the support person identified about being a support. *- Are there people you feel comfortable talking to that can provide you support?* *- Among your family or friends, who do you think you could contact for help during a crisis?* **Professional Supports:** Professional supports are people who can provide professional care and support. *- Are you currently working with any professionals to support your mental health? When is your next appointment with them? If necessary, could you arrange for an urgent appointment with them?* *-"Would you like a referral to a counselor?" "When do you plan to contact the referral we talked about today?"*

	Warning Sign: A warning sign is something the individual thinks, feels, or does as thoughts of risk start to develop. Warning signs may include thinking patterns, physical sensations, activating circumstances, and changes in behavior or daily activities. *-How will you know when to use your Safety Plan?* *- What is happening when you start to experience suicidal thoughts or feel overwhelmed?* *- How do you feel physically before you begin to have thoughts of suicide or harming yourself? (e.g., heart racing, not sleeping or eating well).* **Risk Mitigation/Creating a Safe Environment**: Having items that can be used to harm themselves or others can be dangerous for a person in crisis. What items does the individual have nearby that they may use to harm themselves/others and how might they safely remove those items? *- Educate about impulsivity* *- What can you do to put **space** and **time** between you and those items?* *- How can you avoid locations that may be unsafe for you right now?* *- Are there any individuals that may be unsafe for you to be around right now?* **Contingency**: What will the client do if the plan fails or things get worse or escalate? Who will they reach out to? Examples include but are not limited to: calling back (a crisis line), going to the hospital, or calling 911.
Outcomes drop down	**VUP Chat/Text and Twilio Texts:** Choose the outcome that matches the final steps taken during the interaction. If more than one apply, choose the highest level of intervention conducted item.
Vibrant Unified Platform Documentation	**VUP Chat/Text:** Required Sections in VUP Documentation: - **Contact Information**: Document demographic information provided by the visitor - **Safety plan**: Fully required on chexts with risk. If unable to complete full safety planning, document an explanation in each section

	- **Follow up**: Answering if a CCFU Contact was required, offered, and accepted. It is not required to fill out the 2nd "Follow-up Details" Section since we use of Proteus Outbound Contact scheduling process. - **Reporting and Wrap up**: You can copy and paste your "Clarifying Details and Consultation" section from Proteus to the "Feedback from supervisors and Staff" portion of this section. Disposition information must be completed in this section. **Twilio Texts**: N/A
Requests for Multiple Parties (Third Party Chexts with two or more Assessments)	**VUP Chat/Text and Twilio Texts:** I*f risk or sensitive information about* ***two or more*** *people is assessed*, creating two or more separate documents can be considered and utilized for the sake of clarity, but is <u>not required</u> on chext. Each document will have the same Caller listed, but a different Person of Concern. **For VUP Chat/Text**, the full transcript and case details/contact record must be copied and pasted into <u>each</u> document created. *(Note: if a client requests their records, the transcript is not included as it is not considered part of the record just as a call recording is not considered part of their record.)*