DAVIS BEHAVIORAL HEALTH
Community • Commitment • Change

Policies & Procedures

CLINICAL GUIDELINE SUPPORTING BEST PRACTICE

Section: Clinical Policies

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DBH Practice Guidelines for Chronically Suicidal Clients

Statement of Intent

This statement is intended to guide the treatment of chronically suicidal clients *in most cases*. It is not intended as DBH policy, nor should it limit any individual exceptions made in the best interest of client care.

Background

Most literature on the treatment of suicidal patients assumes that the suicidal condition is a time-limited condition that will abate with the treatment of some acute conditions. Legal responsibility is assigned to the clinician according to a "reasonable care" standard, which is defined according to how the prudent practitioner would be presumed to act. However, there is no clear standard of "prudence" for persons with chronic, unrelenting suicidal thoughts and impulses. No scientific evidence has shown that hospitalization is helpful with chronically suicidal conditions. Many published experts suggest that hospitalization may be harmful to persons with long-term suicidal thoughts.

Practice Parameters

Assessment

1. The risk assessment process will be thorough and ongoing.
   The risk assessment will:
   a. Incorporate changes in the client's clinical condition or life stressors. The assessment will show awareness of the elevated risk of acute-on-chronic suicidal impulses (acute circumstances leading to the impulse).
   b. Be documented.
   c. Assess previous suicidal actions, and documentation will describe the profile and potential lethality of these actions.

   d. Go beyond assessing only the client's report of suicidal ideation, to include all known risk factors.
   e. Focus on identifying risks and weighing treatment options,
   f. Include an assessment of the client's capacity and willingness to:
      i. Give or withhold information
      ii. Seek help when in a crisis.
      iii. Follow through on treatment recommendations.
2. Any elevated risk must be addressed clinically, with documented evidence of the treatment decision (even if the decision is purposeful inaction.)
3. Any client with chronic suicidal impulses should be fully assessed to determine an accurate diagnosis. This should include team staffing with other licensed mental health workers.
4. Substance use should be assessed, and positive findings must be included in an integrated treatment plan.

Treatment

1. When clinically indicated and fiscally feasible, treatment should be consistent with current evidence for the condition assessed. For instance, at this time, Dialectical Behavior Therapy is the treatment considered to be most likely to benefit persons with borderline personality disorder.
2. The treatment plan should include a description of goals, tasks, and the framework upon which treatment will occur. These goals will be negotiated with the client. The goals and approach should be consistent and well-defined yet allow for flexibility and reasonable exceptions.
3. As described in the Utah Public Mental Health System Preferred Practice Guidelines, inpatient treatment should be used when three conditions are met:
   a. There is imminent danger,
   b. There are no available social supports, AND
   c. There is a history of good response to hospitalization or expected positive response to hospitalization.
4. Hospitalization should be as brief as possible in order to minimize therapeutic dependency and decompensation (Utah Public Mental Health System Preferred Practice Guidelines.)
5. Treatment must be coordinated between all providers. Any change in the status of the risk assessment (such as a significant change in the client's social support system) should be communicated between all providers, e.g., case managers, therapists, and prescribers. All involved providers should be aware of both short-term and long-term treatment goals, and any changes in those goals as they occur. During transitions between programs or levels of care, e.g., discharge from inpatient facilities, there should be a clear designation of who is responsible for coordinating the transition and subsequent care. This

coordination should include a staffing or conference call that includes all key providers.

6. During the course of treatment, specific metrics should be defined to systematically assess the ongoing effectiveness of treatment. Such metrics will serve to inform better clinical and risk assessment over time. Examples of metrics include:
    a. Inpatient/residential stays—frequency, duration, and qualitative judgment of outcome.
    b. Suicidal/parasuicidal acts—self-mutilation, overdoses, emergency room visits
    c. Medication trials—types, dosages, trial length and qualitative outcome judgment.