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PROCEDURE
Application

This procedure shall apply to clinical services of The Right Door for Hope, Recovery and Wellness, for persons ages 12 and up.

1. Lead

The Right Door for Hope, Recovery and Wellness believes that suicides can be prevented in Ionia County and is a priority of the entire organization and every staff person to be focused on reducing or ideally, eliminating, suicides. The organization promotes listening, supporting, and changing to better support suicide-safer care.

2. Train

The Right Door for Hope, Recovery and Wellness is committed to a well-informed workforce that is able to provide support and care to persons served. Staff will be trained at a minimum using ASIST, SafeTalk, and RELIAS trainings.

3. Identify

3.1. Screening and Assessment: All persons presenting for intake will receive an initial screening for suicide, which includes a suicide risk assessment, risk formulation and an assessment of the person's mental state. Overriding the recommendation of an evidence-based tool requires strong clinical judgement, thorough documentation of reasoning and consultation with another clinician.

3.2. Screening and Assessment tools include:

3.2.1. Columbia Suicide Severity Rating Scale (C-SSRS)

3.2.2. Patient Health Questionnaire (PHQ9 or PHQA)

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4. Engage

Caring Contacts are messages of support to demonstrate that you care about the person's wellbeing. It is a straightforward intervention that involves sending persons who are/were suicidal, brief non-demanding expressions of care and concern.

5. Treat

5.1. The following evidenced-based best practices and research informed practices are recommended for those experiencing suicidal thoughts and are at risk of suicide:

5.1.1. Cognitive Behavioral Therapy

5.1.2. DBT

5.1.3. DBT-A

5.1.4. Utilization of the C-SSRS, PHQ-9, PHQ-A

5.1.5. Commitment to the philosophies and interventions related to the concept of Zero Suicide

5.1.6. Questionnaire regarding suicide is incorporated to all progress notes.

6. Safety Planning

6.1. One of the purposes of Safety Planning is to provide people who are experiencing suicidal ideation with a specific set of concrete strategies to use in order to decrease the risk of suicidal behavior. The safety plan includes coping strategies that may be used and individuals or agencies that may be contacted during a crisis. Safety Planning is a

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collaborative effort between a treatment provider and the person served and their family. Some of the basic elements of a safety plan include:

6.1.1. recognizing the warning signs and/or triggers of an impending suicidal crisis;

6.1.2. using your own coping strategies;

6.1.3. contacting others in order to distract from suicidal thoughts;

6.1.4. contacting family members or friends who may help to resolve the crisis;

6.1.5. contacting mental health professionals or agencies; and

6.1.6. reducing the availability of means to complete suicide.

6.2. An important part of safety planning is reducing access to lethal means. Documentation of reducing the access to lethal means should be part of the crisis planning and all related conversations as part of any progress notes. A discussion related to all lethal means the person has considered related to suicide is important, including an agreement to limit their access to means. It is ideal if a support person could be present and commit to securing any lethal means and reporting back to the clinician that securing the means have been completed. If the support person does not report back, it is imperative that follow up with the support person occurs to determine status of access to lethal means. The support person should be coached that returning the lethal means is not recommended until all parties agree to the plan of return. If the person served does not agree to the removal of the items identified as "lethal means" a direct conversation about the rational for removing the lethal means should occur.

6.3. Additionally, assisting the person to identify a support person (emergency contact/parent/guardian/caregiver/etc.), providing correct phone number and address of the support person(s) along with a completed Release of Information is critical to good crisis planning.

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7. Zero Suicide Protocols:

7.1. When someone presents with some intent to harm themselves, the following protocols should be followed. Additionally, a clinician may implement the protocols if the person is denying thoughts of suicide but presents with many risk factors for suicide, a person with a recent psychiatric or crisis residential admission within the past 30-days, or other clinical rationale that is supported by data or assessment tools:

7.1.1. Completion of a pre-screen to determine if inpatient psychiatric care is necessary. If determined that inpatient is not necessary (Phase I), a safety plan will be developed with a focus on reduced access to lethal means and on resolution of the immediate crisis

7.1.2. Once the crisis has resolved, the primary clinician shall (Phase II) develop a plan for the person served to have contact a minimum three times each week by a mental health professional that focuses on suicide risk. A review/update of the safety plan should occur as needed. Treatment plan amendment should occur if indicated. There should be a focus on reducing risk.

7.1.3. Once the person served is able to participate in implementing coping skills (Phase III):

7.1.3.1. The clinician should develop a plan for the person served to be seen at least once a week.

7.1.3.2. Review/update safety plan, as needed.

7.1.3.3. Amend the treatment plan, as needed.

7.1.4. Moving into the Follow up Phase (IV):

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7.1.4.1. Primary clinician should amend treatment plan as needed.

7.1.4.2. Caring Contacts shall be implemented.

7.1.4.3. Discussion with treatment team and clinical supervisor regarding removal from Zero Suicide protocols.

7.2. Post psychiatric inpatient/crisis residential stay shall follow the protocol established above for Phase I-IV

8. Removal from Zero Suicide Protocols

The Zero Suicide may be discontinued for a person served when they no longer are identified as at risk for suicide. The decision and rationale to remove someone would be determined by the person's clinical team and primary program supervisor.

9. Transition:

With any transition to a different level of care or to a different clinician warm handoff are encouraged. Additionally, it is recommended that the original "primary clinician" follow up with the person served to assure engagement with the new clinician. This could be done via phone call, a quick note or in person.

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| Kerry Possehn, Chief Executive Officer | Date | | |