ADMINISTRATIVE POLICY STATEMENT Arkansas PASSE	
Policy Name & Number	**Date Effective**
Documenting Self Harm in Residential Settings-AR PASSE-AD-1436	10/01/2024
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Documenting Self Harm in Residential Settings

B. Background

According to The Substance Abuse and Mental Health Services Administration (SAMHSA), individuals who self-harm in any manner are statistically at a higher risk of attempting or dying by suicide without effective intervention(s). Examples of self-harm can include cutting, piercing or burning the skin, biting or pinching oneself, self-poisoning, banging or hitting body regions, deliberately not taking prescribed medication, refusing adequate food or hydration, or sexually exploitive behaviors. Multiple risk factors preclude higher possibilities for self-harm, including biological females between the ages of 10-19, a history of adverse childhood events or trauma, mental health conditions, or high levels of anxiety and depression. Entities and studies publish varying rates of self-harm among all populations, but most concur since approximately 2010, mental health issues in American populations have increased significantly with the largest increases among female adolescents and young women.

Residential settings offer a variety of benefits for the treatment of behavioral health issues, particularly co-occurring diagnostic symptoms. Stability and structure during treatment is a primary benefit while offering a community support network for the creation of healthy coping skills and habits. Removal of unhealthy triggers or other environmental concerns is conducive to increased adaptive behaviors.

Despite the benefits of residential treatment, self-harm behaviors are often a common occurrence. The evaluation of members demonstrating self-harming behaviors is crucial for bridging gaps in treatment and continuing interventions that reduce symptoms. State licensure and certification agencies establish minimum licensing standards with rules promulgated to promote the health, safety, and welfare of persons under care, ensure adequate supervision by capable and qualified staff, and promote safe, healthy physical facilities. States may also delegate mandatory staff to client ratios and other safety protocols to increase the wellbeing and health of residents and/or require minimum training standards for staff.

Safety of members and quality of care is paramount to treatment of behavioral health issues. Practitioners who understand thematic analyses of peer-reviewed literature surrounding self-harm are better equipped to evaluate member intent to harm and intervene to provide individualized and effective interventions. Facilities must create an environment of care that fosters accurate identification and successful management of members at an increased risk for these behaviors. Facility suicide and self-harm prevention activities include not only individual assessment and care prior to admission through discharge but also organization-wide measures taken to create a safe environment with well trained staff.

C. Definitions

- **Harm** – Physical or mental injury.

- **Minor** – Harm that is not life-threatening, does not necessitate significant medical intervention or hospitalization, and has a quick recovery time.
- **Major (Serious)** – Harm that can be or is life-threatening, seriously interferes with a person's health or comfort, and is long-lasting or requires increased recovery time.
- **Self-Harm** – Deliberate or intentional injury to one's body, either direct or indirect, with or without intent to commit suicide or serious bodily injury.

- **Incident** – An event that affects or may affect the health and safety of a member and include events that are reportable, requiring submission of an Incident Report to the Dept of Human Services (DHS) and the PASSE.
- **Safety Precautions** – Determined through objective criteria and typically requiring a physician's order, a member presents a significant risk of harming self and/or others or has other risk factors necessitating the need for increased observation.
- **Suicide** – Death caused by an act of self-harm intended to be lethal.
- **Suicide Attempt –** A nonfatal, potentially injurious behavior directed against the self with an intent to die as a result of the behavior
- **Supervision** – Active visual and auditory monitoring of activities, assessment of risk, and appropriate intervention to maintain safety, including strategic methods of planning and assigning staff to supervise areas where members are present.

D. Policy

I. General Guidelines

A. Any statement, ideation, or gesture of self-harm by a member will result in an assessment to determine lethality and appropriate steps to promote member safety. CareSource requires all providers caring for members in residential settings to comply the following:

1. Staff members will report all instances of threats and acts of self-harm to a staff nurse, and record the incident in the medical record, regardless of the level of harm or whether the act meets criteria for other reporting events (ie, incident reporting, abuse hotline reports, provider policies for reporting).
2. Staff observing incidents of harm to members beyond minor events (see definitions) will immediately assess the situation for continued threats of harm and call a nurse or medical personnel.
3. After appropriate first aid is rendered and the threat is removed, as necessary, a face-to-face lethality assessment will be completed by an appropriately licensed staff member.
4. Upon conclusion of the assessment, the staff member will consult with the staff physician to discuss assessment results, findings, and rationale for safety precautions, while obtaining any orders or other measures (ie, transport to local emergency room, increase observation level, adjust medication, change treatment plan).
5. All staff involved will record any incidents, consultations with others, reports made, or changes in care in the medical record and complete any additional reporting requirements, including PASSE or DHS incident reporting forms, calls to state abuse hotlines, and/or submission of same, if necessary.

B. As required by licensure boards and certifying agencies, all residential staff members must maintain documentation of ongoing education, training, and demonstrated knowledge of the following (variations of below might differ according to certification and/or licensure entity):
    1. techniques to identify member behaviors, events, and environmental factors that trigger emergency safety situations
    2. use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods that prevent emergency safety situations
    3. reporting procedures for incidents, accidents and other events

C. If required and other than incidents requiring immediate reporting, incident reports (IRs) must be submitted to AR DHS and the PASSE within 24 hours of the event. Written IRs are submitted by providers via email to the DHS Quality Assurance unit and to the PASSE Incident Reporting via email inbox or, if available to the provider, via the online AR DHS DDS Incident Reporting Portal. For emailed reports, providers may utilize the DHS QA Report form or an internal reporting document as long as the document provides all required information. Providers may access the CareSource IR form on the provider Health, Safety & Welfare tab on the CareSource website. Members or authorized representatives can make a report to PASSE staff verbally or in writing. After review, CareSource may request follow-up information or a follow-up report from the provider.

II. Best Practice Standards

A. Initial Suicide Screening/Assessment

At admission, intake/admitting staff will assess all members for specific characteristics that increase or decrease the risk of suicide and/or self-harm. Findings of this assessment will be communicated to the supervising physician. Common assessment components should include, at a minimum

1. psychiatric and medical history, including mental or physical illness and past and current medication
2. current or recent thoughts of suicide or self-harm
3. recent and past history of suicide attempts and self-harm
4. evidence of suicidal planning or self-harm and intent
5. clinical presentation, including symptoms and behaviors
6. member engagement and reliability in treatment and compliance
7. risk formulation, including risk status, risk factors, and risk state (eg, mental or physical illness, substance use, recent loss, history of trauma, stress)
8. potential triggers (eg, family issues, discord with peers, isolation, academic issues, physical health issues, discrimination, relationship issues)
9. protective factors (eg, coping skills, cultural identification, perceived reasons for living, support from others, religious beliefs, strengths)
10. changes in appetite or sleep or lack of interest in typical activities (eg, social withdrawal, low energy, flat facial expressions)

The admission nurse will document actions taken or precautions implemented and contact the physician for appropriate orders, including an increase or decrease in level of observation based on immediacy and seriousness of risk

presented. An registered nurse may initiate suicide precautions or an increased level of observation while awaiting a formal order from the physician but may not discontinue precautions or reduce the level of observation, as a physician's order is required for any decreased change in levels. Nursing may request a change in observation level when acuity requirements are not met for 1:1 observation. The psychiatrist, physician, or nurse practitioner will assess suicide and self-harm risk during the initial psychiatric evaluation. All assessments will be considered by the treatment team and incorporated into the member's individualized treatment plan.

B. Reassessment of Risk

Reassessment of suicidality and self-harm will occur every waking shift for all verbal and responsive acute care members and at least weekly for residential members. Based on disposition, the staff member may complete a more in-depth assessment, as indicated. Members rating as a moderate to high risk for self-harm or suicide attempts will be discussed with the staff physician and documentation of consultation will occur in the member's record. Reassessments will be considered by the treatment team and incorporated into the member's individualized treatment plan. All signs of significant concern will be documented in the medical record and can include, but are not limited to

1. suicidal or self-harm statements or actions
2. attempts to elude staff observation
3. abrupt changes in mood, both positive and negative
4. self-isolation
5. psychomotor agitation
6. prolonged insomnia
7. attempts to gain access to items (eg, sharps, housekeeping chemicals)
8. attempts to gain access to contraband
9. identifying circumstantial life changes or triggers from past suicide attempts

For patients on acute units who are non-verbal or not responsive to questions, a daily assessment will account for changes in appetite or sleep, lack of interest in typical activities, social withdrawal, low energy, flat facial expressions, and any additional signs of a possible increase in depression or harming behaviors. The psychiatrist or physician will assess acute unit members of the risk of self-harm during the daily visit and document such in the member's record.

Members continuing or presenting at-risk for self-harm or suicidality will continue on, or be evaluated for, heightened observations or precautions. Any member previously denying suicidal intent but verbalizing such intent or if new information becomes available that materially impacts risk status, an assessment for self-harm or suicidality will be conducted by licensed personnel (ie, RN, APRN, mental health professional). The physician will be notified of any increased risk for self-harm, and the risk will be documented in the member's record.

C. Common Precautions

Evidenced based practice for suicide or self-harm precautions may include, but are not limited to, the following:

1. increased observation and rounding on members every 5-15 minutes or more at staggered intervals and in a varying pattern or sequence, including during sleep confirming and counting at least three respirations from a close proximity
2. supervision in treatment areas to ensure no isolation
3. doors closed when members are not in a room but open when present
4. assignment and member rounds sheets clearly marked with any precautions and increased communication for transitions (eg, change of shift, breaks, lunches)
5. 1:1 observation for restroom breaks with locked doors when not in use
6. room change closer to nurse's station
7. search of member personal articles, belongings, and room, including removal of any potential hazards (eg, brittle plastic, shoelaces, belts, glass, bras)
8. medication ingestion verification to avoid "cheeking" or hoarding for overdose
9. remaining on the unit for meals or activities
10. seclusion and/or restraint by trained personnel in accordance with local law, federal requirements, and/or licensure requirements
11. member verification by photo (if not available, verify by first, last name, and birthdate)
12. furniture in common areas positioned as to not hinder observation
13. easy staff access to automated external defibrillator (AED) and any emergency kits (eg, emergency medication, stethoscope, adult and pediatric sphygmomanometer and AMBU bag, handheld suction, shears, face shields, pulse oximeter, non-latex gloves)

D. Common Screening and Assessment Instruments

While there are numerous types of suicide and self-harm screening and assessment tools available, any tool used inappropriately may hinder intended results. Screening tools assist in the identification of at-risk individuals, whereas risk assessment tools inform clinicians about possible degrees of risk, corroborate findings from clinical interviews or other information, or may identify discrepancy in risk. Facilities must ensure that clinical staff are trained and competent to use tools that have clear instructions and implemented as directed. The following list of validated screening and assessment instruments are widely accepted as industry standard and provided as a courtesy only to assist in the selection of acceptable instruments, which are not all-inclusive or required:

1. Columbia-Suicide Severity Rating Scale (C-SSRS)
2. Ask Suicide-Screening Questions (ASQ) Tool
3. Patient Health Questionnaire (PHQ-9)
4. Beck Scale for Suicide Ideation (BSI)
5. Patient Safety Screener-3 (PSS-3)
6. Beck Suicidal Intent Scale (SIS)
7. Suicidal Behaviors Questionnaire-Revised (SBQ-R)
8. Suicide Ideation Questionnaire (SIQ) & SIQ-Junior (JR)
9. Paykel Suicide Scale (PSS)
10. Self-Harm Screening Inventory (SHSI)
11. Scale for Suicidal Ideation-Current (SSI-C)

E. Discharge Considerations
CareSource recommends the following during discharge planning in addition to normal planning protocols for any member at risk for suicide or self-harm:
1. predischarge suicide or self-harm assessment by licensed personnel
2. discharge safety plan, including access to firearms, medications and substances, or other agents that could be used to self-injure
3. education specific to suicide and self-harm risk

E. Conditions of Coverage
CareSource reserves the right to request member records for analysis or post-payment audit.

F. Related Policies/Rules
Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	06/19/2024	New policy. Approved at Committee.
Date Revised		
Date Effective	10/01/2024	
Date Archived		

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