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ADMINISTRATIVE BULLETIN TRANSMITTAL MEMORANDUM

DATE ISSUED: March 1, 2017 **EFFECTIVE DATE**: March 1, 2017

SUBJECT: **Administrative Bulletin 3:41**
Screening and Assessment of Suicidal Ideation and Behavior

The attached Administrative Bulletin is being forwarded for your review, action if necessary, and distribution to staff as appropriate. Please be advised that each recipient of this order is responsible for being familiar with the content and ensuring that all affected personnel adhere to it.

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VLM:pjt

DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
ADMINISTRATIVE BULLETIN 3:41

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SUBJECT: Screening and Assessment of Suicidal Ideation and Behavior

I. PURPOSE

A. Individuals with serious mental illness are at much higher risk for suicide than the general population. This risk can increase during hospitalization and is known to rise sharply immediately after discharge from a psychiatric hospitalization. Keeping all patients safe during their hospital stay, and beyond, is paramount and therefore identifying current risk for suicide through regular use of standardized suicide screening and assessment tools is required.

B. The use of structured clinical tools can aid in the process of uncovering suicide risk factors but they cannot alone reliably predict suicide risk in patients. Therefore, clinical judgment is the determining factor for identifying risk, interventions and treatment since:

1. Patients with the most serious intent are often less likely to express their suicidal ideation to others and may not be detected as suicidal on any tool;

2. Impulsive patients may lack suicidal ideation and/or planning before an attempt; and

3. Individuals may respond to all questions positively on a screening and/or assessment tool and determined to be at low risk for suicide.

II. POLICY STATEMENT

A. This Administrative Bulletin (AB) describes the use of suicide risk screening and assessment tools from admission, throughout hospitalization, and at discharge.

B. Each facility shall administer modified versions of the Columbia-Suicide Severity Rating Scales (C-SSRS) as described in the Procedure below. The C-SSRS is a brief, structured, valid, reliable, and research-based screening and assessment tool that addresses suicide ideation and behaviors and informs clinical decision making. The C-SSRS consists of several versions to be used at various points of care. This AB describes which modified version shall be utilized throughout the continuum of care.

C. Although the prescribed protocol does not apply to the Special Treatment Unit (STU), the facility staff shall incorporate the modified C-SSRS tools into their clinical practice.

III. DEFINITIONS

In identifying patients at risk for suicide, it is important to understand the different forms of suicidal and self-injurious behavior:

Suicidal ideation refers to thinking or talking about committing suicide. Suicidal ideation can be active such as when the individual is thinking or planning a suicide, with or without a suicide note, or it can be passive, such as a patient stating s/he wishes to be dead without having the intention of committing suicide.

Suicide attempt refers to nonfatal, self-directed, potentially injurious behavior with the intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Non-suicidal self-injury is defined as deliberately injuring oneself without the intent to die.

IV. DESCRIPTIONS OF SUICIDE RISK SCREENING AND ASSESSMENT TOOLS

A. Hospitals will screen and assess for current risk of suicide in patients using modified versions of the C-SSRS that have been re-titled to indicate at which points in the continuum of care they are to be used. For easy reference they were also given abbreviations and numbers in parenthesis (S1, S2, A1; A2)

B. The modified version of the C-SSRS for state hospitals consist of two screening tools and two assessment tools as described below.

1. Screening Tools

   a. The Admission Suicide Risk Screener (S1)

   This tool is used at time of admission on all patients to screen for current and/or past suicide risk. Patients are asked about their suicidal ideation and suicidal/self-injurious behavior within past month and past six months. In addition, the presence of risk and protective factors, clinical status and their treatment history are evaluated (adapted from C-SSRS Risk Assessment). Once an estimated suicide risk status is established, the clinician will describe and explain the risk in the designated section of the form and, if indicated, refer the patient to the unit psychologist for further evaluation via the Admission Suicide Risk Assessment (A1).

The Admission Suicide Risk Screener can be used as a stand-alone tool (S1) or can be integrated into the Initial Psychiatric Assessment and Treatment/Stabilization Plan.

b. The Discharge Suicide Risk Screener (S2) shall be administered to all patients prior to their discharge.

2. Assessment Tools

a. The Admission Suicide Risk Assessment (A1) is used for patients who were referred by the admitting psychiatrist to psychology for further evaluation. However, clinicians may perform a suicide risk assessment on any patient whose potential risk poses a concern. The admission suicide risk assessment covers in depth presence, intensity and frequency of Suicidal Ideation, Suicide Behavior, Lethality, and Risk and Protective Factors. It allows practitioners to gather lifetime history of suicide at a time the person felt most suicidal as well as any recent suicidal ideation and/or behavior (at 1 month, 3, and 6 months). Results of this tool will assist clinicians to arrive at an informed estimated risk status, followed by a formulation and plan for managing suicide risk.

b. The Post Admission Suicide Risk Assessment (A2) is to be used any time after admission when patients need to be assessed or re-assessed for risk of suicide during their hospitalization. It asks about suicidal thoughts or behaviors the patient has or may have had since completion of the most recent screening (S1) or assessment (A1).

   Since many factors may influence an individual's risk of suicide at any given point in time, the Post Admission Suicide Risk Assessment (A2) shall be conducted for any patient who expresses suicidal ideation and/or shows suicidal gestures/behavior during the course of her/his hospitalization.

V. PROCEDURE

A. Screening of Suicide Risk upon Admission and during Admission Assessment

1. Upon admission, all patients will be screened for suicide risk by the admitting psychiatrist using the Admission Suicide Risk Screening (S1) as a component of the initial psychiatric admission assessment. Suicide risk screening results, including risk and protective factors, combined with clinical judgment will be used to determine acuity of risk and whether a referral to the treating psychologist for a suicide risk assessment (A1) will be made. Note: In rare cases individuals may not be able to respond meaningfully to the questions on the tool(s) or it may be clinically contraindicated to ask those questions, however, the screening and

assessment tools are still to be completed using collateral sources of information (e.g., direct observation, family or staff input, prior records, etc.).

2. If a referral for a comprehensive suicide risk assessment was made by the admitting psychiatrist, the treating psychologist will administer the Admission Suicide Risk Assessment (A1) prior to the initial Master Treatment Plan meeting.

3. Information from the Admission Suicide Risk Screening (S1) and Admission Suicide Risk Assessment (A1) will be utilized for treatment development, which will be reflected accordingly on the Master Treatment Plan.

4. If upon completion of the Admission Suicide Risk Screening (S1) a patient is identified to be highly likely to attempt suicide in the immediate future, the appropriate level of special observation in addition to close monitoring shall be provided immediately, independent of results of the Admission Suicide Risk Assessment (A1).

5. For patients identified to be at imminent suicide risk the initial treatment plan will address suicide risk as a problem and list immediate interventions needed for safety (e.g., body/room search, observation/precautions, safety planning, etc.) and treatment (e.g., pharmacotherapy, psychotherapy and psychiatric rehabilitation, family engagement, etc.) specific to the patient's strengths and needs. Reliance on a "no-suicide" contract should not be considered as an intervention strategy. If feasible, Safety or Crisis Plans may be developed in collaboration with the patient with a specific commitment for what this patient *will* do in order to help him/her cope with suicidal feelings and lower his/her risk for suicide.

B. Assessment of Suicide Risk Post Admission

1. The Post Admission Suicide Risk Assessment (A2) shall be used to assess a patient for risk of suicide, including risk and protective factors whether or not s/he was identified as being at risk at admission.

2. It may be utilized when clinically indicated by a clinician at various points of care, such as when a patient expresses suicidal ideation and/or engages in suicidal behavior, special observations are removed or reduced (e.g., PVO; 1:1, granted ground privileges, etc.), patient has experienced a significant situational event/stressor (e.g., death of a loved one;) or patient gets transferred to another unit or complex.

C. Suicide Risk Screening on Discharge

1. Prior to the completion of the Discharge and Aftercare Plan, the psychiatrist will administer a Discharge Suicide Risk Screener to all patients. The result of this screener might call for the administration of a full suicide risk assessment, will further inform discharge planning, the management of risk in the community, (e.g., safety planning, recovery supports, etc.), if indicated, and timing of discharge. If a patient is screened while on Commitment Extended Pending Placement (CEPP) status and determined to be at risk for suicide by a follow-up full assessment, review of the appropriateness of his/her current CEPP legal status is required.

2. In order to address the increased risk of suicide post-discharge in patients with suicidal history, the information shall be communicated to the patient, patient's future community provider(s) and caregiver(s), incorporated in the Discharge and Aftercare Plan and described in the patient's Discharge Summary.

   All screening and assessment tools will become part of the patient's clinical record and shall remain in the active chart (i.e., not purged).

VI. RESPONSIBILITIES

1. The hospital's Medical/Clinical Director have overall responsibility for ensuring that all clinicians are trained and can demonstrate that they can effectively administer all versions of the C-SSRS described herein and adhere to the suicide risk screening and assessment procedures described in this A.B.

2. In order to ensure that the suicide risk screeners and assessments as described herein are administered, regular monitoring and evaluations of compliance shall be conducted as part of chart audits and other quality improvement efforts.

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Assistant Commissioner