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Division of Mental Health and Developmental Services
Rural Services

505.0   Suicidality

505.1   Policy Approval Clearance Record

☐ Mental Health Policy ☐ Developmental Services Policy ☒ Rural Services Policy	This policy supersedes: n/a	Number of pages in Policy: 22
Review by Representative from the Office of the Attorney General: n/a	Date: n/a	Date Policy Effective: 8/8/11
Rural Services Director Approval Signature: *Barbara Legier*	Date: 8/8/11	Policy Lead: Eric Skansgaard, CPM-II

505.2   Statement of Purpose

505.2.1   Policy Statement: All clients will be assessed for suicidality, monitored and/or provided with safety plans if deemed necessary.

505.2.2   Purpose: To provide clear guidelines for the assessment of suicidality, interventions, monitoring and follow-up.

505.3   Authority

NRS 433
NAC 433A
MHDS Policy #4,043 – Coordination of Services for Persons with Dual Diagnosis
MHDS Policy #4.029 – Suicide Risk Assessment Procedure

505.4   Definitions

505.4.1   Suicidality: The likelihood of an individual completing suicide.

505.5   Procedures

505.5.1   Suicidality Assessment

A. For mental health services

  1.   Screening for suicide will occur at crisis contacts, during each session, and during intake.

  2.   When positive risk factors are identified, further evaluation using agency-approved assessment protocols will be completed by a QMHP. If the person presents a **clear and present danger of harm to self,** the QMHP will initiate the process for hospitalization, including Legal 2000. (RC-1005)

B. For developmental services

  1.   During intake, if the intake coordinator notices clear and present signs of self harm, the person will immediately be referred to a QMHP or a psychologist from developmental services.

  2.   The QMHP or psychologist will follow up with appropriate assessment, treatment or referral.

  3.   If the person presents a **clear and present danger of harm to self,** the QMHP or psychologist will initiate the process for hospitalization, including Legal 2000. (RC-1005)

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505.5.2   **Safety Plan and On-going Monitoring**

A. All Rural Services clients (mental health and developmental services) assessed as having suicide risk but not in **clear and present danger of harm to self** will immediately have a safety plan developed and implemented by a QMHP and the support team. For developmental services clients, the support team will include a QMHP.

B. Development of a safety plan will include, but is not limited to the following whenever possible:

  1. Consultation with other professional staff, including psychological services;

  2. Medication evaluation;

  3. Steps to modify risk factors identified during assessment and to strengthen protective factors;

  4. Identification of environmental or natural supports;

  5. Identification of client strengths, existing coping and problem solving skills and enhancement of those skills;

C. The suicide safety plan is a documented plan completed by the clinician in direct collaboration with the individual (and guardians/caregivers, if appropriate). For DS clients and children in the care of caregivers, the plan will be a written plan. The plan will:

  1. Identify warning signs

  2. Specify internal and external coping strategies

  3. Identify people who may offer help

  4. Include contact information for professionals and agencies

  5. Allow for problem-solving for implementation of the plan.

D. Once completed, a copy of any written plan is provided to the individual (and guardian/caregivers, if appropriate) and a copy is placed in the person's file and its presence is documented in the electronic medical record.

E. The clinician will establish a follow-up plan for on-going monitoring. This should include a discussion of informed consent and limitations of confidentiality when working with high risk individuals in an outpatient setting. Discussion can include conditions for no-show follow-up appointments, welfare checks, and notifying local police.

F. On-going Monitoring

  1. For mental health services, the assigned clinician will re-assess suicidality at every contact and update the LOCUS/CASII as needed. Clinical teams in the center will review clients at risk each week.

  2. For developmental services, the comprehensive safety plan will be included in the individual support plan (ISP).   The developmental services QMHP will remain a member of the support team to expert consultation for the DS III and provider.

505.5.3   **Quality Assurance Oversight**

A. For mental health services:

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1. Teams in each center will review the LOCUS/CASII Risk Reports (Crystal Reports) each week to ensure the current QMHP-directed plan is adequate, making changes to the plan as necessary.

   Risk may be downgraded when any risk factor has been modified and clinical judgment projections across the ensuing 6 months indicate that risk of suicide has decreased.

2. Upon entering a new program, the client's program staff must review the client's most recent suicidality assessment and document the review in the client record. This documentation will be noted as "review of suicidal assessment" in a progress note.

B. For developmental services:

1. The assigned DS III will consult with their supervisor who will place the individual's name on the list of at risk individuals to be reviewed at the DS leadership weekly meeting.

2. If the individual is receiving services from Rural Services – Mental Health the DS III will notify the Cooperatively Served Individual (CSI) liaison of the individual for data tracking and coordination of services.

505.5.4   **Procedure for Approval of Suicidality Assessment Protocols**

A. Rural Services Staff will use approved assessment protocols when conducting assessment of suicide risk. Refer to Attachment A – List of Approved Suicidality Assessment Protocols.

B. QMHP staff may propose a new assessment protocol for review. The proposal must include the protocol and supporting literature which includes psychometric values where available and will be sent to the CPM II for initial review. The CPM-II will forward the proposal to MARS which will respond within 30 days of submission.

C. Assessment protocols approved by MARS shall be placed in the shared drive folder with instructions and psychometric values.

505.5.5   **Resolution of Disagreements related to suicide risk and/or treatment planning**

A. Consistent with MHDS policy 4.029, consultation with CPM-II and/or Agency Director will be used to resolve disagreements over suicide risk assessment and subsequent planning and intervention.

505.5.6   **Staff Training**

A. All employees must receive annual training on suicidality assessment, prevention, and the development and implementation of safety plans.

505.5.7   **Timelines:**

Table 505.1: Timelines for Suicidality Policy

Requirement	Deadline	Starting Date	Responsible Party	Actions to be Taken
505.1.A.2 Suicidality Assessment	Immediately, while client is physically present	Upon awareness of suicide risk factors	QMHP	Comprehensive assessment w/ approved assessment tools
505.1.B.1 Suicidality	Immediately	Upon identification of	Intake	Notify QMHP or DS

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Assessment		clear and present signs of self harm	Coordinator	psychologist
505.5.1.B.2	Within same day	Upon referral from Intake Coordinator	QMHP or DS psychologist	Make appropriate referral
505.5.2.A Intervention	Immediately	Upon identification of suicidality	QMHP or DS psychologist w/ support team	Develop and implement safety plan
505.5.2.B.1 Reassessment of suicidality	At every contact		Mental Health QMHP	Update LOCUS/CASII if needed
505.5.3.A.2	Immediately	Enrollment to new program	Assigned program staff	Direct treatment and/or direct service staff review most recent suicide or risk assessment data upon admission to program, document this review in progress note
505.5.3.A.3 Quarterly Review	Quarterly	Date of last treatment plan/ISP review	Direct Services staff	Suicidal ideation or suicide risk.
505.5.3.B.1 Monitoring by DS Leadership	Weekly		DSIII and DSIV	Consult and place name on list of at risk individuals for DS Leadership review
505.5.3.B.2 CSI monthly report to MARS	Monthly		CSI Liaison and DSIII	Update CSI data and present to MARS
505.5.4 MARS response	30 days	Submission of Suicidality Assessment Tool for approval by CPM II	MARS Leadership Team	Review and provide feedback regarding submission. If approved, place in appropriate shared drive folder.
505.5.5 Training	Within 10 days of hire and annually	Date of hire	All Supervisors	Train on policy and assessment tools as appropriate

505.5.8   Documentation:

A. Case File Documentation (paper):

Table 505.2: Case File Documentation for Suicidality Policy

File Location	Data Required
Miscellaneous Legal	Original or copies of any suicidality assessment data, which may include, but are not limited to: laboratory findings, structured or semi-structured interview results, correspondence such as suicide notes, correspondence with physician, law enforcement or hospitals, Legal 2000-R forms, Folstien MMSE.

B. Electronic Documentation:

Table 505.3: Electronic AVATAR DS-NOW Documentation for Suicidality Policy

Applicable Screen	Data Required

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Progress Note	Upon gaining awareness of actual or potential suicide risk, Referral to QMHP. For QMHP: Synopsis or suicidality assessment interview or findings, Folstien MMSE, and disposition or plan as required by this policy.
Progress Note	Entry noting review of most recent suicidality assessment at the time of admission to new program

505.5.9   **Supervisory Responsibility:** Supervisors will provide in-service training to ensure all staff understand the requirements of this policy and its procedures. Supervisors will revisit this policy periodically, but no less than annually for recommendations for improvement or additions.

505.6   Policy Cross Reference

505.6.1   **RS-1005** Legal 2000-R Service

505.7   Attachments

505.7.1   **RS 505 A** – List of Approved Suicidality Assessment Tools

505.7.2   **RS 505 B** – SADPERSONS Suicide Risk Assessment

505.7.3   **RS 505 C** – Suicidality Brief Screening Questionnaire

505.7.4   **RS 505 D** – A Suicide Screening Checklist (SSC) for Adolescents and Young Adults and Manual for Use and Scoring the Suicide Screening Checklist (SSC)

505.7.5   **RS 505 E** – Clinician's Guide: Examination of a Potentially Suicidal Patient

505.7.6   **RS 505 F** - Suicide Safety Plan

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ATTACHMENT 505 A

LIST OF APPROVED SUICIDALITY ASSESSMENT PROTOCOLS

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RURAL SERVICES
LIST OF APPROVED SUICIDALITY ASSESSMENT PROTOCOLS

1. Suicidality Brief Screening Questionnaire

2. A Suicide Screening Checklist (SSC) for Adolescents and Young
    Adults and Manual for Use and Scoring the Suicide Screening Checklist (SSC)

3. Clinician's Guide: Examination of a Potentially Suicidal Patient

4. SADPERSONS Suicide Assessment, Adult and Youth Versions.

5. SAFE-T Suicide and Self Harm assessment in AVATAR.

6. Suicide and Self Harm Assessment in AVATAR

7. Burns Suicidal Urges and Brief Mood Survey

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ATTACHMENT 505 B

SADPERSONS Suicide Risk Assessment

Rural Services: SAD PERSON Suicide Risk Assessment

Name:_____   Date:_____   Time:_____

☐   Sex (M=1)
☐   Age(<25 or >45 = 1)
☐   Depression
     Sleep:_____
     Interests:_____
     Guilt/Worthlessness:_____
     Energy:_____
     Concentration:_____
     Appetite:_____
     Psychomotor Ag/Ret:_____

☐   Previous Attempts / Family History Suicide
☐   Ethanol or other Drug abuse
☐   Rational thought loss (including, but not limited to):
     Production
     Continuity
     Preoccupations
     Ideas of reference
     Attention/Concentration/Planning
☐   Social Supports Lacking
☐   Organized Plan
     Firearms?
☐   No Spouse = 1
☐   Sickness/Illness/Surgery/Pain

     Medications:_____

Notes:

0-2 = follow-up
3-4 = get help
5-6 = protective steps
7-10 = hospitalize

Note: In rural areas access to firearms should be specifically assessed and interventions noted as appropriate, particularly with males. Reasons for living or dying should be assessed. Reasons for living may mitigate against suicide risk.
Top reasons for living: Family, Future, Specific plans or goals, enjoyable things, friends, self, responsibility to others, religion.
Top reasons for Dying (risk): Escape, General descriptors of self ("worthless, awful"), others relationships (want to stop hurting others, or retribution), Feeling hopeless, escaping pain, feeling alone, escaping responsibilities, escaping past, religion (want to meet God)

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ATTACHMENT 505 C

SUICIDALITY BRIEF SCREENING QUESTIONNAIRE

SUICIDALITY BRIEF SCREENING QUESTIONNAIRE
Dan Gunnarson

1. Are you having any thoughts of suicide or self harm? How compelling do they feel?

2. Do you have a plan for how you would commit suicide?

3. Do you have the means to carry out this plan? (e.g., gun, knife, pills, etc.)

4. Do you intend to act on this plan? If so, when? Where?

5. What keeps you from acting on this plan? (e.g., family, religion, fear of death, etc.)

6. What might lead you to act on this plan? (e.g., relationship ending, loss of job, persistent depression, etc.)

7. Have you tried to commit suicide in the past? If so, how? When? Outcome? (e.g., hospitalization, stopped by someone, called for help, etc.)

8. Do you feel able to resist acting on these thoughts? How are you coping with them? What do they mean to you?

9. Is anyone else aware of how you are feeling? Do you have supportive people in your life? Who are they? May I contact them to help keep you safe?

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ATTACHMENT 505 D

**A SUICIDE SCREENING CHECKLIST (SSC)
FOR ADOLESCENTS AND YOUNG ADULTS**

**MANUAL FOR USE AND SCORING THE
SUICIDE SCREENING CHECKLIST (SSC)**

A Suicide Screening Checklist (SSC) for Adolescents and Young Adults

	Yes	No	Uncertain
Suicide history: (max. = 18)			
1. Prior attempt			
2. 2 or more prior attempts in past year (highly lethal = × 2)			
3. Prior suicide threats, ideation			
4. Suicidal attempts in family (× 2)			
5. Completed attempts in family (× 3)			
6. Current suicidal preoccupation, threats, attempt (× 2); detailed, highly lethal* plan (× 2); access to weapon, medication in home (× 4); all three 'yes' = 8			
7. Preoccupation with death			
Psychiatric History: (11)			
8. Psychosis and hospitalization (× 3)			
9. Diagnosis of schizophrenia or manic depressive illness (× 3)			
10. Poor impulse control (current = × 3)			
11. Explosive rage episodes (underline: chronic, single, recent, single past)			
12. Accident-proneness (frequency, examples)			
School (when relevant): −(9)			
13. Grade failure			
14. Rejection			
15. Poor social relations			
16. On probation or dropped out of school (× 2)			
17. Disciplinary crisis (× 2)			
18. Anticipation of severe punishment			
19. Unwanted change of schools			
Family: (27)			
20. Recent major negative change, usually a loss (death, divorce, serious health problem); (irreversible loss = × 3; divorce = × 3; both 'yes' = × 6)			
21. Loss of emotional support, estranged; early loss of parent (× 3)			
22. Loss of employment (parent or self)			
23. Major depression in parent, sibling (× 2)			
24. Alcoholism in family member (× 2)			
25. Psychiatric illness in family member (× 2); (23–25 Yes = 6 × 2)			
26. History of sexual abuse			
Societal: (3)			
27. "Contagion" suicide episode			
28. Economic down-shift in community			
29. Loss of major support system (group, job, career problems)			

	Yes	No	Uncertain

Personality and Behavior; cognitive style: (60)

30. Anger, rage (intense = × 2; held in × 4; Both = 6)
31. Depression (intensely depressed = × 2; agitated depression = × 4; Both = 6)
32. Hopelessness (× 4) (30, 31, 32, all Yes = 6 + 6 + 4 = 16)
33. Mistrust (paranoid = × 2)
34. Disgust, despair
35. Withdrawn, isolate (2)
36. Low "future time" perspective (× 2)
37. High "past" orientation (× 2) (yes on 36, 37 = 4 × 2 = 8)
38. Rigidity or perfectionism (× 2) (Both = 4)
39. Lack of belonging (× 2)
40. Indifference, lack of motivation (boredom = × 2)
41. Worthlessness, no one cares
42. Shame or guilt (Both = × 2)
43. Helplessness
44. Inability to have fun (× 2)
45. Extreme mood or energy fluctuation (Both = × 2)
46. Giving away valuables

Physical: (14)

47. Male (× 3); Caucasian (× 2); (both 'yes' = 5)
48. Significantly delayed puberty
49. Recent physical injury resulting in deformity, impairment (permanent = × 2)
50. Marked obesity (+20%)**
51. Marked recent underweight or anorexia (−15%)** (more than 20% = × 3)**
52. Sleep disturbed (onset, middle, early awakening)
53. Ongoing physical pain

Interview behavior: (20)

54. Non-communicative, encapsulated (× 4)
55. Negative reaction of patient to interviewer (× 4)
56. Negative reaction of interviewer to patient
57. Increasing "distance" during interview (× 3)
58. Increasing hostility, non-cooperation (× 2)
59. Highly self-critical, self-pitying (Both = × 2)
60. Discusses death, suicide (× 4)

Total Score: _____ (Max. = 162)

Suicide Potential Range Risk Guidelines: *Severe*   (110 to 162)
(*Tentative ranges*–to be evaluated by field-testing):   *Moderate*   (60 to 109)
                                                            Low   (below 60)

Confidence Level: _____ High _____ Low   Reasons for low confidence rating:

*"High lethality" defined as method with low degree of reversibility, low risk for rescue (46, 47), substantial medical injury (e.g., comatose).
**Use standard height-weight tables per appropriate age-range.

Manual For Use and Scoring the
Suicide Screening Checklist (SSC):
(Abbreviated Version)

The SSC is completed during and following an interview that includes major focus on areas to be evaluated. When necessary, available friends or relatives may be utilized to collect relevant data to supplement the primary source of patient interview data.

It is critical, initially, to develop as good a level of rapport as possible to ensure maximal amount of involvement and candidness. Inability to develop a high level of rapport is often important data in itself, as lack of cooperation or disruptively high anxiety may be symptomatic of the current level of coping and adaption, as well as ego function.

Care must also be taken to watch for manipulative behavior, in which the person may be desiring to create a negative image to elicit sympathy, attention, etc., or to create a positive image of good psychological health, either due to denial, or because the person is trying to hide their suicidal intent. The degree of manipulation may also be seen in a positive light, as a reflection of the person's maneuverability and skills at seeking control and mastery.

Scoring

Each item is to be scored as present (yes), absent (no), uncertain or unclear (unc).

Weighted items are scored according to the number (multiplier) in parenthesis. If the data fit the highest weighted score when there is more than one score listed, the higher multiplier should be used. For example, if #36 and #37 are both "yes," the total score for the two items is 8 (2 + 2 = 4 × 2 = 8). In #6, a "detailed, highly lethal plan" would be scored a "3," whereas "preoccupation" alone is scored a "2."

Total the scores of all 60 items.

Try to minimize the number of "uncertain" scores (Each "uncertain" score receives a zero score.) Use the cut-off score ranges as guidelines to clinical judgment. A high score should be considered ominous, even if not supported by your own clinical judgment.

On the other hand, a low SSC score that is not supported by clinical judgment needs careful exploration to ascertain if a "false negative" has been obtained. An examination of positive scores on key "item clusters," when a low overall score has been obtained, merits special close scrutiny of the total picture. Secondary (i.e., sequential) screening is usually indicated.

"Low level of confidence" must be evaluated, as this rating raises the question of the validity of the total score. Added sources of data are usually needed.

With successive SSC revisions, based on criterion validity, the total scores and cut-off score ranges should assume increasing levels of objectivity.

A SSC score above 120 or below 20 should be viewed with skepticism, and suggests that responses are being slanted to create a "sick" or "healthy" profile. Until a formal "lie scale" is developed, it is sometimes useful to repeat the same questions at a later point in the interview, to determine the reliability of the original response.

Be wary of the effects of licit or illicit drug usage on mood and level of involvement. Verify amounts consumed if possible and be aware of side effects.

Attempt to corroborate questionable response data by questioning accompanying family members or close friends. Usually a sufficient degree of trust can be established in the interview to minimize doubts about degree of manipulation. Establishing an adequate

rapport is important, so that the pattern and total score of an adequate screening instrument can provide decisive data in the diagnostic process, which is a vital reason for its incorporation into decision-making.

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APPENDIX 505 E

**CLINICIAN'S GUIDE:
EXAMINATION OF A POTENTIALLY SUICIDAL PATIENT**

CLINICIAN'S GUIDE

Examination of a
Potentially Suicidal Patient

Is there a wish to die?
Is there a plan?
What is the method planned?
What epidemiologic risk factors are present?
Is there a history of recent substance use?
What medical illnesses are present?
What psychiatric diagnoses are present?
Is there a past or family history of suicide attempts?
Is there a history of impulsivity?
What is the level of psychological defensive functioning?
Has there been a will made recently?
Is there a history of recent losses, and how do they relate to past history of losses?
Is there talk of plans for the future?
What is the nature of the patient's social support system?

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ATTACHMENT F

SUICIDE SAFETY PLAN

SUICIDE SAFETY PLAN

STEP 1: RECOGNIZING WARNING SIGNS
These signs indicate that I may be starting to get suicidal:

    1.

    2.

    3.

    4.

STEP 2: USING INTERNAL COPING STRATEGIES
These activities may help me distract myself from thoughts about suicide:

    1.

    2.

    3.

    4.

    5.

    6.

    7.

    8.

    9.

STEP 3:   USING EXTERNAL COPING STRATEGIES
These activities may help me distract myself from thoughts of suicide:

    1.

    2.

    3.

    4.

    5.

    6.

    7.

    8.

    9.

SUICIDE SAFETY PLAN

STEP 4: FAMILY OR FRIENDS WHO MAY OFFER HELP

These are people that I would be willing to talk top about my thoughts of suicide in order to help me stay safe:

	NAME	PHONE NUMBER
1.		
2.		
3.		
4.		
5.		

STEP 5: PROFESSIONALS AND AGENCIES TO CONTACT FOR HELP

Therapist:

Primary care physician or psychiatrist:

24-hour emergency treatment:

Call 911

Go to local emergency room

24-hour Emergency Hotline: 1 (800) 273-TALK (8255)

PERSONAL CONTACT INFORMATION

1. Most recent working phone number:

Home:

Cell:

Other:

2. Who can we call if we can't reach you?

Name:

Phone:

During a time of crisis you rating the likelihood that you would be able to follow the steps above as:

Comment: (very likely,   likely,   unlikely,   very unlikely)

SUICIDE SAFETY PLAN

You stated that you could (or could not) think of any reason why you would be unable to complete each step.

Your provider discussed with you how to use this plan during a crisis.

Your provider discussed with you where to keep this safety plan.

Comment: I will keep my safety plan (location(s) of plan):

Your provider will print out this plan and give it to you to refer to.

ADDITIONAL INFORMATION:

_____