Georgia Department of BEHAVIORAL HEALTH and DEVELOPMENTAL DISABILITIES
DBHDD

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# Suicide Prevention, Screening, Brief Intervention and Monitoring, 01-118

## FULL IMPLEMENTATION DATE – JULY 1, 2016

## APPLICABILITY

This policy is applicable to Comprehensive Community Provider (Tier 1) and Community Medicaid Providers (CMP+) organizations approved to serve individuals with mental illness and/or addictive diseases, wherein those services are financially supported in whole or in part by funds authorized through DBHDD.



## POLICY

DBHDD community providers serve many individuals at high risk for suicide. Increased integration of suicide prevention practice has been shown to reduce the number of individuals who die as a result of suicide. As a critical part of the DBHDD safety net, all behavioral health Comprehensive Community Providers (CCPs) utilize evidence based suicide prevention strategy and practices determined by DBHDD.

### BACKGROUND

Suicide is the tenth leading cause of death nationally and in the State of Georgia. Individuals with behavioral health disorders are at high risk for suicide and suicidal behaviors. Some estimates of the number of persons who died by suicide with a diagnosed or undiagnosed behavioral health disorder run as high as ninety percent. In recent years there has been a growing body of research on suicide prevention, screening, intervention, and postvention.

Suicide is now recognized as a distinct clinical issue, separate and apart from other diagnoses, and as such, needs to be screened, assessed, intervened with and monitored separately from other diagnoses. In addition, suicide plays a more prominent part in the DSM-V, with a separate diagnosis for Suicide Behavior Disorder identified as a "condition for further study." Therefore, while it remains important to assess and intervene with psychiatric conditions, this alone is not sufficient with individuals who are suicidal. Addressing suicide risk plays an important part in access to care and providing an atmosphere where individuals served can move securely into the care, and the appropriate level of care needed.

## DEFINITIONS

**Evidence-Based Practice** is defined for the purposes of this policy as interventions that are:

- Category 1
  Interventions are included in Federal registries of evidence-based interventions; OR
- Category 2
  Interventions that are reported (with positive effects on the primary targeted outcome) in peer-reviewed journals.

**The Columbia Suicide Severity Rating Scale (C-SSRS) -** is the only screening tool that assesses the full range of evidence-based ideation and behavior items, with criteria for next steps (e.g. referral for further assessment). Thus, the C-SSRS can be exceptionally useful in initial screenings.

**The Safety Plan Intervention -** is a written, prioritized list of coping strategies and resources for reducing suicide risk. It is a prevention tool that is designed to help those who struggle with their suicidal thoughts and urges cope with these thoughts and urges to prevent escalation of suicidal crisis.

**Gatekeeper Training -** generally refers to programs that seek to develop individuals' knowledge, attitudes and skills to identify people at risk for suicide, help the person understand that help is needed, and get the person to help when necessary.

**Suicidal Ideation -** is the process of thinking about, considering or planning for suicide.

**Suicidal Behavior -** includes suicide attempts, interrupted attempts, aborted attempts as well as preparatory behaviors such as acquiring means to kill oneself, researching ways to die, giving away prized possessions, writing suicide notes and/or plans, and so forth.

**Suicide Risk Assessment -** adds an additional group of risk factors and warnings signs to either the Full or Screener C-SSRS versions. It summarizes the answers from the C-SSRS and documents common risk factors (e.g., psychiatric treatment history, social support/lack thereof, current symptoms of hyperarousal, and documents critical stressors such as anniversary dates of loved ones death, etc) that augment the clinical risk profile.

## PROCEDURE

A. **Suicide Prevention Planning Strategy**

1. The key elements of an acceptable suicide prevention planning strategy include, but are not limited to:
   a. Systematic identification of individuals with suicidal ideation and/or behavior, at every level of service provision.
   b. Triage to identify appropriate level of care.
   c. Provision of self-care and self-help strategies to individuals to help them identify, monitor and manage their suicidality.
   d. Follow-up and management with individuals at moderate and high risk until they are securely in services, defined as two additional appointments in care with an assigned service provider.

e. Ongoing Monitoring of all individuals in service.

f. Application of set standards for quality care and facilitation of communication and coordination between and within all providers.

g. Quality assurance and inter-rater reliability monitoring.

h. Treatment of suicide risk as a primary condition.

i. Involvement of family, friends and caretakers in the management of suicide risk.

j. Use of evidence-based, system-wide practices.

k. Implementation of tools and scoring systems that are embedded into the Electronic Medical Record (EMR).

B. **Use of Approved Suicide Screening Tools**

1. DBHDD requires the use of the C-SSRS. Clinicians that administer the C-SSRS must complete DBHDD approved training before utilizing the instrument.
2. All individuals who present at services are assessed for suicide risk, using the most appropriate of two Columbia Suicide Severity Rating Scale tools:
   a. C-SSRS Screener - **Lifetime/Recent Version (Attachment A)**, or
   b. C-SSRS Screener - **Pediatric/Cognitively Impaired Recent/Lifetime Version (Attachment B)**.
3. The C-SSRS uses information from a variety of informants including the individual who is being assessed, family members, caregivers, friends, hospital records and the agency screener. A "Yes" response from any informant qualifies for inclusion in the analysis.
4. The C-SSRS is used to complete the Suicide Item on the Child and Adolescent Needs and Strengths (CANS) Assessment tool – Trauma Comprehensive Version and the Adult Needs and Strengths Assessment (ANSA) tool.
5. Concurrent to administering the C-SSRS, the screener gathers information about current stressful life events and considers this in the decision pertaining to disposition and triage.
6. If at any time during the course of treatment indicators of suicidal ideation or suicidal behavior are disclosed by, or suspected of, any individual (including those who were previously designated as low risk), a C-SSRS is conducted, a Safety Plan Intervention is developed, and further assessment and triage conducted if necessary.

C. **Screening Results and Planning**

1. Trained staff score and analyze the C-SSRS and rates the completed assessment. Information about current programs of training to learn how to use the C-SSRS is found at http://dbhdd.georgia.gov/mental-health-training-announcements.
2. Any yes answer on Questions 1 and 2, either recent or lifetime, automatically disqualifies the individual from being categorized as "low risk" and means the person is given the full C-SSRS screener.

3. Each provider has a written protocol for triage, directed by the results of the C-SSRS and the Child and Adolescent Needs and Strengths (CANS) Assessment tool – Trauma Comprehensive Version and the Adult Needs and Strengths Assessment (ANSA) tool, taking into account past, current, and future stressful life events.
4. Each individual with a C-SSRS score of 3 or higher and/or who has exhibited suicidal behaviors (suicide attempts, interrupted attempts, aborted attempts as well as preparatory behaviors such as acquiring means to kill oneself, researching ways to die, giving away prized possessions, writing suicide notes and/or plans, and so forth), is provided with an evidence-based Safety Plan Intervention before they leave the visit where the screening takes place. For individuals in the care of Crisis Stabilization Units, a Safety Plan Intervention occurs within 24 hours of discharge.
5. Every individual is asked the likelihood that he will use the safety plan and the safety plan is changed if the likelihood of using a part of the safety plan is low. This discussion must be documented in the record.
6. Individuals deemed to be clinically appropriate for the Safety Plan Intervention but who cannot or will not complete a Safety Plan may be considered a danger to themselves and should be further assessed for suicide risk.

D. **Assessment**

1. All individuals who are screened at moderate or high risk will be referred for further consultation and/or additional assessment that gathers additional information in addition to the CSSRS and the ANSA CANS such as psychiatric diagnoses and symptoms, warning signs, specific suicide related stressors such as anniversary dates of important deaths, access to lethal means, etc.
2. Each provider organization will develop a written protocol regarding how to access further consultation and/or assessment in a timely manner. Individuals who are assessed at high risk must have further consultation and lethality assessment on the same day. Individuals who are assessed as at moderate risk must have further consultation the same day and further assessment if needed.

E. **Monitoring**

1. The individual is monitored by phone, in person, or through email/text until they are safely in contact with ongoing services.
2. While access to ongoing care is sought, staff monitor for suicide risk within 48 hours after the safety plan has been developed, and then weekly until the individual is safely into care as evidenced by:
    a. the individual's attendance at two (2) visits with their ongoing service provider, OR
    b. the individual declines further monitoring.
3. Individuals at risk for suicide in ongoing care must be screened at each visit using the:
    a. **C-SSRS Screener** – **Since Last Visit (Attachment C)**, and/or
    b. **Structured Follow-Up and Monitoring Procedure (B. Stanley and G. Brown), (Attachment E)**, and/or

c. Collaborative Assessment and Management of Suicide (CAMS) Suicide Status Form (SSF) if using CAMS framework for care. **Note**: There is no attachment for the SSF because those trained in CAMS and eligible to use it will already have the form.

4. Staff incorporates the Structured Follow-Up and Monitoring Procedure (B. Stanley and G. Brown) and/or the C-SSRS Screener – Since Last Visit into their follow-up with individuals who miss scheduled appointments.
5. Staff ensures that routine monitoring is not perfunctory, by asking relevant questions directly related to the individual's circumstances, current and impending life events that are likely to influence their thoughts and negatively impact their mood, in order to effectively gauge risk of suicidal behavior.
6. Individuals served in the community, who are at moderate or high risk for suicide must address the treatment of suicidality in the Treatment Plan. In the Treatment Plan the level of care should be commensurate with the level of suicide risk. Whenever indicated and possible providers should use effective suicide-specific treatments, such as Cognitive Behavioral Therapy for Suicide (CBT) or Dialectical Behavior Therapy (DBT).

F. **Documenting Screening, Safety Plan Intervention and Treatment Planning**

1. All suicide screening, assessment, safety plan interventions, treatment planning, intervention and monitoring is documented in the individual's clinical record.
2. Each record must contain a formulation of risk and how that level of risk was determined using the Formulation of Risk Model used in Assessing and Managing Suicide Risk: Core Competencies for Behavioral Health Professionals developed by the Suicide Prevention Resource Center (revised April 2014).
3. All individuals are given a copy or copies of their **Safety Plan Intervention, (Attachment D)**, and the service provider keeps a copy of all developed or revised Safety Plan Interventions in the clinical record.
4. The provider will flag the medical record in a prominent place to assure that all staff associated with the individual are aware of suicide risk.
    a. All individuals who have been hospitalized or have been served in Crisis Stabilization Unit (CSU) care with suicide ideation or behavior are flagged "high risk for suicide" for at least four months. This flag is changed to "suicide history" if there has been no ideation or further behavior within the four months. When a "high risk for suicide" flag is changed to "suicide history" it is important to note that the person remains at moderate risk. All individuals who have a history of suicide behavior any time in their lifetime are flagged with "suicide history".
    b. The Crisis Stabilization Unit (CSU) will be responsible for initiating a "high risk for suicide" flag for all consumers who are in their care with suicide ideation or behavior in the EMR before the consumer leaves the unit. CSUs are also responsible for communicating that the flag exists to other levels of care when the consumer leaves CSU care.
    c. Any clinician who finds and/or documents recent or past history of suicide ideation or attempts is responsible for initiating a "suicide history" flag in the record.

G. **Care Coordination**

1. Treatment for suicidality received by individuals is coordinated between healthcare providers, such as CSUs, private hospitals and community providers.
2. All providers participate in discharge planning and preparation, to ensure appropriate information sharing and seamless transition between services. (As relevant see Transition Planning Process for Individuals on the ADA Ready to Discharge List, 01-507, and Follow-up for Individuals Discharged from the State Hospital Who Were on the ADA Ready to Discharge List, 01-508).
3. Providers receive and review relevant documentation relating to clinical history, before the individual attends the first appointment with the receiving service provider, so that the level of suicidal risk can accurately be noted, screened and treated.

H. **Training**

1. Providers develop an annual strategic training plan that sets out a specific plan to train all staff in suicide prevention. This plan is to ensure that:
    a. Staff is trained in an evidence-based basic gatekeeper training program to enhance awareness and vigilance around the signs of suicide (e.g., Question, Persuade and Refer (QPR), Safetalk, Mental Health First Aid).
    b. Staff conducting screening, assessment, intervention and monitoring with individuals are trained in the basic competencies required in Assessing and Managing Suicide Risk (AMSR) and are trained or certified in the use of tools and/or interventions before they use them in practice. Documentation of training is kept in their personnel file.
        i. Staff is given opportunity to participate in additional suicide prevention training as needed, but at least annually.
        ii. Providers are encouraged to provide training in evidence based suicide prevention interventions such as, but not limited to, Applied Suicide Intervention Skills Training (ASIST), Collaborative Assessment and Management of Suicide Risk (CAMS), Cognitive Behavioral Therapy for Suicide (CBT-S) and Dialectical Behavior Therapy (DBT).
        iii. Staff is provided with updates on evidence-based suicide prevention at least annually from the DBHDD Office of Behavioral Health Prevention.
    c. Clinical application of screening and assessment tools, intervention and monitoring of suicide is routinely reviewed in clinical supervision.
    d. An ongoing internal training team of at least two (2) trainers is established to provide training relating to suicide within the organization. These designated trainers will be Certified trainers in the practice referenced in this policy prior to the delivery of training to colleagues.

I. **Quality Assurance**

1. The provider conducts regular quality assurance monitoring of records within their agency to include monitoring of the elements of this suicide prevention policy.

## RELATED POLICIES

Transition Planning Process for Individuals on the ADA Ready to Discharge List, 01-507

Follow-up for Individuals Discharged from the State Hospital Who Were on the ADA Ready to Discharge List, 01-508

## RELATED INFORMATION

Question, Persuade and Refer (QPR), QPR Institute

Applied Suicide Intervention Skills Training (ASIST), National Office for Suicide Prevention

Mental Health First Aid USA

Self-Directed Violence Surveillance: Uniform Definitions and Recommended Data Elements

**Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals**

http://www.sprc.org/training-institute/amsr

## Attachments:

- A: C-SSRS Screener, Lifetime Recent - Clinical
- B: C-SSRS Screener, Pediatric/Cognitively Impaired - Lifetime Recent - Clinical
- C: C-SSRS Screener – Since Last Visit - Clinical
- D: Safety Plan Intervention
- E: Structured Follow-Up and Monitoring Procedure (B. Stanley and G. Brown).



## Approval Signatures

| Approver | Date |
|---|---|
| Anne Akili, Psy.D.: Policy Director | 7/12/2016 |
| Monica Johnson, MA, LPC: Director, Division of Behavioral Health | 7/12/2016 |
| Travis Fretwell: BH Prevention Director | 6/30/2016 |
| Anne Akili, Psy.D.: Policy Director | 6/28/2016 |