

Sample Suicide Safe Care Policy for a Behavioral Health Organization

- I. PURPOSE:** To outline procedures for providing suicide prevention and suicide safe care to all clients of Center in line with national best practices to promote life.

- II. SCOPE:** This procedure is applicable to all Center employees

- III. PROCEDURE:**
 - A. WORKFORCE COMPETENCY:**
 1. Center shall have a workforce competent in the recognition of and provision of suicide care. All staff will be provided ASIST training and a booster training will be required every 3 years.
 2. Staff working directly with clients in a clinical capacity will be required to take a basic crisis training course during which they will learn how to conduct a basic triage or screening (including the CSSR-S) to know whether or not a full assessment is needed. This basic crisis training will also include training on safety planning using the Barbara Stanley Safety Planning Intervention.
 3. Staff working in a capacity to complete full assessments will be required to take advanced crisis training to learn about full risk assessments and least restrictive environment (LRE), and safety planning.
 4. Any staff member working with potentially suicidal individuals in a case management setting will take case management of suicidal clients which will incorporate the philosophy of Collaborative Assessment and Management of Suicidality (CAMS).

 - B. IDENTIFICATION OF RISK:**
 1. Staff will use the Triage form(incorporating the CSSRS since last visit) and decision tree to identify risk in the following situations:
 - a. When the client scores a 2 or a 3 on the ANSA or CANS on the suicidal ideation questions.
 - b. When the client presents for an appointment and begins to report “at risk” behavior or concerns such as suicidal ideations, homicidal ideations, increased psychosis, manic symptoms, going off medications suddenly, a sudden significant stressor, or other clinically indicated situation/symptom.

2. Staff will work with the client to gather all of the information on the triage form. Once the information is gathered. Staff will use the decision tree to determine a risk level of moderate or high.

C. INTERVENTIONS:

1. Clients determined by staff to be at moderate risk will be referred to these clinically appropriate interventions: Safety planning including means restriction as needed, walk-in with med clinic for medication intervention, ASIST interventions, increased case management visits including CAMS interventions when appropriate, changes in level of care, and/or referrals to other outside agencies as needed.
2. Clients determined to be at high risk will:
 - a. be referred to the crisis team either MCOT or the psych triage facility for a full risk of harm assessment,
 - b. Case managers will call the MCOT triage phone for other options.
 - c. be assessed for risk of harm by case managers
 - d. be referred to inpatient treatment if the individual has private insurance and wants to go inpatient.
 - e. Staff will not leave the individual alone while transition between providers or to another level of care is being arranged.

D. FOLLOW UP DURING TRANSITIONS:

1. Center staff will make every effort to follow up with all clients hospitalized in an inpatient psychiatric facility on the day of discharge or the next business day for aftercare.
2. If a client is on contracted bed days, or is at the state hospital, the client report to Center for aftercare if the client is discharged during business hours. If discharged after business hours or on the weekend, an appointment will be schedule for the next business day. Clients known to have discharged on weekends will receive phone follow ups or face to face as needed by MCOT.
3. Staff will schedule an appointment to see the client for another appointment within 7 business days of the discharge from the hospital to follow up and ensure the client is receiving the appropriate level of care. The client's safety plan will be reviewed and client's suicidal ideations will be assessed using the since last visit CSSRS. At this appointment, the schedule for further follow up will be set based on client need. At least weekly face to face appointments will be kept with the individual as long as he/she is considered to be at elevated risk.

4. A client discharged from the Crisis Residential Unit (CRU) will receive a follow up with his/her case manager within 2 business days of the discharge from CRU. At this appointment, the case manager will ensure the client is receiving the appropriate level of care. The client's safety plan will be reviewed and client's suicidal ideations will be assessed (using the CSSRS since last visit). Staff will schedule the next appointment within 7 business days.
5. At the 7 day follow up, the case manager will review the crisis plan, assess suicidal ideations and schedule further follow up based on client need. Clients will be seen at least weekly as long as they are determined to be at elevated risk.
6. If a client does not attend his/her appointments case management appointments, staff will immediately attempt to contact the client to reschedule the appointment.

E. COMPASSION FATIGUE:

1. All clinical staff are required to take the Center's self-care training.
2. All staff are encouraged to consult with their immediate supervisor, and take personal time off (PTO) anytime he/she is struggling with burn out.
3. All staff are encouraged to debrief with their immediate supervisor following a difficult assessment/situation for additional support.
4. Following all suicide deaths of current clients, recent clients, staff members, or staff family members, a Critical Incident Stress Management (CISM) trained debriefing team of 2-3 staff members will form to meet with all effected staff to debrief the incident within 48 business hours of being informed of the incident. The group will meet again after 2 weeks to debrief again and discuss lessons learned as appropriate to the situation.
 - a. The debriefing team members will always be those not directly associated with the staff member or client who has passed away (i.e. if the client is being served in crisis services the debriefing team will be from regular services and if the client is from regular services the debriefing team will be made up with staff from crisis services.)
5. Debriefing team staff will follow up individually with providers as needed and will offer resources to outside agencies or providers as needed.
6. The administrator of crisis services is available any time for consultation or assistance.

7. All Administrators or their designees will discuss self-care and compassion fatigue in their team meetings and provide suggestions for monitoring and engaging in self-care.
8. Staff will be encouraged to download and use the provider resiliency app available for Apple and Android to monitor compassion fatigue.