

This document is designed to be a tool to facilitate completion of instruments pertinent to the suicide risk screening initiative. It contains the required screening questions and scoring criteria to help you determine next required steps for purposes of this initiative.

Below are the items for the PHQ-2+i9 (depression and primary suicide risk screen) and the PC-PTSD-5+i9 (PTSD and primary suicide risk screen). Please use this tool to help with administration of either or both instruments, depending on which are required for the patient you are seeing. If being administered outside of the context of clinical reminder requirements (e.g., for a pain clinic intake), please use the PHQ-2+i9 to conduct the primary screen for suicide risk. Expectation of clinical reminders completion pertains to many outpatient clinics and is a distinct responsibility from each setting's specific requirements of the suicide risk screening initiative, despite the reminders having been made consistent with this initiative.

PHQ-2+i9

Items to administer:

Over the past two weeks, how often have you been bothered by:

1. Little interest or pleasure in doing things
 - Not At All (0)
 - Several Days (1)
 - More Than Half the Days (2)
 - Nearly Every Day (3)

2. Feeling down, depressed or hopeless
 - Not At All (0)
 - Several Days (1)
 - More Than Half the Days (2)
 - Nearly Every Day (3)

3. Thoughts that you would be better off dead or of hurting yourself in some way?
 - Not At All (0)
 - Several Days (1)
 - More Than Half the Days (2)
 - Nearly Every Day (3)

PC-PTSD-5+i9

Items to administer:

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- A serious accident or fire*
- A physical or sexual assault or abuse*
- An earthquake or flood*
- A war*
- Seeing someone be killed or seriously injured*
- Having a loved one die through homicide or suicide*

Have you ever experienced this kind of event?

- Yes *If yes, continue to item 1*
- No *If no, continue to item 6*

In the past month, have you...

1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?
 - Yes (1)
 - No (0)

2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
 - Yes (1)
 - No (0)

Scoring:

PHQ-2 (depression screen) score is obtained by adding response values for item 1 and item 2. A score of 3 or greater represents a positive depression screen.

The primary suicide risk screen (item 3 above) is positive if score is greater than 0 on item 3.

3. Been constantly on guard, watchful, or easily startled?

- Yes (1)
- No (0)

4. Felt numb or detached from people, activities, or your surroundings?

- Yes (1)
- No (0)

5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

- Yes (1)
- No (0)

6. Over the past two weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?

- Not At All (0)
- Several Days (1)
- More Than Half the Days (2)
- Nearly Every Day (3)

Scoring:

PC-PTSD-5 (PTSD screen) score is obtained by adding response values for items 1-5. A score of 3 or greater represents a positive PTSD score.

The primary suicide risk screen (item 6 above) is positive if score is greater than 0 on item 6.



Disposition:

For Clinical Reminder Administration: If the depression, PTSD and/or primary suicide risk screen was/were positive, the follow-up reminder (see screen shot below) will need to be completed same day by a Licensed Independent Provider. One of the disposition options below will have to be chosen; please follow-up with the patient accordingly. Additionally, if the primary suicide risk screen was positive, the secondary screen (C-SSRS Screener) must be administered (see items below).

Reminder Resolution: Follow-Up Pos PTSD/Depression/SI

Positive Depression/PTSD follow-up version 5.0

Patient has positive Depression and/or PTSD screen(s) which require a follow-up on the same day as the positive screen

Click here to review prior Depression and PTSD screen results

Patient revealed suicidal ideation over the last 2 weeks, which indicates a POSITIVE primary screen for Risk of Suicide, this requires a secondary suicide risk screen using the Columbia Suicide Severity Rating Scale (C-SSRS) screener on the same day as the positive primary screen.

Columbia Suicide Severity Rating Scale (C-SSRS) screener

----- MENTAL HEALTH SCREEN DISPOSITIONS -----

I have reviewed the results of the Mental Health screens and have evaluated the patient. Based on the evaluation, the following disposition plan will be implemented. Select as many options from the list below as needed

No further intervention is needed at this time. Contact information and instructions for accessing emergency services provided.

Already receiving needed treatment. Contact information and instructions for accessing emergency services provided.

Patient to obtain further evaluation/treatment outside this VA. Contact information and instructions for accessing emergency services provided.

Patient to be evaluated by Mental Health

Patient to be managed in Primary Care

Patient declines further intervention or evaluation at this time. Contact information and instructions for accessing emergency services provided.

Other

For Other Administration Contexts: If the depression and/or PTSD screen was positive, this positive screen needs to be followed up on. Clinical considerations include: whether the patient requires further evaluation for depression and/or PTSD, is already in care for this condition, can be treated in primary care, and/or should be referred to mental health specialty care. If the primary screen for suicide risk was positive, you are required to administer the secondary screen for suicide risk (i.e., the C-SSRS Screener; items below).

The Columbia Suicide Severity Rating Scale (C-SSRS) Screener is intended to be administered by individuals whose scope of practice such administration falls under (see Staff Specific Guidance document).

C-SSRS Secondary Screen

1. Over the past month, have you wished you were dead or wished you could go to sleep and not wake up?
 - Yes *Proceed to question #2 regardless of response.*
 - No

2. Over the past month, have you had any actual thoughts of killing yourself?
 - Yes *If 'Yes', proceed to question #3*
 - No *If 'No', proceed to question #7*

3. Over the past month, have you been thinking about how you might do this?
 - Yes
 - No *Proceed to question #4 regardless of response.*

4. Over the past month, have you had these thoughts and had some intention of acting on them?
 - Yes
 - No *Proceed to question #5 regardless of response.*

5. Over the past month, have you started to work out or worked out the details of how to kill yourself?
 - Yes *If 'Yes', proceed to question #6*
 - No *If 'No', proceed to question #7*

6. If yes to Q5, at any time in the past month did you intend to carry out this plan?
 - Yes
 - No *Proceed to question #7 regardless of response.*

7. In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life (for example, collected pills, obtained a gun, gave away valuables, went to the roof but didn't jump)?
 - Yes *If 'Yes', proceed to question #8*
 - No *If 'No', proceed to scoring*

8. If yes to Q7, was this within the past 3 months?
 - Yes
 - No *Proceed to scoring*

Secondary Screener Scoring:

A positive C-SSRS (Columbia) score is a 'Yes' response to items 3, 4, 5, or 8.



If a positive screen has been determined, administration of the VA Comprehensive Suicide Risk Evaluation template must be completed on the same day by an LIP.