HealthWest
Muskegon's Behavioral Wellness Connection

Procedure Title: Suicide Assessment and Intervention	**Procedure #: 12-012**	**Review Dates**	
Category: Clinical **Subject:** 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.	**Prepared by**: Suicide Safer Care Committee Workgroup **Approved by:** DocuSigned by: Rich Francisco AA7EBD48ABB04A3... Rich Francisco, Executive Director	09/18/2025	
	Effective Date: 03/01/2010	**Last Revised Date:** 10/07/2025	

I. PROCEDURE

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

II. APPLICATION

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

III. PROTOCOL

A. DEFINITIONS

a. Assessing And Managing Suicide Risk (AMSR) – A comprehensive training for clinical staff that is recommended by the Zero Suicide Institute at The Educational Development Center (EDC). This approach ensures a comprehensive and compassionate response to individuals at risk of suicide. We use AMSR for risk formulation, (also see The Columbia Suicide Severity Rating Scale below), and an outline for how we communicate and consult peers.

b. Caring Contact - A caring contact is an evidence-based suicide prevention intervention that involves sending brief, non-demanding, no "strings attached" messages of care and concern to individuals at risk of suicide. Research has shown that caring contacts can significantly reduce the risk of suicide and improve mental health outcomes and can be done at a very low cost.

c. The Columbia Suicide Severity Rating Scale (C-SSRS) – A tool used to assess the severity and immediacy of suicide risk through a series of simple, plain-language questions. It helps identify individuals at risk and guides appropriate interventions. It is often referred to as just "The Columbia".

d. Counseling on Access to Lethal Means (CALM) – is a training recommended by Zero Suicide and EDC. It is an intervention aimed at reducing access to methods

individuals might use to harm or kill themselves. It involves HealthWest staff working with at-risk individuals and their families to identify and limit access to lethal means, such as firearms or medications.

e. Root Cause Analysis (RCA) is a method used to identify the underlying causes of problems or events. The goal is to determine the root cause, which is the fundamental reason for the occurrence of a problem, rather than just addressing its symptoms. By identifying and addressing the root cause, organizations can implement effective solutions to prevent recurrence.

f. Stanley-Brown Safety Plan - is a brief, collaborative intervention designed to help individuals experiencing suicidal thoughts or thoughts of self-harm. It involves creating a personalized plan to recognize warning signs, employ coping strategies, and access support to mitigate risk and enhance safety. This plan is developed jointly by the clinician and the individual to ensure it is practical and effective.

g. Structured Professional Judgment (SPJ) is an evidence-based approach used in risk assessment that combines empirically validated tools with the expertise and judgment of trained professionals. It helps systematically evaluate and manage risks, such as violence or suicide, by integrating structured guidelines (assessment tools) with professional insights.

h. Substance use disorder (SUD) – A medical and mental health condition characterized by an inability to control the use of a particular substance or substances despite harmful consequences.

i. Suicide Care Pathway - The Suicide Care Pathway is a structured approach that guides the care of individuals at risk of suicide through a series of predetermined steps. It works to ensure continuous engagement, high-quality care, and clear communication among healthcare providers. This pathway aims to create a safe, supportive environment that helps individuals feel secure and research has shown it to save lives.

j. Suicide Safer Care – This is what HealthWest calls the Zero Suicide work within our organization. (The name Zero Suicide can cause trauma in staff if there is a death by suicide).

k. Suicide Safer Care Committee – The committee that implements and monitors Suicide Safer Care for the agency.

l. Zero Suicide - Zero Suicide is a comprehensive, evidence-based approach aimed at preventing suicide within health and behavioral health care systems. It is used around the world and boasts a minimum of a 50% reduction in suicide deaths within healthcare systems that implement it by fidelity.

B. PROCEDURE

a. All staff will be trained in suicide prevention.

1. Clinical staff and all staff who work directly with individuals in services will be trained in Counseling on Lethal Means.
2. Clinical staff and all staff who work directly with individuals in services will be trained in Assessing and Managing Suicide Risk.
3. Non-clinical staff will be trained in Question, Persuade, Refer (QPR)
4. Clinical staff are encouraged to take Applied Suicide Intervention Skills Training.

b. Identification and Assessment – When should staff assess for suicide?

1. We will assess and screen for suicide using the Columbia Suicide Severity Rating Scale Screener – Recent (C-SSRS Screener - Recent). The assessment will take place as follows:

i. At the first clinical encounter or when the staff member first meets the individual.
ii. Annually during the Biopsychosocial assessment
iii. When there is a new or intensified identifiable stressor(s).
iv. When there is a change, progress or regression, in clinical presentation/mental status.
v. When a change or a transition is happening such as hospital discharge, change in primary worker, discharge from services, etc.
vi. Additional screenings may be required based on the individual's needs and within clinical decision making utilizing Structured Professional Judgement.

c. If an individual in services is found to have suicidal thoughts or is at risk of a suicide, we enter them into the Suicide Care Pathway. That Pathway is as follows.

C. THE SUICIDE CARE PATHWAY

a. Safety Planning

1. If an individual in treatment is deemed to be suicidal or having suicidal thoughts staff will complete a Stanley Brown Safety Plan with the individual and their family/guardian if applicable.

2. Filling out a Stanley-Brown Safety Plan involves several key steps to ensure a comprehensive and personalized approach to managing suicide risk.

i. Identify Warning Signs: List specific thoughts, images, moods, situations, and behaviors that indicate a crisis may be developing.

ii. Internal Coping Strategies: Identify activities the individual can do alone to take their mind off problems without contacting another person.

iii. Social Contacts and Settings: List people and social settings that can provide distraction and support.

iv. Contacting Family and Friends: Identify individuals whom the person can ask for help during a crisis.

v. Professional Help: List of mental health professionals and agencies to contact during a crisis, including phone numbers.

vi. Making the Environment Safe: Plan for reducing access to lethal means, such as securing firearms or medications.

3. If necessary, staff will complete a crisis intervention note. (Staff should consult the supervisor or manager on this step).

b. Counseling on Access to Lethal Means (CALM)

1. Staff will utilize CALM and work to separate the individual from means of self-harm (e.g., remove sharps, secure/remove firearms, etc.).

c. Communication and Notifications

1. All clinical staff will be trained in Assessing and Managing Suicide Risk (AMSR) and use the communication model that is laid out within AMSR as a part of formulating risk. Communication must provide clinical data and information on the following areas:

a. More enduring

I. The individual's strengths and protective factors
II. The individual's long term risk factors
III. Impulsivity/Self Control concerns including any SUD concerns
IV. Past suicidal behavior(s)

b. More dynamic

I. Recent/present suicidal ideation and/or behaviors
II. The individual's current stressors, precipitants, and/or prodromal signs.
III. Current symptoms, suffering, and/or recent changes
IV. The individual's level of engagement and alliance with HealthWest

2. When an individual in services is found to have suicidal thoughts or intentions staff must communicate this to others on the treatment team or those staff that are involved with the individual on a clinical level. This includes, but is not limited to, the supervisor, team members, and prescriber about the individual's suicidal thoughts and the communication must include the 8 areas listed above.

3. Staff should include the individual primary care doctor, external therapist, external SUD team, and other service providers with whom we have permission to communicate with.

d. Scheduling and Follow-Up Appointment

1. The individual that has been identified as suicidal will have appointments scheduled at a minimum of once per week though some individuals will need to be seen more frequently based on risk and needs. Staff need to consult the treatment team and supervisor to determine if a greater frequency of contact is needed.

e. Missed Appointments

1. If the individual in treatment misses any appointment while in the Suicide Care Pathway, staff will reach out and make contact as soon as possible starting on the same day as the missed appointment.

    I. Staff will continue to try to reach the individual, which may require repeated calls and/or home visits.

    II. If staff are still unable to contact the individual, staff should reach out to natural support(s), if a release is on file and as specified in the Stanley Brown Safety Plan.

    III. If the staff member has exhausted all efforts to contact the individual, staff now need to consult with the treatment team/supervisor about involving law enforcement or the LEAD team for a wellness check.

f. Individualized Plan of Service (IPOS)

1. Revisit the IPOS and update contact frequency as needed.

g. Caring Contacts

1. Staff will send a caring contact in the form of a handwritten card to the individual in services. This should be done within 72 hours of discovering that the individual is having thoughts of suicide.

2. At 4 weeks, another caring contact should be sent.

h. Assessment and How an Individual Exits the Suicide Care Pathway

1. Individuals in the Suicide Care Pathway will stay in that pathway for a minimum of 90 days.

2. While in the Suicide Care Pathway, the individual will be reassessed for suicide at each visit using the Columbia-Suicide Severity Rating Scale Screener-Recent (C-SSRS Screener - Recent).

3. If someone answers “no” to being suicidal at least 4 times and they have been in the pathway for a minimum of 90 days, consult with you team and determine if they can exit the pathway.

    a. If there is a Supervisor and Master level clinician on the team, they should be consulted on individuals exiting the Suicide Care Pathway. If there is no Master level clinician involved in the case, the supervisor should be consulted.

i. Key factors that might indicate readiness to leave the pathway include:

1. Stabilization of Symptoms: The individual shows significant improvement in their mental health symptoms.

2. Reduced Suicide Risk: There is a marked decrease in suicidal thoughts and behaviors.

3. Increased Coping Skills: The individual has developed effective coping mechanisms and strategies to manage stress and emotional distress.
4. Support System: The individual has a strong support network in place, including family, friends, and mental health professionals.
5. Engagement in Treatment: The individual is actively participating in ongoing treatment and follow-up care.
6. It's important to note that the decision to transition out of the suicide care pathway is made collaboratively, involving the individual, their healthcare providers, and often their support network to ensure a safe and supportive transition.

D. DOCUMENTATION

a. All actions taken and interactions on behalf of or with the individual must be documented in the electronic health record. This includes safety plans, crisis intervention notes, CALM activities, notifications, appointment schedules, follow-up contacts, IPOS updates, caring contacts, and assessment results.

b. If staff do not enter someone into the Suicide Care Pathway who has been identified as suicidal or if staff do not utilize one or more steps outlined in the Suicide Care Pathway Procedure, staff must document clearly the rationale for their decision.

E. DATA COLLECTION AND ROOT CAUSE ANALYSIS

a. Meaningful data collection on suicide attempts and deaths will be collected.

b. Meaningful data will also include reviewing the electronic health record to assure staff are utilizing the Suicide Care Pathway and to make certain that each step is being followed.

c. If there is a sentinel event such as a suicide attempt that required a medical intervention or admission to a hospital or a death by suicide, at least one member of the Suicide Safer Care Committee will participate in the Root Cause Analysis.

F. REVIEW AND UPDATE

a. This policy should be reviewed annually and updated as necessary to ensure it remains effective and aligned with best practices.

IV. REFERENCES

Assessing and Managing Suicide Risk (AMSR), 2019
Stanley-Brown Safety Plan, 2024
Zero Suicide Institute

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