HEALTHWEST

Practice Guideline

No. 12-012

Prepared By:

Zero Suicide Workgroup

Effective: March 1, 2010
Revised: April 6, 2018

Approved By:

Subject: Suicide Assessment and Intervention

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I. PRACTICE GUIDELINE

To enable the Agency to provide consistent and effective assessment and intervention of individuals at risk of suicide.

II. PURPOSE

HealthWest strives to protect the safety of all individuals served, and to ensure all staff have the knowledge, resources, and confidence to recognize and address risk of suicide and to intervene effectively.

III. APPLICATION

This practice guideline applies to all HealthWest employees and contract providers.

IV. PROTOCOL

A. ASSESSMENT: Individuals should be screened for suicidal thoughts and behaviors routinely at intake and regularly throughout treatment for individuals with high risk factors. Screening will take into consideration: (a) Warning Signs, both direct and indirect; (b) Risk Factors; and, (c) Protective Factors (C266).

1. Warning Signs are defined as acute indications of elevated risk. They signal potential risk for suicidal behavior in the near future.

a. Direct indications of acute suicidality are given the highest priority. Each direct warning sign indicates potential for suicide in its own right; and requires rigorous follow-up.

(i) Suicidal communication: Someone threatening to hurt or kill him or herself or talking of wanting to hurt or kill him or herself.

(ii) Seeking access to method: Someone looking for ways to kill him or herself by seeking access to firearms, available pills, or other means.

(iii) Making preparations: Someone talking or writing about death, dying, or suicide when their actions are out of the ordinary for the individual.

b. Indirect warning signs may also indicate signal risk for suicidal behavior, so these signs require further follow-up questions to determine if they are indirect acute suicidality. Questions may be remembered by the mnemonic IS PATH WARM: Ideation, Substance Abuse, Purposeless, Anxiety, Trapped, Hopelessness, Withdrawing, Anger, Recklessness, Mood changes.

2. Risk Factors are indicators of long-term or ongoing risk.

a. Prior history of suicide attempts
b. Family history of suicide
c. Severe substance abuse
d. Co-occurring disorders/diagnoses
e. History of childhood abuse
f. Stressful life circumstances
g. Personality traits
h. Firearm ownership or access to a firearm
i. Bi-sexual, gay, lesbian sexual orientation
j. Chronic Pain
k. Age
l. Gender
m. Race and Ethnicity
n. Potential Reasons for Suicidal Behavior

3. Protective factors are buffers that lower long-term risk. The presence of protective factors does not change the assessment that preventive actions are necessary and may provide no protection in acute crises.

a. Reasons for living.
b. Being clean and sober.
c. Attendance at support groups.
d. Religious attendance and/or internalized spiritual teaching against suicide.
e. Presence of a child in the home and/or child rearing responsibilities.
f. Supportive relationship/marriage.
g. Trusting relationship with a counselor or service provider.
h. Employment.
i. Trait of optimism.
j. Future plans.
k. Safe environment
l. Social connectedness

Information gathering for the assessment may utilize the screening tool(s) that addresses the factors described above, such as the Columbia-Suicide Severity Rating Scale (C-SSRS), Beck Depression Inventory (BDI), or the Hamilton Depression Rating Scale, as well as follow-up questions about suicidal ideation, intent, and previous attempts.

B. CONSULTATION: Supervision and/or consultation will be accessed when working with individuals with suicidal concerns. Suicide risk should never be managed alone, and judgment about the seriousness or risk should be made in consultation with a supervisor and/or a treatment team, and not by a staff person acting alone.

1. Circumstances that require access to immediate supervision/consultation:

   a. Direct warning signs are evident, and follow-up questions to suicide screening questions suggest there is current risk.

   b. Follow-up questions to indirect warning signs suggest there is current risk.

2. Circumstances that require access to regularly scheduled supervision/ consultation:

   a. One or more indirect warning signs are present, but follow-up questions indicate there is no reason to suspect current risk for suicidal behavior.

   b. One or more risk factors are present, but there are no accompanying warning signs or other indicators to suspect current risk for suicidal behavior.

   c. The individual discusses a history of suicidal thoughts or suicide attempts, but there are no accompanying warning signs or other indications to suspect current risk.

   d. Additional intervention suggests the individual has a history of suicidal thoughts or attempts, or the individual reports a history you had not previously been aware of, but there are no accompanying warning signs to suspect current risk.

   e. The individual with a history of suicidal thoughts or behavior experiences an acute stressful life event or setback in treatment, but there are no accompanying warning signs or other indications to suspect current risk of suicidal behavior.

3. All clinical staff will receive training on suicidality annually and can demonstrate basic competency in screening and treating individuals with suicidal thoughts and behaviors.

C. INTERVENTION: Action plans will be developed for individuals who have a history or who evidence suicidal thoughts and/or behaviors. Potential actions can be described along a continuum of intensiveness. Generally, more serious risk may result in more intensive actions.

1. The primary worker of an individual with suicidal risk must work with the individual to develop a Crisis Plan/Safety Plan, or a WRAP plan, if one does not already exist.

2. Individuals with emerging suicidal risk may be provided a Commitment to Treatment agreement (C265) which focuses the individual's attention to specific behaviors promoting recovery and potentially reducing suicidal thoughts/behaviors, including:

3. Individuals in an acute suicidal risk may require an increase in the level of care such as crisis residential or Inpatient psychiatric when their acuity (whether it be suicidal behavior or risk, psychosis, or other psychiatric symptoms) cannot be managed in a less restrictive setting.

D. FOLLOW-UP: Since individuals who are suicidal commonly experience a return of suicidal risk following any number of setbacks, or even when there is a substantial improvement in mood or energy, follow-up is essential. Frequency will be determined on an individual basis, but contacts may include the following:

1. Confirm the individual has kept a referral appointment.

2. Coordination with Brinks or hospital staff.

3. Inquire about any recurrence or change in suicidal thoughts or attempts.

4. Check in with family members about any recurrence of a change in suicidal thoughts or attempts.

5. Keep family members engaged in the treatment process with a suicide crisis process.

6. Observe the individual for signs of a return of risk.

7. Confirm the individual still has a Safety Plan.

8. Confirm the individual still does not have access to a major method of suicide.

9. Monitor and update the treatment plan as it concerns suicide.

V. References

Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment, Tip 50, U.S. Department of Health and Human Services, SAMHSA, 2009.
Linehan, M., Assessment and Treatment of Suicidal Behavior, 1997.
Gathering Information Regarding Suicidality, C266
Assessing Suicide Risk: Initial Tips for Counselors, M175
Safety Card, M174
Commitment to Treatment Statement, C265

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