Mental Health & Substance Use Follow-Up after Acute Care Discharge

Site Applicability

VCH: All Mental Health and Substance Use (MHSU) programs (Acute, Tertiary, and Community), including Acute & ED clients admitted under Psychiatry

Acute and Emergency Department clients with a primary MHSU concern (48 Hour Follow-up Only)

PHC: Acute Mental Health Units (SPH PASU, 2N, 8C, 9A, 4NW and MSJ-1S), including ED clients admitted under Psychiatry

Tertiary Mental Health Units (Alder and Parkview)

Emergency Department clients (SPH, MSJ) with a primary MHSU concern (48 Hour Follow-up Only)

Practice Level

All Aspects of MHSU Follow-Up after Acute Care Discharge:

- Basic skill: RN, RPN, NP, MD, SW, OT, Clinical Counsellor and Psychologist, within the competencies of their scope of practice and/or job duties
- Advanced competency for LPN:
  - require an orientation consistent with LPN entry level competencies
  - work in a team nursing approach when providing care for these clients after successfully completing additional education

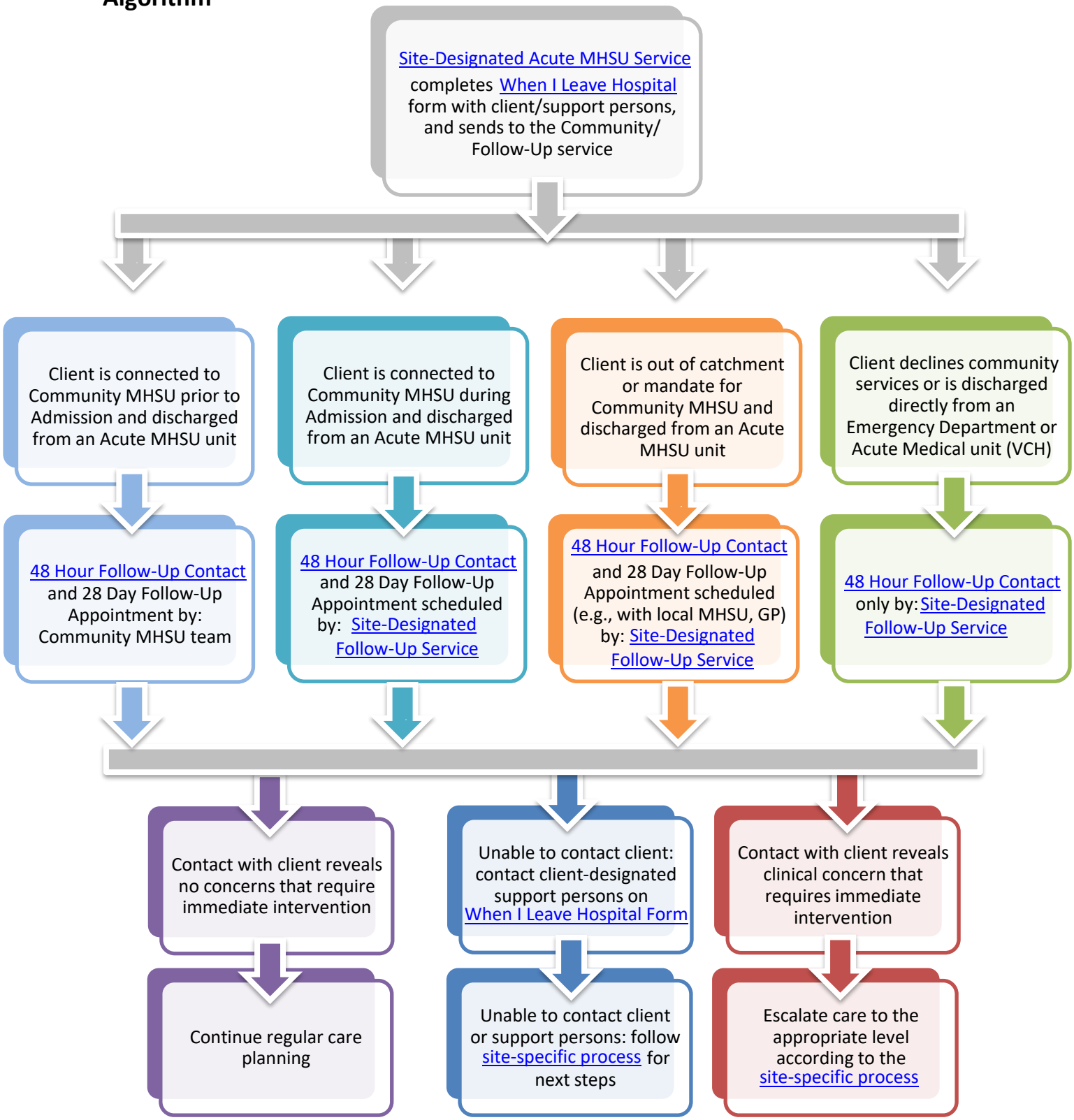
Screening and/or Coordinating Follow-Up Appointment Only:

- Basic skill for unregulated health care providers as outlined in their roles and responsibilities and job descriptions, and/or within their employer training and job descriptions and under direction of appropriate regulated/unregulated health care professional

Requirements

- All clients discharged with a primary mental health and/or substance use (MHSU) concern from an emergency department (ED), acute medical unit (VCH only), or acute/tertiary psychiatric unit will receive follow-up contact within 48 hours of discharge (see Algorithm below).
- All clients discharged from an acute or tertiary psychiatric unit (including clients admitted under Psychiatry but on other Acute/ED units due to overflow) will have a follow-up appointment in the community within 28 days of discharge, scheduled before discharge (see Algorithm below).
- Each site or Community of Care (CoC) must have site-specific workflows in place to identify the specific staff and processes to fulfill these requirements at all sites.
- This document applies to sites serving adult clients (ages 19 and over).

Algorithm



Need to Know

Many studies have found that the risk for suicide is exceptionally high after psychiatric hospitalization (Chung et al., 2019). The suicide rate of psychiatric clients during the first 3 months after discharge is 100 times the global rate (Haglund et al., 2019). In addition, recent discharge is associated with a higher risk of suicide death than any other risk factor (Chung et al., 2019). Rate of suicide attempts has been found to be highest immediately after discharge and gradually decline over time (Forte et al., 2019). Across VCH/PHC sites, a 2019/20 data analysis revealed that 43% of MHSU readmissions take place within 0-7 days of discharge and rates of suicide attempt are highest during the first 48-72 hours post discharge.

Risk of death due to toxic drug exposure is also significantly elevated after hospitalization. One in 20 clients discharged from ED after a non-fatal toxic drug exposure were found to be dead within a year – two-thirds by subsequent toxic drug exposure and many within the first 2 days after discharge (Weiner et al., 2020). Fatal toxic opioid exposures are 4 times more likely within the 48 hours after discharge than at other times before or after this time period (Lewer et al., 2021). The 2022 Review of Illicit Drug Toxicity Deaths by the BC Coroners Service found that the majority of those who died had accessed the health care system recently, many for mental health and/or substance use concerns, while few had accessed non-pharmaceutical treatment.

This highlights the importance of follow-up and treatment after discharge from hospital for MHSU concerns (Haglund et al., 2019). When assessing for risk before discharge, it can be difficult to consider all of the variables that will occur after discharge; thus, follow-up contact is an important opportunity to reevaluate suicide risk (Madsen et al., 2021). Planning, monitoring, and implementation of follow-up care should begin prior to discharge, and monitoring and supporting the client should be carried on immediately after discharge (Forte et al., 2019). For overdose risk, harm reduction education and connection to treatments such as Opioid Agonist Therapy (OAT) promotes safer outcomes after discharge (BC Coroners Service, 2022).

Guideline

Overview

For clients who are discharged from an acute hospital unit for a primary MHSU concern, it is crucial to follow up with community services to maintain the benefits gained from treatment in hospital and continue to build on them. The two requirements for follow-up after discharge are:

A. **Follow-up contact within 48 hours of discharge**, which requires:
   - Reviewing client status
   - Screening for suicide risk, including reviewing/updating Safety Plans and enacting site-specific escalation plan if needed
   - Identifying other issues that arose during the transition from hospital to community, and intervening to support continuity of care

B. **Follow-up appointment with community services within 28 days of discharge** for discharges from Acute MHSU units only, which requires:
   - Arranging an appointment with the client's community (or primary care) provider(s) prior to discharge (including community-based OAT prescriber if applicable)
   - Providing information about local resources for clients who decline a follow-up appointment

General Workflow

A. At Discharge – by designated staff from the site-designated Acute MHSU service:

- Complete the When I Leave Hospital form with the client. Where possible, include the client's family/support person(s) (see Family Involvement/Presence Policy for VCH or PHC). Review the form and follow-up process, including the date and time of the scheduled follow-up appointment with Community MHSU, community contact names/numbers, contact numbers for support persons, and consent to contact support persons if the client cannot be reached.
- Review the Harm Reduction postcard (Appendix D) with the client if applicable. Provide a copy of the postcard, along with a Take Home Naloxone kit, safer use supplies, and/or other resources (see Harm Reduction guideline for VCH or PHC).
- Notify the client's Community MHSU team of the upcoming discharge, obtain a follow-up appointment date within 28 days of discharge, and send a copy of the When I Leave Hospital form. For clients who do not currently have an active referral with a Community MHSU team, notify the CoC/site-designated follow-up service.
- With the client's consent, connect them to local resources that support their transition process and recovery journey, such as peer support workers and caregiver supports.

B. At Follow-up – by designated staff from the Community team (for clients who are already connected) **or CoC/site-designated follow-up service** (for clients who are not connected):

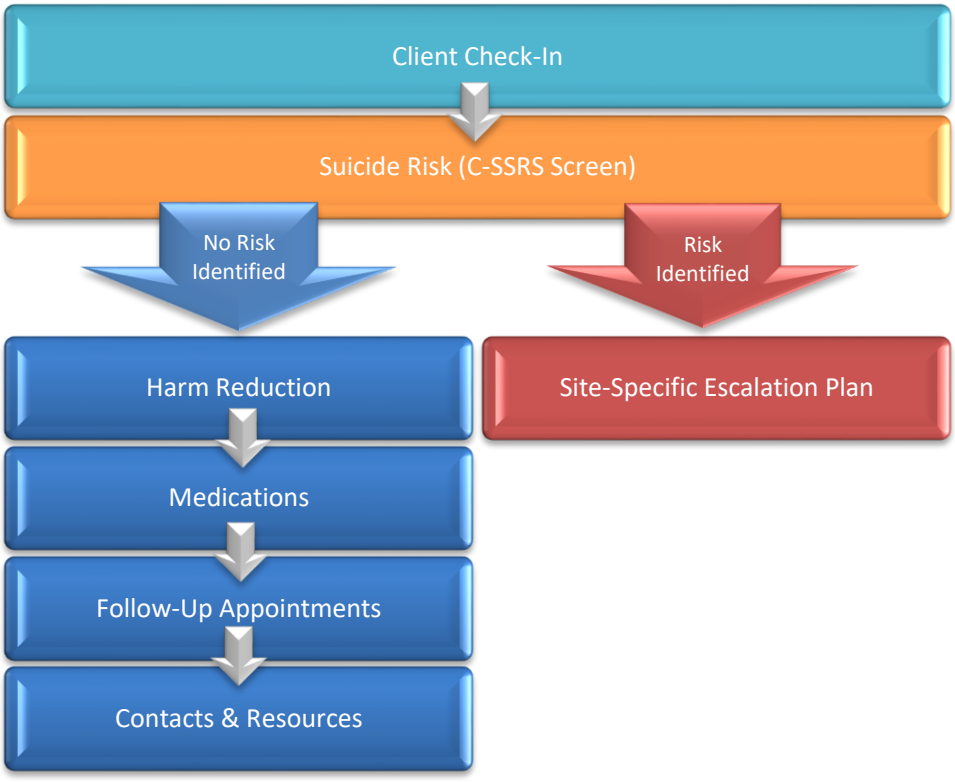
- Contact the client within 48 hours of discharge to assess client status, inquire about prescriptions, and confirm follow-up appointment date(s), see 48 Hour Follow-up Contact below for details.
- Should a follow-up contact determine that the client needs further support or immediate assistance (e.g., identified risk on the Columbia-Suicide Severity Rating Screen (C-SSRS)), follow the site-specific escalation plan.
- If unable to contact the client, contact the support person(s) (with the client's consent as indicated on the When I Leave Hospital Form).
- Follow the site-specific plan if unable to contact the client and support person(s) and/or if the client is out of mandate for Community MHSU.

48 Hour Follow-up Contact

Follow-up contact can be virtual, in person, by phone, or by text message. See also Appendix B for sample scripts. Key points to discuss with the client/support person during follow-up contact within 48 hours after discharge (and using the client's When I Leave Hospital Form for reference) are:

- Client check-in
- Suicide risk (see Appendix B for sample scripts with integrated C-SSRS Screen):
    - If risk is identified, follow the CoC/site-specific escalation plan
    - If no risk is identified, continue with the key points of follow-up contact
- Review of harm reduction education (if applicable as indicated on the When I Leave Hospital Form)
- Medications
- Follow-up appointment(s)
- Contact numbers & resources

Figure 1. Key Points of the Follow-Up Contact



Site-Specific Practices

Each CoC/site will create site-specific workflows for their local programs, and develop implementation strategies that take into consideration:

- Which MHSU service(s) will contact clients within 48 hours, and how they will be notified when a client will be discharged from hospital
- The follow-up contact process for clients who are out of mandate for Community MHSU programs
- Next steps if contact attempts to client and support person(s) are not successful and they cannot be reached within 48 hours
- Escalation plan if the follow-up contact identifies that a client is in need of immediate assistance
- A rubric for matching the level of risk determined during the follow-up contact to appropriate local services (e.g., home visit; re-check within another 48 hours; assess for recertification/ readmission)
- Maintenance of an up-to-date list of appropriate local services for follow up and referral pathways
- Reduction of barriers to provide 48 hour and 28 day follow-up to clients who choose client-initiated discharge, do not have a phone, do not have stable housing and cannot be contacted by phone, or are out of catchment/mandate and do not have a family doctor or other local services.

Documentation

See Documentation Policy. For teams using PARIS, see also MHSU PARIS Data Entry.

A. **At Discharge – by designated staff from the site-designated Acute MHSU service:**

- Complete the When I Leave Hospital form. This includes: client contact preferences for 48 hour follow-up, consent to contact support person(s) if the client cannot be reached, 28 day follow-up appointment day(s) and time(s), medication follow-up, harm reduction review applicability, and safety plan.
- Send a copy of the When I Leave Hospital form (with attached safety plan if applicable) to the follow-up teams as per site-specific workflow. File the white original copy in the client chart and provide the yellow copy to the client, golden copy to the family/support person(s), and pink copy to the Clinical Nurse Leader or designate (for auditing purposes).

B. **At 48 Hour Follow-up – by designated staff from the Community team** (for clients who are already connected) **or CoC/site-designated follow-up service** (for clients who are not connected):

- Complete a C-SSRS Screen (C-SSRS Quick Screen or Full Screen for Cerner sites, and C-SSRS Screen Version for non-Cerner sites) as part of the follow-up contact (see Sample Script).
- Document in a narrative note in the client's electronic chart as per site-specific process (e.g., Cerner, PARIS, EMR). Include: all follow-up attempts and successful contacts, what day/time they were made, who was contacted (i.e., the client or support person), if the suicide screen (C-SSRS) indicated risk, client responses to the key points of the follow-up contact, if care was escalated (and if so, to who/where), if any other resources were provided to the client/support person, etc.

C. **At 28 Day Follow-up – by Community team** (as indicated on the When I Leave Hospital form):

- Document client contact in the client's electronic chart (e.g., Cerner, PARIS, EMR) as per the site-specific process. (For PARIS sites, document according to the regional guidelines.)

Client and Family Education

While completing the When I Leave Hospital form, staff will inform clients and families/support persons (where possible and with the client's consent) of the purpose of MHSU follow-up. Follow-up after an acute MHSU visit can be important for several reasons:

- To reduce risk of suicide: Follow-up contact within 48 hours of discharge provides the opportunity to screen for risk during a time of significantly elevated risk, and to implement safety interventions if needed.
- To reduce risk of toxic drug exposure: It is important for clients to continue with any medications that were prescribed for their substance use during their hospital stay. For example, Opioid Agonist Treatment (OAT) is an evidence-based treatment for opioid use disorder and significantly reduces the risk of toxic drug exposure. For more Harm Reduction strategies to discuss with clients and families (including naloxone kits and Overdose Prevention Sites), see Appendix D.
- To assess treatment progress: Following an acute MHSU visit, it is important to monitor the client's response to treatment. Regular follow-up appointments can help the care provider evaluate the effectiveness of the treatment plan and make adjustments if necessary. This can help ensure that the client receives the best possible care and achieves the best possible outcomes.

- To identify any new symptoms or concerns: During the recovery process, clients may experience new symptoms or concerns. Follow-up appointments allow the care provider to identify these issues early on and address them before they become more serious.
- To prevent relapse: MHSU conditions can be chronic and require ongoing management. Regular follow-up appointments can help prevent relapse by ensuring that the client's symptoms are well-managed and any new concerns are addressed promptly.
- To provide support and education: Follow-up appointments provide an opportunity for the care provider to offer support and education to the client and their family, as appropriate. This can include guidance on coping strategies, self-care techniques, and how to access additional resources and support.
- To connect to other resource supporting wraparound care for the client and promote health and wellness based on their individual needs. For example:
  - Family doctor/primary care
  - Indigenous Patient Navigators: Client & family support, access to Elders, traditional ceremonies, and healing practices, and consultation for staff (see Indigenous Health).
  - Peer support worker (if available): To provide first hand knowledge and navigational support during the transition process from hospital to community care.
  - Dietitian: Nutrition improves physical and mental health, reduces risk of relapse, and supports long-term recovery.

Related Documents

- Columbia-Suicide Severity Rating Scale (C-SRSS) Screen Version
- Community Dietitian Services (VCH & SPH)
- Community Mental Health & Substance Use PARIS Data Entry Documentation
- Consent to Health Care Policy (VCH or PHC)
- Cultural Competency and Responsiveness
- Documentation Policy
- Family Involvement Policy (VCH) or Family Presence Policy (PHC)
- Harm Reduction (PHC Guideline or VCH Policy/Acute DST/Community DST)
- Indigenous Cultural Safety Policy (VCH or PHC)
- Suicide Risk Assessment & Management: Acute and Tertiary Mental Health (development in progress)
- Suicide Risk Assessment & Management: Long-term Care and Community Mental Health & Substance Use (development in progress)
- Trauma Informed Practice

Staff Training (Optional)

- Columbia (C-SSRS): https://learninghub.phsa.ca/Courses/20313/columbia-c-ssrs-e-learn
- Safety Planning intervention for Suicide prevention: https://practiceinnovations.org/resources/scorm/safety-planning

- Suicide Risk Assessment: https://learninghub.phsa.ca/Courses/6700/suicide-assessment-and-management-sam

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Appendices

Appendix A: When I Leave Hospital Form and My Safety Plan

Appendix B: Follow-Up Contact – Sample Scripts

Appendix C: Columbia-Suicide Severity Rating Scale (C-SRSS) Screen Version

Appendix D: Harm Reduction Strategies

Appendix A: When I Leave Hospital Form

Available soon via Cerner (FormFast) and VCH Forms.

Providence Health Care | Vancouver CoastalHealth

WHEN I LEAVE HOSPITAL
MENTAL HEALTH & SUBSTANCE USE

Discharge Date: _____

My family/support person(s) are: ☐ aware of my discharge (where possible and with my consent) ☐ not aware of my discharge

MY FOLLOW-UP CALL

I will receive a check-in call within 48 hours of leaving the hospital. **If I cannot be contacted, my support person(s) and/or emergency services may be contacted to make sure I am safe.**

☐ I prefer to be contacted at this phone number(s): _____

☐ I decline follow-up contact and/or I am not able to receive follow-up contact because: _____

If I cannot be reached, it is ok for staff to contact my support person: ☐ Yes ☐ No	Name:	Relationship:	Phone #(s):
If I cannot be reached, it is ok for staff to contact my support person: ☐ Yes ☐ No	Name:	Relationship:	Phone #(s):

MY NEXT APPOINTMENT(S)

Name & Service	Date	Time	Address & Phone Number

If a follow-up appointment has not been scheduled, specify why not: *(does not apply to certified patients on extended leave)*

☐ I do not wish to have a follow-up appointment because: _____
☐ I am receiving/seeking other services from: _____
☐ I live out of town/country and will schedule my own follow-up appointment when I return home *(for clients outside VCH/PHC)*
☐ I'm being transferred or discharged to an acute or tertiary hospital, or sub-acute site at: _____
☐ I've chosen to leave against medical advice, I'm absent without leave, or I did not return from pass

MEDICATIONS ☐ N/A ☐ 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 _____

HARM REDUCTION SUPPORT PROVIDED

☐ Education	☐ Handout	Take Home Naloxone Kit: ☐ Yes ☐ No (specify reason): _____

MY SAFETY PLAN ☐ Attached ☐ N/A

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

Name:	Phone #(s):	Name:	Phone #(s):

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

BC Crisis Centre: 1-800-SUICIDE (24h) or Crisis Centre Chat (12pm-1am)	**Talk Suicide Canada:** 1-833-456-4566 (24h) or text 45645 (4pm-12am)	**Kuu-Us Indigenous Crisis Line:** 1-800-588-8717	

Reviewed by: _____ Patient Name _____ Support Person (where possible with consent) _____ Staff Name

EPS207

Distribution: **WHITE ORIGINAL** – Copy to Follow-Up Service then Patient Chart (in front of Nursing Notes) **YELLOW** - Patient Copy **PINK** - CNL or Designate **GOLDEN** - Family

Safety Plan

For VCH: Available soon via VCH Forms, Cerner (FormFast), PARIS, and Profile EMR.

MY SAFETY PLAN

Date of Safety Plan/Update: _____

My family/support person(s) are: ☐ aware of my Safety Plan (where possible & with my consent) ☐ not aware of my Safety Plan

Step 1 Warning Signs that a crisis may be developing *(e.g., thoughts, images, mood, situation, behaviour)*
1. 2. 3.
Step 2 Coping Strategies I can do myself to take my mind off my problems *(e.g., relaxation technique, physical activity)*
1. 2. 3.
Step 3 People and Social Settings that provide distraction
1. 2. 3.
Step 4 People I Can Ask for Help
1. Name: Contact: 2. Name: Contact: 3. Name: Contact:
Step 5 Professionals or Services I Can Contact
Step 6 Make My Space Safer *(e.g., remove unsafe items)* **or Go to a Safer Place**
1. 2. 3.
Step 7 Call or Chat with Crisis Lines
Step 8 Receive Emergency Services

Reviewed by: _____ Patient Name _____ Support Person (where possible with consent) _____ Staff Name

For PHC: Available via FormFast (Form 10236-PS293).

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

Page 1 of 1

Appendix B: Follow-Up Contact – Sample Scripts

Sample Script A: Nurses

The following script is recommended for 48 hour follow up. Nurses may choose to use their own approach in favour of this script, as long as the key points are included (see 48 Hour Follow-Up Contact).

1. **Introduction & assessment of well-being**

   "Hello [client name], this is [your name] from [clinic/hospital name]. I am calling to check in with how you are doing. Have you had any issues or concerns arise since leaving the hospital? Do you still have a copy of your 'When I Leave Hospital' Form?"

   - If NO, "Would you like a copy mailed to [address on file]?", then continue with the script.

2. **Screen for suicide risk (with C-SSRS Screen)**

   "Next we have a few questions that we ask all of our clients to make sure everyone is safe. Is this ok with you? [Wait for client to respond before proceeding.] Have you wished you were dead or wished you could go to sleep and not wake up? Have you actually had any thoughts of killing yourself?"

   - If YES, continue with the rest of the C-SSRS Screen (Appendix C) and connect to local services according to site-specific escalation plan. Review and update client's Safety Plan as needed.
   - If NO, "Have you ever done anything, started to do anything, or prepared to do anything to end your life?"
     - If YES, connect to local services according to the site-specific escalation plan. Review and update client's Safety Plan as needed.
     - If NO, continue with the script below.

3. **Harm reduction** (if applicable – see "Harm Reduction" section of When I Leave Hospital form)

   "Do you still have a copy of the Harm Reduction handout with tips on staying safe? You were not using while you were in hospital so your tolerance may have gone down. If you plan on continuing to use, you need to be very careful and start with a very low amount to decrease your risk of overdose. Try to use with a buddy or at an OPS."

4. **Confirm prescriptions**

   "Were you able to get your prescriptions filled at the pharmacy? Have you been taking the medications? Have you experienced any symptoms or issues that you would like to discuss?"

5. **Confirm contact numbers**

   "As also noted on your 'When I Leave Hospital' Form, your main contact person for community services is [name] and their contact number is [number]. If none of the numbers for support or crisis on the form are available and you need help, you can go to your nearest ED."

6. **Provide additional resources**

   "Are there other resources or support services that you think would be helpful to you at this time? We want to make sure you have all the resources you need to continue on your path to recovery."

7. **Encourage follow-up appointments**

   "Following your stay in hospital, it's important to continue with your treatment plan to ensure you maintain your progress. Would you please confirm the day & time of the follow-up appointment on your 'When I Leave Hospital' Form?"

8. **Conclusion**

   "I appreciate learning about how you have been doing since you went home. If there is anything we can do to help you through your recovery journey, or if you have questions or concerns in the future, please don't hesitate to reach out to the contacts on your When I Leave Hospital form. Take care."

Sample Script B: Allied Health Clinicians

The following script is recommended for 48 hour follow up. Clinicians may choose to use their own approach in favour of this script, as long as the key points are included (see 48 Hour Follow-Up Contact).

1. **Introduction & assessment of well-being**
   "Hello [client name], this is [your name] from [clinic/hospital name]. I am calling to check in with how you are doing. Have you had any issues or concerns arise since leaving the hospital? Do you still have a copy of your 'When I Leave Hospital' Form?"
   - If NO, "Would you like a copy mailed to [address on file]?", then continue with the script.
2. **Screen for suicide risk (with C-SSRS Screen)**
   "Next we have a few questions that we ask all of our clients to make sure everyone is safe. Is this ok with you? [Wait for client to respond before proceeding.] Have you wished you were dead or wished you could go to sleep and not wake up? Have you actually had any thoughts of killing yourself?"
   - If YES, continue the rest of the C-SSRS Screen (Appendix C) and connect to local services according to site-specific escalation plan. Review and update client's Safety Plan as needed.
   - If NO, "Have you ever done anything, started to do anything, or prepared to do anything to end your life?"
     - If YES, connect to local services according to the site-specific escalation plan. Review and update client's Safety Plan as needed.
     - If NO, continue with the script below.
3. **Harm reduction** (if applicable – see "Harm Reduction" section of When I Leave Hospital form)
   "Do you still have a copy of the Harm Reduction handout with tips on staying safe? You were not using while you were in hospital so your tolerance may have gone down. If you plan on continuing to use, you need to be very careful and start with a very low amount to decrease your risk of overdose. Try to use with a buddy or at an OPS."
4. **Confirm prescriptions**
   "Were you able to get your prescriptions filled at the pharmacy? Are you having any issues with your medications?"
   - If YES, add "I will have our nurse/physician follow up with you shortly", then continue script.
5. **Confirm contact numbers**
   "As also noted on your 'When I Leave Hospital' Form, your main contact person for community services is [name] and their contact number is [number]. If none of the numbers for support or crisis on the form are available and you need help, you can go to your nearest ED."
6. **Provide additional resources**
   "Are there other resources or support services that you think would be helpful to you at this time? We want to make sure you have all the resources you need to continue on your path to recovery."
7. **Encourage follow-up appointments**
   "Following your stay in hospital, it's important to continue with your treatment plan to ensure you maintain your progress. Would you please confirm the day & time of the follow-up appointment on your 'When I Leave Hospital' Form?"
8. **Conclusion**

   "I appreciate learning about how you have been doing since you went home. If there is anything we can do to help you through your recovery journey, or if you have questions or concerns in the future, please don't hesitate to reach out to the contacts on your When I Leave Hospital form. Take care."

Appendix C: Columbia-Suicide Severity Rating Scale (C-SSRS) Screen Version

For non-Cerner sites: Available via VCH Forms. (Also coming soon to PARIS and Profile EMR.)

Vancouver CoastalHealth

PATIENT LABEL

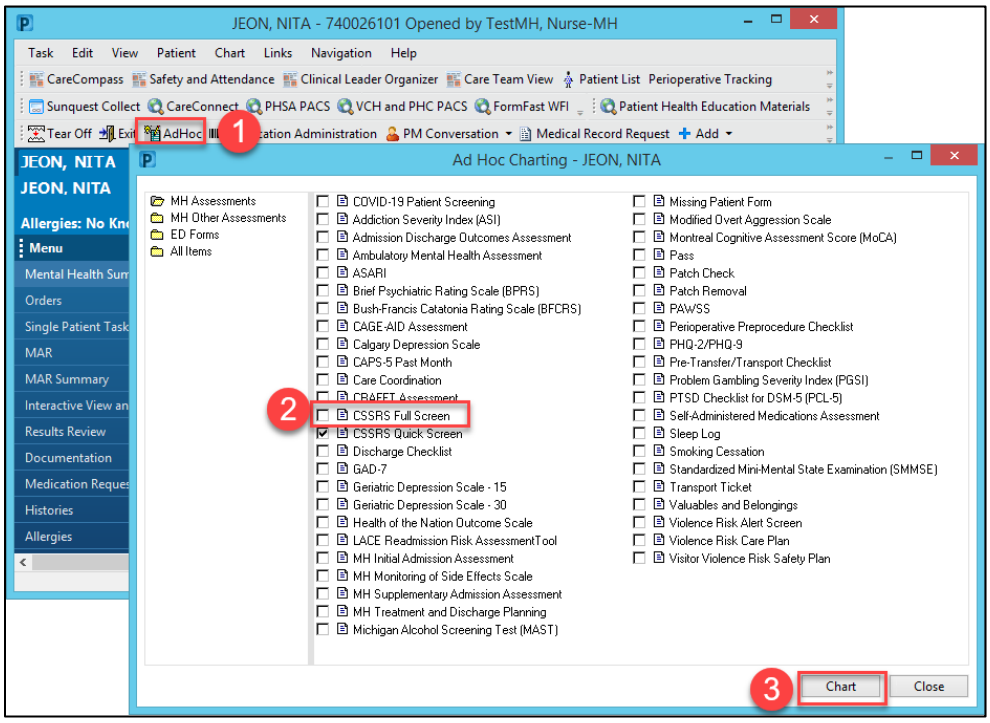
COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		

6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** *Was this within the past three months?*	**YES**	**NO**

For Cerner sites: CSSRS (Quick Screen OR Full Screen) is available via the AdHoc Folder.



CSSRS Powerform via Adhoc Folder

Appendix D: Harm Reduction Strategies

For VCH: Available via VCH Forms.

For PHC: Available via PHC PHEM.

Providence Health Care
How you want to be treated.

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

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Patient Approved
This material has been reviewed and approved by patients, families and staff

providencehealthcare.org

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	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
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