BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 4	**Care and Treatment**		
Section: 3	**Assessment**		
Topic: 13	**Suicide Assessment and Intervention Practice – Prevention, Intervention, and Post-intervention**		
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Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) that the primary goal for services will always be to provide for the safety and treatment needs of individuals receiving services, both through BABHA directly operated programs and contracted providers.

Purpose

This policy and procedure is established to assure all individuals who receive services at BABHA are evaluated initially for risk of self-harm and throughout their treatment, and that a suicide assessment protocol will be followed.

The protocol will be used to identify individuals with suicide risk factors, ~~utilize alerts in the medical records,~~ provide monitoring, communicate status of suicide risk via encrypted email or through Phoenix, complete a suicide risk assessment, or lethality measurement scale, and/or Level of Care Utilization System (LOCUS), or the Child and Adolescent Level of Care Utilization System (CALOCUS), determine the need for inpatient care, and assure continuity of care for individuals with suicidal ideation.

Education Applies to

☐ All BABHA Staff
☒ Selected BABHA Staff, as follows: Clinical Management, All Clinical Staff, Ancillary Care, and Clinical Nursing Staff
☐ All Contracted Providers: ☐ Policy Only ☐ Policy and Procedure
☒ Selected Contracted Providers, as follows: Primary Care/Outpatient, Licensed Independent Practitioners
☒ Policy Only ☐ Policy and Procedure
☐ Other:

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Definitions

Active Suicidal Ideation: Current thoughts about committing suicide with or without intent. There may or may not be a plan or a method being considered by the individual.

Risk Assessment: The dimension of the clinical assessment that evaluates the individual's potential for significant ~~self-harm~~self-harm up to and including suicide. The clinical data can be part of a clinical interview (face-to-face or telephone contact) or symptom questionnaires. The assessment will include a comprehensive mental status which includes an observational and interactive evaluative process, (subjective and objective) as well as identifying any risk factors for suicide.

Procedure

All individuals will be evaluated at the time of their initial face-to-face assessment for suicidal ideation and risk for ~~self-harm~~self-harm. The individual's presenting problem, including the subjective complaints along with the clinician's assessment, will be utilized to identify or rule out suicidal risk. Direct inquiry about suicidal ideation will be included as part of the mental status questions. Any history of prior suicidal thinking or previous attempts will be documented. If there is suicidal ideation reported, the clinician will assess for risk (is there intent? does the person have a plan?). If the individual denies having a plan or intent to commit suicide, it will be documented. The Columbia Suicide Severity Rating Scale (C-SSRS) has been imbedded into the Risk Assessment portion of the clinical assessment, the pre-admission screening, and the access screening.

During the initial intake ~~appointment~~appointment, the individual will be assessed for the following risk factors and the results will be documented in the assessment:

1. A prior suicide attempt
2. History of impulsive behaviors
3. Poverty and/or economic stressors
4. Co-morbid condition of substance abuse
5. Chronic pain condition.

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In those cases where the individual reports suicidal ideation and has one or more of the risk factors (poverty\economic stressors, substance abuse, impulsive behaviors, prior suicide attempt, or chronic pain), a suicide risk scale will be completed (e.g. C-SSRS Columbia Suicide Severity Rating Scale, Beck Scale for Suicide Ideation, Beck Hopelessness Scale, or other lethality scale measurement). The completed scale will be scanned into the Electronic Medical Record (EMR).. If the results on the suicide risk measurement assessment endorse suicide indicators and are considered to be in moderate to severe range, an additional assessment to rule out the need for psychiatric hospitalization or crisis stabilization services will be conducted. In those cases where an individual has identified suicidal ideation, one of the risk factors, and a suicide lethality scale score in the moderate to high range, ~~the EMR will be flagged with the appropriate alert.~~ and the individual is not willing or able to safety plan, the individual will be referred to the Emergency and Access Services Department for a pre-admission screening to be completed as necessary. The referring clinician may need to complete a petition in the event that the individual is not willing to present for screening voluntarily.

In those cases when suicidal ideation has been reported on the initial assessment, the clinician will initiate routine assessment of suicide risk. When there is a risk of suicide, the clinician will involve the family in treatment as needed. The mental health professional will complete safety planning, i.e. ask the individual whether there are lethal means including weapons~~weapons~~ in the home; and instruct the individual and his/her family (or significant others) to either remove the ~~weapons~~ lethal means or have them locked them up. In those cases where an overdose of medication has been expressed, or the individual presents with a history of overdose attempts, ~~the individual's access to medications will be determined, along with the recommendation that access to all medications be restricted~~the recommendation to restrict the individual's access to all medications in the home will be made. Any instructions pertaining to access to weapons or medication supervision will be documented in a progress note and included in the clinical record.

Suicide risk assessment will not be limited to the initial contact or just during subsequent periods of crisis. The clinical progress note for the individual sessions will identify whether there is suicidal ideation.

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If an individual has suicidal ideation and one of the risk factors, the treating psychiatrist or prescriber will be ~~notified..~~notified via progress note, contact note, or crisis contact, etc.

At any point during treatment, the individual's mental status may change with the report of suicidal thoughts. The clinician will follow the same suicide assessment protocols used during the initial assessment. The clinician will notify the treating prescriber of such change in the individual's mental status.

During treatment, the presence of risk factors should also be measured. If an individual presents with suicidal ideation and is seen on a crisis basis, a pre-admission screening for hospitalization will be completed.

Based on the clinical presentation of an individual, it may be necessary to complete a screening for hospitalization. In those cases when the suicide scale results are in the moderate to severe range, a hospital pre-admission screening should be completed. The ~~hospital~~ pre-admission screening will include the Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization System (CALOCUS), as well as the C-SSRS. The composite score from the LOCUS or CALOCUS will give a level of care determination. However, a score of four or more on any of the following domains, Risk of Harm, Functional Status, or Co-Morbidity, would support the need for hospitalization.

Any negative pre-admission screening for hospitalization (i.e. criteria for hospitalization is not met) will be reviewed by either the site supervisor or the BABHA Medical Director (only in those cases that are not accompanied by a petition) in the event of a second opinion request. In the case where the hospital screening endorses the need for hospitalization and the individual refuses, the clinician will immediately consult with the treating psychiatrist and or a clinical supervisor. A determination will then be made as to whether or not to complete a petition for involuntary hospitalization.

In those cases where the individual informs the clinician they are no longer taking his/her medication as directed by the psychiatrist, or the individual has not re-scheduled an appointment with the psychiatrist, the clinician will notify the treating psychiatrist. The responsible case worker will also determine, when possible, what reasons the individual has for not following up with the psychiatrist.

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~~References and Applicable Standards~~

Training and Clinical Debriefing

All clinical staff (including nurses and other professionals who work directly with people enrolled in services as well as all paraprofessionals~~,~~ and peer specialists~~, and Access Center staff~~) will receive an overview of suicide risk assessment and an introduction to the Emergency and Access -Services Department during their new employee orientation (which is required within their first 30 days of employment) and online suicide prevention education within 30 days of their new employee orientation date. In addition, all identified staff will receive annual training and education pertaining to suicide and risk assessment. This will include an online update during Staff Development Days as well as annual classroom or virtual education arranged by the Staff Development Center. ~~The training will include the needs of survivors and staff debriefing.~~ When a suicide has occurred, a critical incident review will occur within 72 hours of the reporting of the suicide. The appropriate staff from the treating clinical team and the Medical Director as well as other individuals from the agency's Health Practices Committee (HPC)will be involved in the debriefing process. Documentation of the critical debriefing will be part of the HPC meeting minutes.

In addition to the critical incident debriefing, staff who are part of the treatment team (clinical or administrative) will be given the opportunity for individualized debriefing through the BABHA employee assistance program. The clinic site supervisor will be responsible for coordinating the necessary resources to provide debriefings.

Determinants for Risk Assessment

A. Risk assessment for suicidal behavior includes the identification and documentation of specific risk factors (reasons for dying) and protective factors (reasons for living) that may increase or decrease an individual's risk for suicide.

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B. Risk and protective factors are typically determined while completing an assessment, psychiatric evaluation, or a formal mental status examination. Information may include comments from the individual, ancillary treatment and medical records, referring treatment providers, and collateral sources, such as family, significant other and friends.

C. Assessments of minors must always include appropriate input from family and/or collateral sources.

D. Intent refers to how an individual sees suicide as the sole and preferred solution to ~~his/her~~their ~~-~~current situation, and typically manifests itself via a persistent disinclination/rejection of any and all viable treatment alternatives (refusal to safety plan.) The level of true intent cannot be accurately established without the completion of a comprehensive suicide assessment, which includes a thorough mental status examination.

E. Relevant ~~high risk~~high-risk factors, which should be actively explored in assessment typically include:

1. Suicidal Preoccupation: Current suicidal ideation, intent, plan, current and suicidal behaviors, aborted behaviors, suicide rehearsal or non-suicidal self-injury.

    a. Current suicidal ideation by definition includes such variables as: frequency, intensity, duration, plan, and related behaviors.

    b. Exploring suicidal ideation occurring over the past three months and during the past 48 hours is critical to the determination of risk.

    c. If a plan is identified, it is important to identify lethality and evaluate any steps taken to enact the plan.

    d. Exploring ambivalence (i.e., reasons for dying versus reasons for living) is critical to the determination and assignment of risk.

e. Among adolescents and adults, especially those who present with mood or externalizing disorders and extensive familial chaos, assessment for the presence of non-suicidal injury is critical to determination of risk.

f. Although history provides a context within which the current individual's presentation is evaluated for level of risk, the most salient component for risk determination is, in fact, the individual's current presentation.

g. Warning signs of imminent risk include: hopelessness, un-abating anger, recklessness, feeling trapped, increased substance use, withdrawal from friends and family, heightened anxiety, dramatic mood changes, and loss of a purpose in life.

2. Current and Past Psychiatric Diagnoses: In particular, mood disorders (depressed or mixed phase), schizophrenia, bipolar disorders, alcohol/substance use disorders, ~~-~~personality disorders/traits, eating disorders, and anxiety disorders are indicative of high risk. Risk increases among individuals with more than one psychiatric disorder, as well as with substance use.~~.~~

3. Hopelessness: The presence of a profound sense of hopelessness, even in the absence of any salient psychiatric disorder, can place an individual at a moderate to high level of suicidal risk.

4. Physical Illness: Certain medical diagnoses and conditions are associated with higher risk of suicide, especially those associated with chronic pain. Examples of such are: malignant tumors, HIV/AIDS, peptic ulcer, kidney failure, pain syndromes, organic brain injuries, Multiple Sclerosis and Temporal Lobe Epilepsy. There should be a low threshold for seeking medical/psychiatric consultation in these situations, particularly in the presence of even mild depressive symptoms.

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5. Family History: Suicide attempts increase with individuals whose ~~first degree~~first-degree relatives present with suicidal behavior and mental illness.

6. Acute and Chronic Psychosocial Stress: Suicide risk increases with losses (interpersonal, occupational, physical, and social status, including shame or public humiliation), chronic medical illness (especially brain or nervous system disorders), financial difficulties, legal problems, family discord, and history of abuse or neglect.

7. Key Symptoms: The following symptoms typically increase suicide risk: a lack of pleasure seeking, impulsivity, hopelessness or despair, anxiety/panic, global insomnia, an inclination to be tunneled in view; that is seeing death as the only viable option to get release from pain, and command hallucinations.

8. Cognitive Dimensions: Suicide risk intensifies with the presence of thought constriction and polarized thinking.

9. The Phenomenology of Suicide: The phenomenology of suicide refers to the concept that suicidal behavior does not have a singular cause but rather is an accumulation of historical experiences of a traumatic nature. Histories of sexual/physical abuse, neglect, and parental loss increase suicide risk.

~~9.~~

10. Demographics: Men tend to be proportionately at a higher risk for completing suicide attempts. ~~Elderly~~The elderly are at the greatest proportionate risk compared to the rest of the population. Adolescents and young adults present with the second highest number of suicides.

F. Specific psychiatric symptoms; environmental variables, such as access to lethal means; and limited social supports are risk factors, which can be modified through either appropriate treatment or specific precautionary intervention.

G. Comprehensive suicidal assessment should include the identification of risk factors, which can be ameliorated and protective factors that can be enhanced. Risk factors fall

across the biopsychosocial spectrum. They can include: ~~-~~mental disorders, states of mind, history, recent negative experiences, physical ailments, salient losses, unemployment, cultural and social ~~beliefs~~beliefs, and the like. Protective factors can include: ~~-~~successful past responses to stress, positive coping skills, spirituality, capacity for reality testing and frustration tolerance, children or pets in the home, positive therapeutic relationships, and sense of responsibility to family and social supports.

Attachments

N/A

Related Forms

Level of Care Determination Grid (G:/Clinical Services/Master Clinical Files)
Bay Arenac Behavioral Health Suicide Lethality Scale (G:/Clinical Services/Master Clinical Files)

Related Materials

LOCUS Instrument Version 2010
CALOCUS Instrument Version 2010
Columbia Suicide Severity Rating Scale C-SSRS

References/Legal Authority

N/A

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SUBMISSION FORM

AUTHOR/ REVIEWER	APPROVING BODY/COMMITTEE/ SUPERVISOR	APPROVAL /REVIEW DATE	ACTION (Deletion, New, No Changes, Replacement or Revision)	REASON FOR ACTION - If replacement list policy to be replaced
P. Baker	CLT	03/16/09	New	
G. Wise	J. Pinter	05/26/10	Revision	Revised to include updates for staff training- suicide prevention/assessment
K. Withrow P. Baker	PNLT	11/07/13	Revision	Triennial review: updated with First Person language, added clinical nursing staff to applicability section. Update procedure to reflect current practice.
K. Amon	SLT	06/29/15	Revision	No policy changes. Changed Committee name/DSM change for personality Dx.
J. Hahn	J. Hahn	10/1/18	No changes	Triennial Review-no changes
K. Moore	J. Hahn	02/01/21	No changes	Triennial Review -no changes
S. Krasinski	J. Hahn	11/15/23	Revision	Revised to current processes