**CONSIDERATIONS:**

1. Home health patients have a higher risk for suicide than the general population. The purpose of this procedure is to help clinicians assess, identify and intervene appropriately when suicide risk is present.
2. Several OASIS questions may indicate that suicide risk should be assessed:
   a. M1036: Risk Factors: Alcohol and drug abuse/dependency
   b. M1730: Depression Screening PHQ2 score of 3 or greater
   c. M1740: Cognitive, Behavioral and Psychiatric Symptoms: presence of abnormal thinking or acting can indicate suicide risk, e.g. hallucinations commanding self-harm
   d. M1745: Frequency of Disruptive Behavior Symptoms: presence of any physical, verbal or other disruptive/dangerous symptoms that are injurious to self or others can indicate poor impulse control
3. If the PHQ-2 (M1730) is positive, administering the PHQ-9 is recommended in the literature:
   a. Question 9 asks: "Over the past two weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way"
   b. A positive answer such as 1, 2, or 3 indicates suicide risk
   c. A positive answer indicates a need for follow-up questions about suicidal thoughts
4. A mnemonic used to identify risk factors for suicide is: SAD PERSONS:
   a. SAD PERSONS risk factors:
      i. Sex: Women are more likely to attempt suicide; men are more likely to be successful
      ii. Age: Men over 45, women over 55 are at risk, and teenagers
      iii. Depression: Especially feelings of hopelessness and worthlessness (M1730)
      iv. Previous suicide attempt
      v. Ethanol (alcohol) or drug use. Consider responses to OASIS M1036 - Risk factors
      vi. Rational thinking loss. Consider responses to M1735 and M1740 about psychiatric symptoms and disruptive behaviors
      vii. Social supports lacking. Lack of involvement with others
      viii. Organized plan, especially with lethal means available (gun, pills)
      ix. No spouse. Living alone increases risk (M1100)
      x. Sickness, with chronic debilitating illnesses (M1020/1022)
   b. Many of these risk factors are included in the OASIS
   c. The more risk factors, the higher the suicide risks
5. If patients are at risk for suicide, the clinician must decide the severity of the risk and the interventions required. A tool for determining interventions is the Weill Cornell Suicide Risk Spectrum (See *Addendum D: Weill Cornell Suicide Risk Spectrum).*
6. Home health patients have a range of thoughts about death:
   a. Thoughts range from normal thoughts of death and dying to suicidal thoughts
   b. Many patients will not reveal depressive or suicidal thoughts during the initial assessment. Reassessment is always appropriate

**EQUIPMENT:**

PHQ-9 (see *Addendum B: PHQ-9*)
SAD PERSONS (Addendum D: SAD PERSONS Scale)
Weill Cornell Suicide Risk Spectrum (See *Addendum E:)*

**PROCEDURE:**

1. Establish a therapeutic relationship with patient.
2. Ask patient questions about feelings in a conversational and caring way.
3. Perform PHQ-2.
4. If PHQ-2 is positive or if other signs indicate depression, consider the following options:
   a. Perform PHQ-9
   b. Perform SAD PERSONS risk assessment
   c. Ask patient questions about level of hopelessness and thoughts of death
5. PHQ-9:
   a. Include the answers from the PHQ-2 on the PHQ-9. (The PHQ-2 are the first two PHQ-9 questions)
   b. Either:
      i. Give patient a copy of the PHQ-9 to complete
      ii. Ask patient the questions from the PHQ-9, completing form
   c. Score the PHQ-9, using directions on *Addendum B: PHQ-9*
   d. If response to question 1 is 1, 2, or 3, indicating suicidal risk, ask about thoughts about dying
6. SAD PERSONS Assessment: (See Addendum D):
   a. Complete SAD PERSONS assessment, obtaining most answers from comprehensive OASIS assessment
   b. Score patient's risk, by assigning one point for each risk factor
   c. Compare patient's score to the SAD PERSONS intervention recommendations
   d. Ask patient about thoughts and feelings about dying
7. Questions about Suicidal Thoughts:
   a. Ask patient: Are you feeling hopeless about your life

b. If the patient answers "yes", ask: Have you ever felt that life isn't worth living
c. If the patient answers "yes", ask the following questions as appropriate to patient's responses:
    i. What kinds of thoughts go through your head?
    ii. Have you had thoughts about ending your life?
    iii. How often do these thoughts bother you?
    iv. Do you have a specific plan to end your life? If yes, ask:
        1. What is the plan?
        2. Do you have the specific items you need to complete the plan?
    v. Have you ever acted on any plans to end your life in the past:
        1. When? How often? What did you do?
        2. What was the outcome?

8. Compare data gathered through assessment and interview to the Weill Cornell Suicide Risk Spectrum, see *Addendum E: Weill Cornell Suicide Risk Spectrum.*
9. Consult *Suicide Risk Management* procedure.

**AFTER CARE:**

1. Document in the patient's medical record:
    a. Scores on depression and suicide risk scales
    b. Any instructions given to patient/caregiver
    c. Any interventions to promote patient safety
    d. Communication with primary provider about patient's status
2. Teach patient/caregiver:
    a. Signs and symptoms of worsening depression and increased suicidal risk
    b. To call home health agency or physician if thoughts/feelings worsen
3. Communicate with primary provider:
    a. Determine if need to consult about suicide risk is emergent, urgent or routine
    b. Report scores on depression and suicide risk scales
    c. Recommendations from Weill Cornell Suicide Risk Spectrum
    d. Referrals for:
        i. MSW or Psych mental health nurse
        ii. Community based mental health services

**REFERENCE:**

American Psychiatric Association (2004) Quick Reference to the American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders, *Compendium 2004.* Arlington: Author.

Bruce, M., Sheeran, T., Raue, P., Reilly, C., Greenberg, R., Pomerantz, J., Meyers, B., Weinberger, M., & Johnston, C. (2011). Depression Care for Patients at Home (Depression CAREPATH): Intervention Development and Implementation, Part 1. *Home Healthcare Nurse*, 85(3), 416–426.

Patterson, W., Dohn, H., Bird, J., & Patterson. (1983). Evaluation of Suicidal Patients: The SAD PERSONS Scale. *Psychomatics*, 24(4), 343-349.

Veterans Administration/Department of Defense (n.d.) Essentials for Depression Screening and Assessment in Primary Care. Retrieved on June 12, 2012 from http://www.healthquality.va.gov/mdd/MDDTool1VADoDEssentialsQuadFoldFinalHiRes.pdf

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