High Risk Transitions for Vancouver Mental Health & Substance Use (MHSU) Program Clients

Site Applicability

Transitions from hospital units to community teams, including the following:

VCH

- Vancouver Community Adult Mental Health and Substance Use teams including Vancouver Intensive Supervision Unit (VISU), Downtown Community Court (DCC), Early Psychosis Intervention (EPI), Assertive Community Treatment (ACT), Assertive Outreach Team (AOT), Acute Home Based Treatment (AHBT), Outpatient Services, and Access and Assessment Centre
- Vancouver Primary Care Mental Health Services (Heatley, Pender, Downtown Community Health Centre)
- Vancouver General Hospital- Acute MHSU Inpatient Units and PAU
- UBC Hospital- Salus

PHC

- St. Paul's Hospital (SPH) - Acute Psychiatric Units and Psychiatric Assessment and Stabilization Unit (2N, 8C, 9A, and PASU)

Practice Level

Basic Skill:

- RN, RPN, SW, OT within scope of practice, role and competencies
- Clinical Counsellors within their employer training and job descriptions

Requirements

Acute and community clinicians will assess for risk factors as outlined. For identified risk factor(s), they will work in collaboration to determine appropriate interventions to minimize risk upon discharge from hospital.

This Decision Support Tool (DST) is to be used in tandem with Vancouver MHSU Communication Protocol and the Mental Health and Substance Use Follow-Up after Acute Care Discharge.

Acute and community clinicians will ensure that a minimum of one in-hospital visit/virtual care visit with the client and family by a community clinician occurs prior to discharge to plan the transition from acute. At this meeting:

- The client is introduced to the community clinician who will be providing ongoing care.
- The client's goals and self-management plans are provided in writing to the client and family and community team. This includes the "When I Leave Hospital Form" and may include a safety plan.

- Education is provided to the client and family relevant to client specific needs.
- Following the meeting, documentation is strengths-based, trauma-informed and follows organization and regulatory body documentation standards.

There are additional in hospital/virtual visits as per Vancouver MHSU Communication Protocol during the client's hospitalization.

Need to Know

Transitions in care can be challenging for many clients and families but they are especially high risk for clients with complex care needs. Complex clients require specialized and collaborative discharge planning that ensures their unique risks are identified and mitigation plans are put into place. High risk is defined negative outcomes that can result upon discharge from hospital such as re-hospitalization, near miss such as medication error, death, harm to self or harm to others.

Family members are encouraged to be involved and supportive of the client and are integral to the overall well-being of the client. As a first step, it is always best to talk to the client to learn who should be involved in their care and in their decision making. This includes learning more about their relationships as there may be instances where it may not be appropriate or helpful to have family involved.

The purpose of the Adult Guardianship Act (AGA, part 3) is to respond to situations of suspected adult abuse, neglect and self-neglect and provide support and assistance to vulnerable adults. A vulnerable adult is an adult who is abused and/or neglected and is unable to seek support and assistance due to physical restraint, mental or physical disability, illness or injury. In all situations where an adult is at risk of abuse, neglect and self-neglect and may not be able to seek support and assistance refer to a Designated Responder or Designated Responder Coordinator per the Adult Protection: Abuse, Neglect or Self-Neglect of Vulnerable Adults policy.

Protocol

Assessment

Clients may have multiple risks with variable degrees of potential harm. When collaborating on discharge planning, the risks that have imminent harm and high probability of occurring to client or others will be prioritized for care planning and risk mitigation. Assessments that can help to identify risks include but are not limited to:

- Columbia Suicide Severity Rating Scale (C-SSRS) (acute VCH/PHC, community VCH)
- Mental Status Exam
- Violence Screen (Violence Screen in Cerner, Risk Screen)
- Cognitive Screens (Montreal Cognitive Assessment, Screen for Cognitive Impairment in Psychiatry, Mini Mental Status Exam)
- Adult Protection Investigation
- Substance Use (acute VCH/PHC, community VCH)
- Psychosocial Assessment
- Supportive & Palliative Care Indicator Tool (SPICT)

Collaborative Care Planning

Collaborative care planning includes:

- Using a trauma informed, strengths-based and culturally safe approach
- Identifying client strengths and areas of struggles
- Reviewing challenges to a safe transition and collaboratively discussing approaches to addressing challenges
- Working with client's learning style and communication
- Involving client and family, include support for family and time for questions (need to have family contact details prior)
- Planning for follow up upon hospital discharge
- Reviewing providers and services currently involved in client's care
- Reviewing housing situation

Collaborative care planning requires communication between acute and community partners and can include:

- Direct phone and/or email communication may be used in lieu of a formal meetings when there is a clear disposition plan and a clear plan to address risks.
- Formal collaborative case conferences are organized between community and acute team members for complex patient admissions and discharge planning.
- Integrated case conferences are organized between community and acute team members (often more than one team member from each group) for the most complex patient admissions and discharge planning. Transition Services Team is involved for dispositions to long term care or complex discharge planning requiring access to community resources including but not limited wound care and home support.

Interventions

Clients may require close monitoring upon discharge in the community by a community team where there is an increased frequency in contact and assessment of risk.

The When I Leave Hospital form (Appendix A) is completed with the client in the acute setting and where possible, includes the client's family/support person(s) (see VCH Family Involvement with Mental Health& Addiction Services Policy/ PHC Family Presence Policy). This form includes the date and time of the scheduled follow-up appointment in the community, community contact names/numbers, contact numbers for support persons, and consent to contact support persons if the client cannot be reached.

Community teams will follow up with the client within 48 hours of discharge.

- For clients who do not have a phone, the clinician/site leadership will make a plan to establish contact with the client upon discharge e.g. have client sent to team via taxi from hospital on date of discharge. If contact cannot be made the same day, the hospital discharge summary and collateral will be reviewed to determine when and how to follow up. This may include contacting clients' supports (i.e. family, housing provider, shelter, referral to AAC for weekend contact, etc.) in order make contact with the client within 2 days of calendar days of discharge.
- For clients who do have a phone, the clinician/site leadership will make a plan to establish

contact with the client upon discharge. If the client has a scheduled appointment and does not attend, a phone call will be made same day. If no contact made, another phone call attempt followed by outreach visit will be made the next calendar day.

As part of discharge planning, if assessment and collaborative care planning identifies the following risk factors, below are interventions acute and community may implement to minimize risk to the client:

1. **Violence**

   Violence/ aggression can occur in a hospital unit, in the client's home or in community. Violence may occur by the client towards others and/or towards the client by others. Clients are at increased risk of violence perpetrated by others, including but not limited to intimate partner or family violence.

Acute	Community
• Review history of risk with community team and family (and document in EHR). • If there is any violent incident on the unit, involved family and community team will be informed. If the incident is serious i.e. assault to staff, there will be a manager/ lead to manager / lead phone call. • Complete violence screen in Electronic Health Record (EHR) and implement Violence Prevention care plan/ Process Alerts if indicated. • Document behavioural management plan in (EHR, share same with family and community. • Through a handover, communicate risks to community team. • Inform others who need to be aware e.g. housing provider, etc.	• Update the community risk screen (CRS) in PARIS or EMR (the CRS is a two way interface and one system will auto populate the other) • Update alerts in PARIS or EMR • Create a behavioural management plan. Include components of acute plan if relevant in community. Communicate with family and client. • Create discharge plan that includes strategies to minimize risk. This may include family involvement, outreach, more frequent contact and/or more support, in addition to clear plans for what to do when client does not engage with the team. Identify risk triggers if known. Ensure client involvement in plan. • If contact attempts of client/family are not successful d within 48 hours of discharge continued attempts will made • An escalation plan will be established if the follow-up contact identifies that a client is in need of immediate assistance e.g. contacting family, utilizing Car 87/88 to locate client, etc.

2. Suicide

Clients may present with suicide risk factors and/or may be at imminent risk of harm to themselves

Acute	Community

• Complete Columbia Suicide Severity Rating Scale (C-SSRS)prior to discharge to screen for risk potential
• Review history of risk with community team and family (and document in EHR)
• VGH
  ○ discharge to Outpatient Services/SAFER: SAFER to visit the client on the unit and complete the safety plan.
  ○ discharge to other teams: OT on unit completes safety plan and Wellness Recovery Action Plan (WRAP) where possible.
• SPH: RN/RPN to complete a safety plan. Appendix B
• Once a safety plan is in place, it will be documented in the EHR and shared with community team and family.
• Safety plan will be given to client upon discharge.
• Work collaboratively with community staff to plan removal of items in the home with client consent (e.g. rope, lots of medications, etc.).
	• Enter safety plan details from Cerner into EMR or PARIS.
	• Create discharge plan that includes strategies to minimize risk and screen for suicide risk within 48 hours of discharge including reviewing/updating safety plans. This may include family involvement, outreach, more frequent contact and/or more support, in addition to clear plans for what to do when client does not engage with the team.
	• If contact attempts of client/family are not successful within 48 hours of discharge continued attempts will made.
	• An escalation plan will be established if the follow-up contact identifies that a client is in need of immediate assistance e.g. contacting family, utilizing Car 87/88 to locate client, etc.

3. Substance Use

Clients may have substance use that is problematic and different goals regarding their substance use e.g. continue use, reduce, abstinence, etc.

Acute	Community

• Review history of risk with community team and family (and document in EHR)
• VGH: Medical consult from Chronic Pain Addictions Services (CPAS) completed and documented in EHR.
  ○ Update clinical care plan in EHR to include addiction information e.g. OAT prescriber, pharmacy info.
SPH: Refer to Addiction Medicine Consult Team (AMCT) – AMCT MD and/or SW to complete documentation in EHR.
  ○ Most Responsible Provider (MRP) to updated clinical care plan to include addiction information e.g. OAT prescriber, pharmacy info and to note if patient has declined AMCT involvement.
• Train clients and/or family on Take Home Naloxone kits. Unit must offer to dispense a kit and/or advise client where to access in the community.
• Engage client (and family) in substance use safety planning VCH/PHC, review harm reduction strategies VCH (Appendix C) / PHC (Appendix D) and document plan.
• Handover to community for clients on Opioid Agonist Therapy (pharmacy, community follow up plan)
• If client indicates interest in reducing or stopping substance use, work with client to apply for programs that meet client goals. Liaise directly with community program staff to support effective transition to this program and share this information with community MHSU staff.
	• Engage client (and family) in substance use safety planning, review harm reduction upon discharge
	• Enter safety plan details from Cerner into EMR or PARIS. This includes documenting Opioid Agonist Therapy (OAT) plan and any other steps community may take re: client OAT follow up in community.
	• Create discharge plan that includes strategies to minimize risk. This may include family involvement, outreach, more frequent contact and/or more support, involvement of housing provider when appropriate, offer flexible appointment times and locations, allow for self-referral for services, provide harm reduction supplies, information about supervised consumption services in addition to clear plans for what to do when client does not engage with the team.
	• If contact attempts of client/family are not successful within 48 hours of discharge continued attempts will made.
	• An escalation plan will be established if the follow-up contact identifies that a client is in need of immediate assistance e.g. contacting family, utilizing Car 87/88 to locate client, etc.
	• Follow up on referrals/program applications that were initiated in hospital. Liaise directly with community program staff to support effective transition to this program.

4. Housing (Discharge to Shelter or No Fixed Address [NFA])

Some clients may be discharged to a shelter, without a fixed address, or to otherwise precarious housing.

Acute	Community
• Review history of risk with community team and family (and document in EHR). If client is NFA use team referral process to engage client in team choice and community teams in referral process.	• Create discharge plan that includes strategies to minimize risk. This may include family involvement, outreach, more frequent contact and/or more support, in addition to clear plans for what to do when client does not engage with the team. ○ Consider short term intervention teams for support as clinically indicated and/or collaborated with for client with higher risk of harm to others ○ If client does not have their own phone, contact shelter staff or outreach to client residence. Identify locations where client frequents, as well as contacts and a description of client to allow for easier location. • If contact attempts of client/family are not successful within 48 hours of discharge continued attempts will made. • An escalation plan will be established if the follow-up contact identifies that a client is in need of immediate assistance e.g. contacting family, utilizing Car 87/88 to locate client, etc. • If client is NFA, use team referral process to prepare for potential discharge. Once confirmed, document shelter information in PARIS or EMR. Ask for confirmation of client's arrival at the shelter or ask for client be sent to team upon discharge from hospital via taxi.

5. Cognitive Impairment

Cognitive impairment includes neurocognitive disorder or impairment, brain injury and developmental disabilities.

Acute	Community
• Review history of risk with community team and family and document in EHR. OTs perform functional and cognitive assessment when there are concerns with Activities of Daily Living (ADL)/ Instrumental Activities of Daily Living (iADL). Documents recommendations/interventions and contacts community OT to share this information. • If indicated, connect with TST to discuss home support. • SW or CML connect with community clinician. • Involve Adult Protection SW, Risk and Ethics as needed for complex care. • PHC: Consider Neuropsychology referral.	• Create discharge plan that includes strategies to minimize risk. This may include family involvement, outreach, more frequent contact and/or more support, in addition to clear plans for what to do when client does not engage with the team • Community OT to liaise with hospital OT regarding functional assessment outcomes/needs regarding concerns with ADLs/iADLs. Recommendations/interventions documented in PARIS/EMR by community OT. • If contact attempts of client/family are not successful within 48 hours of discharge continued attempts will made. • An escalation plan will be established if the follow-up contact identifies that a client is in need of immediate assistance e.g. contacting family, utilizing Car 87/88 to locate client, etc.

6. Medication

Clients may have experienced past challenges with medication adherence or may be starting on a new medication. Some medications are associated with high risk of adverse effects.

Acute	Community
• Complete Plan G and special authority prior to discharge. If approval not obtained prior to discharge, discuss strategies to mitigate risk of medication non-adherence e.g. provide medications from hospital pharmacy. Acute to inform community of status at discharge as well as any plans for risk mitigation.	• Monitor client attendance to appointment(s) with physician(s) before prescription expires. Support client to attend follow up appointments and explore barriers to adherence.

• Prior to the client being discharged to community, the acute clinician will confirm pharmacy based on client choice or program requirement (e.g. certain housing providers with medication management programs use a particular pharmacy). • Review role of team in supporting medication management in the community including terms of extended leave with the client • Document pharmacy information on When I Leave Hospital Form • When documenting team follow up appointments, ensure discharge medication prescription will last until the client's appointment with physician in the community (there may be two separate appointments if client sees a psychiatrist and substance use medicine provider separately). • Provide education to client and family about medication, including verbal communication and paper/online references. Communicate clearly with client and family when there is an ongoing taper of medication e.g. client transitioning to depot, still on oral medication • If client is prescribed clozapine ensure physician to physician handover occurs; discuss optimizing dosage timing to support medication adherence e.g. once a day administration. Also discuss potential impact of returning to nicotine use in community. Clozapine discharge fax sent to community and patient hand out is provided to client.	• Encourage Daily Witnessed Ingestion (DWI) at pharmacy until the client's appointment at the team. This can be reassessed when client is assessed by community physician. • Provide education to client and family about medication, including verbal communication and paper/online references. Communicate clearly with client and family when there is an ongoing taper of medication e.g. client transitioning to depot, still on oral medication. • If client is prescribed clozapine ensure physician to physician handover is provided. Ensures client continues their blood testing.

7. Other Risks/Health Care Treatment

Other risk factors may be identified in which acute and community clinicians will work collaboratively to determine the interventions that would be appropriate, using a similar framework to the previously mentioned risks:

- Reluctance to engage in health care services due to negative experiences
- Social support network risks (this could include but is not limited to social isolation; supports encouraging alternative discharge plans than acute/community plans; involvement of

Ministry of Child and Family Development or Vancouver Aboriginal Child and Family Services Society (VACFCSS)).

- Financial, structural, health and/or social barriers (e.g. marginalization, stigma, inadequate housing, inadequate food/water, poverty, etc.)
- Co-morbidity of serious illness (e.g. cancer)
- Abuse, neglect or self neglect of a vulnerable adult as defined under Adult Guardianship Act

8. Discharges involving Extended Leave

Acute	Community
• Renew Form 6 if due within 14 days of discharge • For new extended leave, facilitate physician to physician communication • Notify community mental health team through team lead to team lead communication • If a review panel hearing has been scheduled, collaborate with community on completion of review panel note • Acute clinicians to liaise with client and family on the conditions, expectations and consequences of discharge on extended leave	• Communicate need for reset of dates, if indicated • For new extended leave, facilitate physician to physician communication • If a review panel hearing has been scheduled, collaborate with acute on completion of review panel note

Documentation

In acute settings, assessments, interventions, care plans and narrative notes are documented in Cerner EHR. In community settings, risk screen, alerts, safety plan, and notes are documented in PARIS or EMR.

Patient and Family Education

Education is provided to the client and family about the discharge plans, diagnoses and medications, and ways to mitigate risk in order to support continuity of care between transitions.

Related Documents

Related Policies

PHC:

- Family Presence Policy
- Violence Risk Alert Policy

PHC & VCH:

- Documentation Policy
- Medication Reconciliation Policy

VCH:

- Adult Protection: Abuse, Neglect or Self-Neglect of Vulnerable Adults
- Cultural Competency and Responsiveness Policy
- Domestic Violence Routine Screening Policy for Patients Policy
- Family Involvement with Mental Health & Addiction Services Policy
- Harm Reduction Practice Policy
- Indigenous Cultural Safety Policy
- Possession of Controlled Substances for Personal Use

Guidelines/Procedures/Forms

PHC:

- Harm Reduction and Managing Substance Use- Acute Care
- Mental Health Program Harm Reduction Tips

PHC and VCH:

- Clozapine: Care of Patient Receiving (Mental Health)

VCH:

- Close Monitoring of Clients
- Clozapine Monitoring and Management in Community
- Community Mental Health Review Panel Hearing
- Community MHSU Documentation Standard
- Community Risk Screening Standard
- Dispensing/Distributing Take Home Naloxone Kits to be used for Suspected Opioid Overdose
- Harm Reduction and Safety Planning in Acute Care
- Harm Reduction and Substance Use Safety Planning- Community and Long Term Care
- Interprofessional Standardized Cognitive Screening
- Instructions for Use of the Community Risk Screen Tool
- Maintenance of Alerts in PARIS
- Matching Levels of Intervention to Client Risk Checklist
- Matching Levels of Intervention to Client Risk Guide
- Post Hospital Discharge
- Promoting Safe and Respectful Care Interactions

- Regional Palliative Approach to Care
- Team Referral Process
- Trauma Informed Practice
- Vancouver Acute to Community Transitions Package
- Violence Prevention Guidelines
- When I Leave the Hospital Form (VCH and UBC)

VCH & PHC:

- Clozapine: Care of Patient Receiving (Mental Health)
- Cognitive Evaluation and Intervention Guideline for the Adult Population
- CST Cerner Help
- Mental Health & Substance Use Follow-Up after Acute Care Discharge
- Opioid Overdose: Management of Suspected Opioid Overdoses in Community Settings
- Opioid Overdose (Suspected): Management, Including Naloxone Administration without a Provider Order
- Suicide: Risk Assessment, Prevention and Management (Community and Long-term Care)
- Suicide Risk Assessment and Management: Acute and Tertiary Mental Health
- Supporting Choices Through Informed Decision Making and Collaboration
- VCH & PHC Occupational Therapy Cognitive Assessment Inventory

Definitions

Clinician refers to case manager, MHSU clinician, care coordinator, case management leader, clinical nurse leader, nurse, social worker, occupational therapist, clinical counsellor

Family or Family Member means a person who has been identified by the Client, the Client's representative or the Client's Care Provider as being in a relationship of importance to the Client and who provides support or care for the Client on a regular basis. Family members are the people who provide the primary physical, psychological, or emotional support for the patient or resident. Family is not necessarily blood relatives.

Appendices

Appendix A: When I Leave Hospital Form

Appendix B: PHC Mental Health Safety Plan

Appendix C: Harm Reduction Strategies

Appendix D: Mental Health Program Harm Reduction Tips

Appendix A: When I Leave Hospital Form

Vancouver CoastalHealth Providence HEALTH CARE

Vancouver MENTAL HEALTH & ADDICTION

☐ **UBC Hospital** ☐ **Vancouver General Hospital**

Attach patient label on white chart copy only

WHEN I LEAVE HOSPITAL

Date of discharge: _____ For: _____

MY NEXT APPOINTMENT(S)

Name of Service Provider	Date	Time	Address & Phone Number
	____ Month ____ Day ____ Year	____:____	
	____ Month ____ Day ____ Year	____:____	
	____ Month ____ Day ____ Year	____:____	

If a follow-up appointment has not been scheduled, specify why not:

☐ I do not wish to have a follow-up appointment (specify reason): _____

☐ I would prefer to schedule my own follow-up appointment (specify reason): _____

☐ I live out of town/country and will schedule my own follow-up appointment when I return home *(for clients outside of Vancouver Coastal Health / Providence Health Care)*

☐ I'm being transferred or discharged to an acute or tertiary hospital, or sub-acute site (specify location): _____

☐ I've left against medical advice (AMA), I'm absent without leave (AWOL), or I did not return from pass

MEDICATIONS *(indicate N/A if not applicable)*

☐ I have received my discharge prescription

☐ I will pick up my medications at this pharmacy _____

☐ I will get my medications delivered to me from _____

☐ I will get my next injection medication at _____ on _____

☐ I have received Take Home Naloxone Kit & education

MY FIRST PEOPLE TO CONTACT if I feel unwell or I am in crisis are:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

If I am in crisis and CANNOT REACH MY FIRST PEOPLE TO CONTACT, I will phone one of the other numbers below or go to the Emergency Department

Vancouver Access & Assessment Centre (AAC) Mental Health Emergency Services	604-675-3700
Provincial Crisis Centre – 1-800-SUICIDE	1-800-784-2433 or 1-604-872-3311
Addiction Access Central (Detox referral line)	1-866-658-1221
Smoking Cessation Support – QUIT NOW	1-877-455-2233 or Text 654321

Reviewed with patient by: _____ _____

Staff signature Printed name

VCH.VA.0071 | JUL.2019

Distribution: WHITE ORIGINAL - Patient Chart (in front of Nursing Notes)
YELLOW - Patient Copy PINK - CNL or Designate

Providence Health Care

ST. PAUL'S HOSPITAL
MENTAL HEALTH & ADDICTION
WHEN I LEAVE HOSPITAL

Date of discharge: _____

MY NEXT APPOINTMENT(S)

Name of Service Provider	Date	Time	Address & Phone Number
	____ Month ____ Day, ____ Year	__:__	
	____ Month ____ Day, ____ Year	__:__	

If a follow-up appointment has not been scheduled, specify why not:

- ☐ I do not wish to have a follow-up appointment (specify reason): _____
- ☐ I would prefer to schedule my own follow-up appointment (specify reason): _____
- ☐ I live out of town/country and will schedule my own follow-up appointment when I return home *(for clients outside of Vancouver Coastal Health / Providence Health Care)*
- ☐ I'm being transferred or discharged to an acute or tertiary hospital, or sub-acute site (specify location): _____
- ☐ Left against medical advice (AMA), absent without leave (AWOL), did not return from pass

MEDICATIONS *(indicate N/A if not applicable)*

- ☐ I have received my discharge prescription
- ☐ I will pick up my medications at this pharmacy _____
- ☐ I will get my medications after they are delivered to _____
  from _____ pharmacy
- ☐ I will get my next injection medication at _____ on _____

TAKE HOME NALOXONE KIT and Education Provided

☐ Yes ☐ No (specify reason): _____

MY FIRST PEOPLE TO CONTACT if I feel unwell or I am in crisis are:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

If I am in crisis and **CANNOT REACH MY FIRST PEOPLE TO CONTACT**, I will phone one of the other numbers below or go to the Emergency Department

Vancouver Access & Assessment Centre (AAC) Mental Health Emergency Services	604-675-3700
Provincial Crisis Centre – 1-800-SUICIDE	1-800-784-2433 or 1-604-872-3311
Addiction Access Central (Detox referral line)	1-866-658-1221
Smoking Cessation Support – QUIT NOW	1-877-455-2233 or Text 654321

Reviewed with patient by: _____ _____

Staff signature Printed name

Form No. PS207 (R. 23 March 2023)

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Appendix B: PHC Mental Health Safety Plan

Place Patient Form Label Here

PHC MENTAL HEALTH SAFETY PLAN

* 1 0 2 3 6 *

Mental Health Assessment

Step 1. **Recognize my warning signs** *(thoughts, images, mood, situation, behavior)* that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2. **Try using my coping strategies** - Things I can do myself to take my mind off my problems without contacting another person *(relaxation technique, physical activity):*

1. _____
2. _____
3. _____

Step 3. **Remind myself of reasons for living:**

1. _____
2. _____
3. _____

Step 4. **Call someone I can ask for help:**

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____

Step 5. **Go to a safer place:**

1. _____
2. _____
3. _____

Step 6. **Call 1-800-SUICIDE** (1-800-784-2433) or the **Access and Assessment Centre** (604-674-3700).

Step 7. **Go to the Emergency Room at the nearest hospital.**

Step 8. **Call 911 and request transportation to the hospital if I feel that I can't get there safely myself.** They will send someone to transport me safely.

Step 9. **After the crisis has passed, I will care for myself by:** _____

_____

_____

Clinician signature _____ Printed name _____ Date _____

FORM ID - 10236 (PHC-PS293) VERSION 2022 AUG 11

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Appendix C: Harm Reduction Strategies

Appendix D: Mental Health Program Harm Reduction Tips

Mental Health Program Harm Reduction Tips:

Staying safer in a drug poisoning crisis

We care about you and want you to be safe

Things we can do to help keep you safe:

- Give you medications to treat your withdrawal, cravings and pain
- Support you if your goal is not to use - let us know and tell us what will help
- Provide take home naloxone kits

Things you can do to help keep you safe:

- Talk to your care provider if your Opiate Agonist Therapy (e.g., methadone) isn't managing your withdrawal or cravings
- Be aware that your tolerance might be lower (e.g., if you have been using less when in hospital and/or due to feeling unwell)
- **Don't use alone:**
  - Use with a friend or ask someone to check on you
  - Use somewhere where people can see you
- **Start low and go slow:** Use a little first (test dose), then the rest
- Check your drugs at an Overdose Prevention Site (OPS) or with take home test strips from an OPS
- **Have a phone?**
  - Use while on the phone with a friend so they can send help if you become unresponsive
  - If you have a smartphone download the Lifeguard app to alert 911 if you become unresponsive
- Get sterile injection and smoking supplies from the Overdose Prevention Site (OPS)

Adapted from a VCH community handout - March 2023

DB.500.MS28.PHC (Aug-23) Page 1 of 1 Patient Approved providencehealthcare.org

First Released Date:	17-NOV-2023	
Posted Date:	17-NOV-2023	
Last Revised:	17-NOV-2023	
Last Reviewed:	17-NOV-2023	
Review Due by:	17-NOV-2026	
Approved By: *(committee or position)*	PHC	VCH
	PHC Professional Practice Standards Committee	VCH: (Regional DST Endorsement - 2nd Reading) Health Authority & Area Specific Interprofessional Advisory Council Chairs (HA/AIAC) Operations Directors Professional Practice Directors Final Sign Off: Vice President, Professional Practice & Chief Clinical Information Officer, VCH
Owners: *(optional)*	PHC	VCH
		Clinical Nurse Specialist, Vancouver Community MHSU Operations Manager, Vancouver Community MHSU