St. Clair County Community Mental Health
Providing Opportunities for Health, Wellness, & Connection

Administrative Policy

Policy Title: **Zero Suicide: Suicide Prevention Program**

Policy #: **03-003-0080**

Effective Date:	01/29/2025
Approved by:	Telly Delor, Chief Operating Officer
Functional Area:	Program Services
Responsible Leader:	Kathleen Gallagher, Chief Clinical Officer
Policy Owner:	Kristen Thompson, Adult Services Director
Applies to:	All SCCCMH Staff, Directly Operated Programs

Purpose: To describe St. Clair County Mental Health's system-wide approach to preventing suicide deaths using the evidence-based ZERO SUICIDE model of care.

I. Policy Statement

It is the policy of St. Clair County Mental Health (SCCCMH) that suicide deaths for individuals under the care of SCCCMH are preventable. This policy sets the standards of care that will be implemented with individuals receiving SCCCMH services to ensure a commitment to individual safety and active engagement while striving for *zero suicide*s per the ZERO SUICIDE evidence-based model of care.

It is essential to continuously assess risk, engage patients in their person-centered safety plan, treatment plan, and *suicide* care management plan and re-engage patients at every encounter, no matter what the reason for the visit.

II. Standards

A. SCCCMH clinical practice guidelines will follow the foundational beliefs of Zero Suicide that suicide is preventable.

B. All SCCCMH staff members have crucial roles in preventing suicide. Safer suicide care begins from the moment a person interacts with a staff member at any level in the organization.

C. SCCCMH staff will seek advice and support from supervisors and/or veteran staff when concerns arise.

D. SCCCMH Zero Suicide guidelines shall be adopted with input from community service providers, hospital systems, local health department, and survivors of suicide.

E. SCCCMH completes an environmental scan that reviews risk factors, protective factors, incidents, means, and gaps in resources and services. A committee meets to review the elements of the suicide prevention plan quarterly. Individuals with lived experience are included in the review of the prevention activities.

F. Individuals are referred when appropriate to additional community resources.

G. Staff receive competency-based trainings which are on-going and documented.

III. Procedures, Definitions, and Other Resources

A. Procedures

Responsibilities

Position	Responsibilities
Clinician	Assess suicide risk with every individual receiving services at intake stage and use all facets of the Zero Suicide model of care to support the SCCCMH's goal of preventing suicide deaths.

Actions

Action Number	Responsible Stakeholder	Details
1.0	Clinician	1. Complete the Columbia Suicide Severity Rating Scale (C-SSRS), in Oasis, with all individuals receiving SCCCMH services at Intake (CIU Clinician) and annually, at minimum, at the time the Biopsychosocial is completed. This is completed in order to assess and safely manage care for individuals at risk for suicide. a. If the answer to the first two questions on the C-SSRS are "no," the *suicide risk* assessment process is complete and no further action is needed; however, if clinical judgement determines that suicide risk may still be present, the following screening assessments can be used to determine trauma and suicide risk: 1) Life Events Checklist (LEC in OASIS) – a self-report measure designed to screen for

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		potentially traumatic events in an individual's lifetime. This screening assesses exposure to 16 events known to potentially result in PTSD or distress. 2) Lethality assessment (in OASIS) 3) PCL-5 (in OASIS) b. If the answer to the first two questions on the C-SSRS is "yes": 1) Suicide risk immediately becomes a primary focus of assessment if an individual indicates current or past suicidal thoughts or attempts or is identified as at risk through screening. Same-day access to services is provided for individuals who are determined to be at immediate risk. 2) Complete the rest of the C-SSRS tool, which includes the SAFE-T assessment. All of which includes a risk formulation in the narrative section that includes the following: i. Description of the risk. Explain the underlying mechanisms of the presenting problem and propose a hypothesis regarding actions to facilitate change. ii. Predisposing factors. Bring together the assessment information to develop an understanding of the target behavior to direct treatment and care management plans. iii. Precipitating or trigger factors. Specify factors likely to increase the risk of suicidal behavior and those likely to decrease it. iv. Protective factors. Seek to establish clinical reasons behind the increased risk and any factors which would protect against suicidal acts in order for this to be incorporated into treatment plans. 3) Complete the MySafetyPlan to ensure comprehensive risk assessment and *safety planning* are in place for the individual

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		potentially at-risk of suicide. The MySafetyPlan should be completed collaboratively between the individual and clinician and scanned into the EHR when completed. 4) Ensure reduction of access to lethal means by implementing CALM strategies as appropriate based on clinical judgement. 5) Add a note in the Health & Safety warning orange tab at the top of the individual's EHR chart that says "At Suicide Risk" 2. Compete C-SSRS is also completed when there is: a. A belief that risk level may have changed. b. A change in the individual's circumstances that might lead to an increased risk of suicide. c. At transition points between services or treatment settings. d. Prior to in-patient hospital discharge and at 7-day follow-up appointment. e. When there is a marked observed change in the individual's mood and/or a resistance to treatment. 3. Complete *Crisis Response Planning* with all individuals who complete a SAFE-T Plan, and all individuals who are being discharged from the hospital for psychiatric inpatient treatment. 4. Closely follow every individual who is identified as being at risk for suicide through a suicide care management plan or pathway to care. a. Suicide prevention path is included in the clinical pathways in OASIS. This is used for all individuals with major depressive disorder as a primary diagnosis, and with any other person who is at risk. 5. Link the individual with evidence-based practices targeted for individuals who are at-risk for suicide (Cognitive Behavioral Therapy for Suicide Prevention). 6. Use *non-demand caring contacts* to supplement treatment to keep individuals engaged, follow up with patients who are difficult to engage, and extend the connection between provider and individual served after treatment has ended. Individuals at high risk of suicide are often among the highest percentage of those dropping out of treatment. Motivational enhancement strategies may be used to

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		increase the likelihood of engagement in further treatment. Improvements in rates of appointments kept can be obtained through intensive follow-up, case management, contacts, and visits. a. For an individual who is at-risk for suicide: 1) Attempt to outreach at every missed appointment. A member of the treatment team must make and document a minimum of three phone attempt, until contact is made. If contact is not made via phone, a member of the treatment team or mobile crisis unit staff must attempt an in-person outreach. i. If the individual is homeless, clinician/treatment team member must use clinical judgement to determine most likely places this person frequents, such as Port of Hopes, friends, family, parks, etc. 2) For all individuals receiving SCCCMH services, regardless of suicide risk: i. Clinician or treatment team member must make at least three telephone follow-up calls to all individuals after discharge, until contact is made. If contact is not made via phone, a member of the treatment team or mobile crisis unit staff must attempt an in-person outreach. 7. BTPRC conducts monthly lethality reviews, behavioral treatment plan reviews and risk analysis for high-risk individuals. Recommendations are made based on the findings and may involve the need for additional staff training, case record reviews or improvements on a more systemic agency level.

B. Related Policies

N/A

C. Definitions

1. *Care Transitions:* The movement of an individual between one care setting or care provider to another
2. *Columbia Suicide Severity Rating Scale (C-SSRS):* A validated and reliable screening tool that measures current and past suicidal ideation, suicide attempts, preparatory behaviors, and non-suicidal self-injury.
3. *Crisis Response Planning:* A brief intervention in which individuals plan out steps for self-identifying personal warning signs, coping strategies, enlisting social support, and accessing professional services
4. *Evidence Based Treatment:* Treatment that is backed by scientific evidence. Cognitive Behavioral Therapy for Suicide Prevention is implemented at SCCCMH to provide evidence-based treatment to this identified population.
5. *Lethal Means Restriction:* SCCCMH uses the "Conversation on Access to Lethal Means" (CALM) strategies for talking to individuals about means reduction. A key component of Zero Suicide is reducing access to methods that could be used for suicidal acts and if possible, restricting access during an acute suicidal crisis.
6. *Non-demand caring contacts:* A sustainable intervention for suicide prevention that sends caring messages to people at risk.
7. *Safety Planning:* A brief intervention involving a prioritized list of concrete, specific coping strategies and supports developed collaboratively between an individual and a clinician. The safety plan incorporates elements of several evidence-based suicide risk reduction strategies, including lethal means reduction, brief problem-solving and coping skills, social and emergency crisis support, and motivational enhancement for treatment. A safety plan is **not** a contract for safety or a no-suicide contract, as there is no evidence that these contracts are effective. Safety planning, also known as crisis response planning, has been found to be more effective than a safety contract.
8. *Suicide:* When an individual directs violence at themselves with the intent to end their life, and they die because of their actions.
9. *Suicide Assessment:* Refers to a more comprehensive evaluation done by a clinician to confirm suspected suicide risk, estimate the immediate danger to the patient, and decide on a course of treatment. Although assessments can involve structured questionnaires, they also can include a more open-ended conversation with a patient and/or friends and family to gain insight into the patient's thoughts and behavior, risk factors (e.g., access to lethal means or a history of suicide attempts), protective factors (e.g., immediate family support), and medical and mental health history.

10. *Suicide Assessment Five-Step Evaluation and Triage (SAFE-T):* A screening tool that guides clinicians to identify risk and protective factors, inquire into suicidal thoughts, plans, behavior, and intent, determine risk level, and choose an appropriate intervention. Incorporates the American Psychiatric Association Practice Guidelines for suicide assessment.
11. *Suicide Risk:* The level of suicide risk for an individual is determined by the C-SSRS, clinical judgement, and/or recent suicide attempt.
12. *Suicide Screen:* a procedure in which a standardized instrument or protocol is used to identify individuals who may be at risk for suicide. Suicide screening can be done independently or as part of a more comprehensive health or behavioral health screening. Screening may be done orally (with the screener asking questions), with pencil and paper, or using a computer.
13. *Zero Suicide:* A system-wide, organizational commitment to safer suicide care in health and behavioral health care systems. The framework is based on the realization that suicidal individuals often fall through the cracks in a sometimes fragmented and distracted health care system. A systematic approach to quality improvement in these settings is both available and necessary.

D. Forms

N/A

E. Other Resources (i.e., training, secondary contact information, exhibits, etc.)

N/A

F. References

1. CCBHC Expansion Grant
2. CARF 2019 Standards – Behavioral Health
3. Zero Suicide Program

IV. History

- Initial Approval Date: 09/2021
- Last Revision Date: 09/2023 BY: Adrienne Luckenbacker and Latina K. Cates
- Last Reviewed Date: 12/2024 BY: Kristen Thompson
- Non-Substantive Revisions: N/A
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