Southeast Florida
BEHAVIORAL HEALTH NETWORK

Zero Suicide Checklist

Initials of Consumer Name: Click or tap here to enter text.
Medical Record Number: Click or tap here to enter text.

Program

1. PHQ-9 assessments should always be completed at encounter. This is labeled in the file as “PHQ-9”.
    - Is a PHQ-9 recorded as being completed upon intake? ☐ YES ☐ NO
    - If completed, what is the score of the PHQ-9 at intake? Click or tap here to enter text.
        - A score of 15 – 19 indicates moderate depression.
        - A score above 20 indicates severe depression.

2. Validated risk assessments, such as the Columbia Suicide Severity Rating Scale (C-SSRS), should be completed with individuals at encounter.
    - Is a risk assessment recorded as being completed upon intake? ☐ YES ☐ NO
    - If a risk assessment is completed, is it labeled as the “Columbia Suicide Severity Rating Scale” or “C-SSRS” or “Karolinska Suicide Risk Assessment”? ☐ YES ☐ NO
        - If not, what is the risk assessment labeled as? Click or tap here to enter text.
    - Upon reviewing the risk assessment are any of the following indicated (check all that apply):

      ☐ Thoughts of suicide

      ☐ A plan for suicide

      ☐ Intention to act upon a plan

      ☐ Have they started to do anything to end their lives?

      ☐ Plan does not include all of the above

        - If so, which of the above are missing?
          Click or tap here to enter text.

Referrals and Linkage to Services

Note: **A** safety plan should not be waived due to “clinical determination of not needed” or similar verbiage. Please make a note below if this is the case.

**** Additionally, individuals receiving MRT response with PHQ-9 scores of 15 or above, with risk assessments that indicate thoughts of suicide and intention to act on the plan, do not include service recommendations, linkage to coordination should be further reviewed between agencies.**

1. PHQ-9 assessments should always be completed at every encounter.
    - Is a PHQ-9 being completed at the encounter? ☐ YES ☐ NO

- If completed, what is the score of the PHQ-9 at intake? Click or tap here to enter text.
    - A score of 15 – 19 indicates moderate depression.
    - A score above 20 indicates severe depression.

2. Validated risk assessments, such as the Columbia Suicide Severity Rating Scale (C-SSRS), should be completed with individuals at discharge, regardless of the PHQ-9 scores for individuals who are being assessed
    - Is a risk assessment being completed upon assessment? ☐ YES ☐ NO
    - If a risk assessment is completed, is it labeled as the "Columbia Suicide Severity Rating Scale" or "C-SSRS" or "Karolinska Suicide Risk Assessment"? ☐ YES ☐ NO
        - If not, what is the risk assessment labeled as? Click or tap here to enter text.
    - Upon reviewing the risk assessment are any of the following indicated (check all that apply):

    ☐ Thoughts of suicide

    ☐ A plan for suicide

    ☐ Intention to act upon a plan

    ☐ Have they started to do anything to end their lives?

    ☐ Plan does not include all of the above

        - If so, which of the above are missing?
          Click or tap here to enter text.

3. Validated, complete safety plans should be done for every discharge from detox, the ASU and CCSU, **regardless** of PHQ-9 and Risk Assessment scores at discharge.
    - Is a safety plan being completed upon discharge? ☐ YES ☐ NO
    - If a safety plan is completed, is it labeled as the "Stanley Brown Safety Plan"? ☐ YES ☐ NO
        - If not, what is the risk assessment labeled as? Click or tap here to enter text.
    - Upon reviewing the safety plan are any of the following indicated (check all that apply):

    ☐ Specific activities for coping and/or de-escalation from crisis

    ☐ MRT education/contact and/or other crisis resources

    ☐ Specific people and resources to contact (with phone numbers, emails, and other point of contact)

    ☐ Plan does not include all of the above.

        - If so, which of the above are missing?
          Click or tap here to enter text.

4. Linkage to services should be in the files, and they should be comprehensive and address individual needs, as well as specifically suicidality.

- Is there linkage to Care Coordination? ☐ YES ☐ NO
- Is there a crisis plan in the file? ☐ YES ☐ NO
- Upon reviewing the assessment and safety/crisis plan are any of the following indicated (check all that apply):

  ☐ Services and supports identified

  ☐ Suicidality specifically addressed

  ☐ Concrete plans to implement services and support from staff

  ☐ Plan does not include all of the above

  - If so, which of the above are missing?

    Click or tap here to enter text.

5. Did documentation address family/All Significant Parties concerns and needs? ☐ YES ☐ NO

   Click or tap here to enter text.

Please summarize the contents of the MRT response and note services, recommendations, warm-handoffs, connections Supervisory review and consult, etc.

Click or tap here to enter text.

Additional Notes

As a result of the above review, what changes were made to the individual's discharge to ensure consumer safety?

Click or tap here to enter text.

Additional Comments / Issues

Click or tap here to enter text.

Date of Encounter for Individual Click or tap here to enter text.

Date Review Completed: Click or tap to enter a date.