Suicide Risk Assessment

Linehan Risk Assessment & Management Protocol
Ft. Belknap Case Study

Dewey J. Ertz, Ed.D & Regina S. Ertz, Ph. D

September 13, 2023

Current Need for Suicide Risk Assessment

Suicide in youth ages 10-14 and 15-19 years of age have increased 178% and 76% respectively in the past decade in the United States.
(Hughes, et al (2023)

Suicide is now a national priority with the Surgeon General releasing a call to action in 2021.
(https://www.hhs.gov/surgeongeneral/reports-and-publications/suicide-prevention/index.html)

Our Focus Today

1. Identify individuals who are experiencing suicidality
2. The use of various tools to address suicidality and risk assessment
3. Linehan Risk Assessment and Management Protocol (LRAMP)
4. Review case study from Ft. Belknap regarding application of suicide risk assessment

Identifying Individuals who are Experiencing Suicidality

Individuals experiencing suicidality are often classified in three levels of risk.

These levels are further referred to as **high, medium, and low risks** for self harm.

Level 1 (Lower Risk)

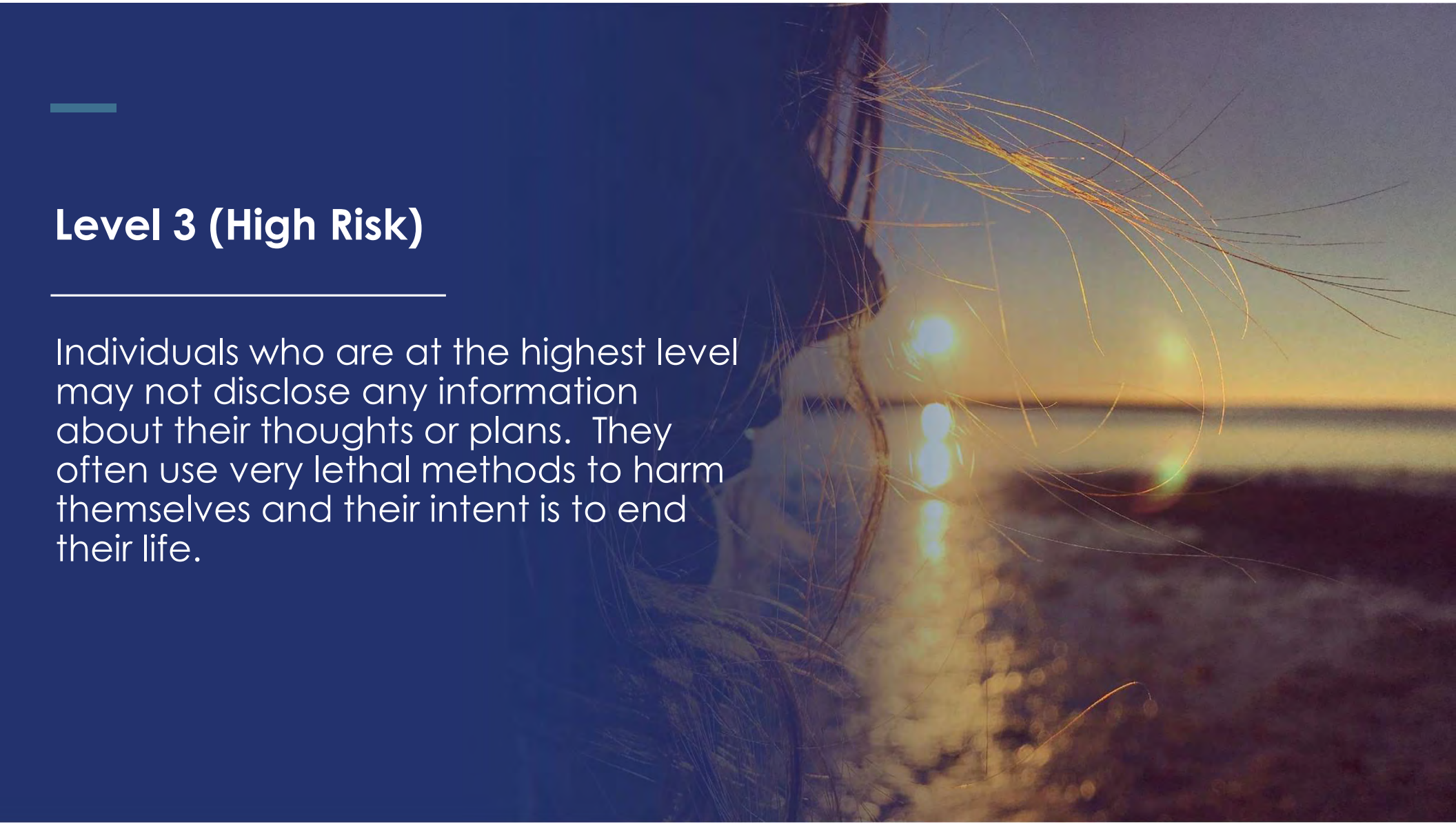
Individuals at this level frequently provide a great deal of information regarding what they are thinking, and their history is easily solicited using standard mental health interviewing methods.

Level 2 (Medium Risk)

These individual are less likely to share pertinent information about their thoughts of harming themselves and related triggers they may experience. They often employ more lethal methods when attempts are made to harm themselves. They avoid seeking help from mental health professionals and other people.

Level 3 (High Risk)

Individuals who are at the highest level may not disclose any information about their thoughts or plans. They often use very lethal methods to harm themselves and their intent is to end their life.



Tools to address Suicidality and Risk Assessment

Several assessment tools have been developed to address these wide needs of intervention. Intervention decision making needs to focus on the person and when they are seen.

It is important to understand that risk levels are not static among individuals with thoughts or plans to harm themselves and these risks can change between occasions and individuals.

Protocols

- Protocols are used to identify procedures for use in certain situations.
- They may contain specific processes or a diverse range of techniques.
- Protocols change over time with new information and research.

Both best practices, which are methods agreed on by practitioners, and evidence-based practices that are based on specific research studies showing causation, are included in these approaches.

Using Protocols

The onset of protocol use is difficult to date; however, protocols were used in Western culture during the 1500s or even before this date.

The **use of protocols in practice expanded** every year during the 48 years of my career.

This corresponded to the use of the following:

- **Better research**
- **Lower error rates in psychometric testing**
- **Improved treatment methods** that were evidence-based rather than based on best practices and
- **Identifying risk factors** that had not been previously identified.

Assessing and Interviewing Patients

•There is not "a correct way" to complete interviews and assessments with patients experiencing suicidality.

•Research has identified that "thinking about suicide is the challenge lurking below the surface".

•Protocols are used to ensure that needed areas are considered and/or questioned.

Example of Protocol Use

Using a specific protocol with individuals who had made some type of comment or displayed actions of self-harm before they were released from custody (lower or medium risk levels).

One criterion in this protocol was that individuals were not seen until they had reached a zero level on PBT testing, (primary breath test). The time between the person's last consumption of alcohol and when this criterion was met is usually longer for females than males.

Protocol Use & Risk

Individuals displaying a higher level of risk received increased screening. Mental status examinations and at times psychological evaluations were completed with individuals who displayed repeated episodes or other types of increased safety concerns. A log was maintained every year for individuals who displayed some type of suicidal concern.

Gestures and attempts **decreased from 77 per year to 33 per year** when these techniques were implemented.

The LRAMP as a Tool

The Linehan protocol **provides a history of suicidal thought, attempts, and information on suicidal self-injury**. It can be utilized at various times.

A suicide risk assessment is provided with **acute risk factors and protective factors**. It also provides a section for suicide risk management.

The LRAMP as a Tool (2016 Version)

- Structure Formal Assessment of Current Suicidal Risk
- Select Acute Suicide Risk Factors
- Population/Setting Specific Acute Suicide Risk Factors
- Suicide Protective Factors
- Suicide Risk Management
- Final Disposition

The UWRAP and UWRAMP

(University of Washington Risk Assessment Protocol/University of Washington Risk Assessment and Management Protocol)

- These protocols are previous versions of the Linehan.
- No interrater reliability assessments were identified from these protocols.
- The protocols were identified as representing minimum standards of care in a 2012 article.
- No research using American Indian/Alaska Native subjects was identified.

Using the LRAMP: A Case Report

Carmel (2018). This article utilized the 5/10/16 edition of the LRAMP.

- The case study reviewed the person's history of suicidal behavior, the individual's urges to self-injure, increased suicide ideation, suicide communication, and suicide attempts/self-injury history.
- The individual was identified as a complex patient and the case report included an individual crisis plan.

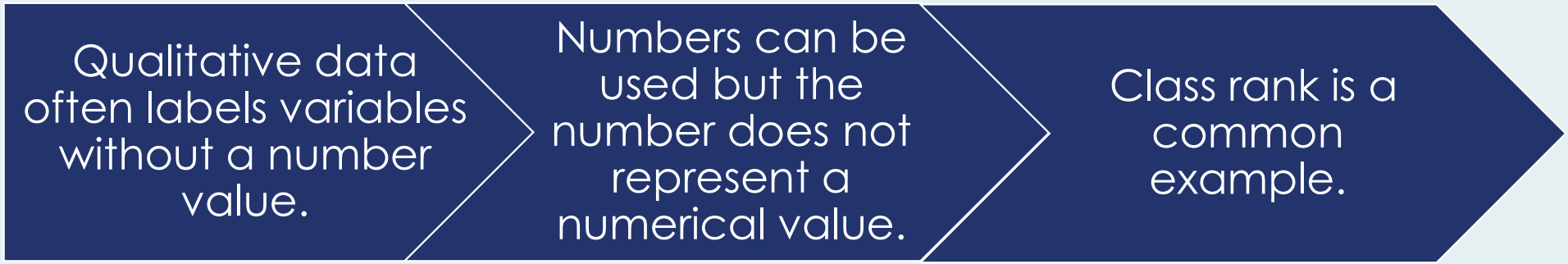
Data from a Recent Systematic Review

A systematic review published in 2023 identified that chronic suicidality is often found in borderline personality disorder and other depressive disorders.

This co-morbidity has been previously identified and it is a reminder for clinicians to consider various areas in evaluating risks.

Types of Data

To understand statistics and research, it is first important to understand the types of data and how it is used.



Ordinal Data

Qualitative data is based on the order of the variables.

- These scales are used to measure information such as wellness, happiness, and whether something is likely or unlikely.
- The differences between the labels are not usually specified using specific numbers or amounts.

Interval Data

Quantitative data involves both order and difference between your numbers.

- It allows you to measure or count values such as means and standard deviation.
- You can make statements about what has caused something to occur by using this approach.

Fort Belknap Indian Community (FBIC) – Case Study

- FBIC has experienced frequent suicidal concerns.
- Suicides ranged around 14 in one year.
- The tribe transitioned from an HIS Program to a 638 contract with a major emphasis on their behavioral health program.
- Crisis calls have been reduced from about 40-60 per month to around 3-5 per month

Behavioral Health Program Structure

Clinical Psychologist, Behavioral Health Program Manager

LCPC therapist-in person

4 telehealth therapists
(1 clinical psychologist, 2 LPC, 1 LAC/LADC/MH)

Community Response Advocate
(responds to crisis situations in person)

We are also involved in the schools through our school-based health grant.

Barriers to Treatment Reduced

Policies written to allow for verbal consent for services, removing the need for patients to complete formal intake forms to receive services.

Options provided for telehealth allowing patients the convenience of not needing to come to an office.

Through our school-based grant, we reach high-risk youth in the schools with verbal permission from caregivers.

Criticism of Telehealth

Telehealth services were criticized in the beginning, however, have flourished and are highly requested.

- Patients often do not want to come into the IHS building for privacy reasons.
- When someone is in crisis, they want help immediately and it no longer matters if it's in person vs. telehealth.

Telehealth services can be a huge asset when you have quality providers who are able to use telehealth services to the fullest.

- Given the demand for telehealth, we had to add 2 more providers.

Intensive Outpatient Services

We meet with high-risk/high-need patients as frequently as needed to stabilize them as outpatients.

Our success has come from our clinical therapists providing routine/structured therapy services to reach baseline in mood symptoms for patients.

- This may include meeting with patients 3x weekly, and slowly reducing that over time.
- Establishing routine therapy services has been the basis of improvement to reduce our crisis intervention needs.

Community Response Advocates

- A **community response advocate is available 24/7** for crisis calls (this was reduced from four to one).
- **In home contact is made** to gather information for the clinical therapist.
- A **therapist is contacted to review the information and decide if they can provide interventions** for the patients to remain in the family's care or if they would need to bring the patient to the IHS ER.

24/7 Access and Response

Our clinical therapists provide open access 24/7 for crisis interventions for patients. This resembles a concierge model centered on individualized, client-centered, approaches to mental healthcare.

- Traditional mental health services might have patients coming into the office or visiting via telehealth once a week or a few times a month.
- This model is less structured than traditional practices, making therapists more accessible to clients during their healing process.
- For clinical providers, this means improving the quality of care that is offered to clients who come through our organization.

Collaboration with IHS

Our working relationship with IHS has improved.

We receive consults for behavioral health services from the IHS ER when patients enter the ER. We are not involved in the ER when assessing suicide severity.

However, we do collaborate together to get patients involved with behavioral health services.

Questions?

Thank you for your time today!

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Aaniiih-Nakoda Integrated Behavioral Health
Safety Planning Intervention Packet

The purpose of the Safety Planning Intervention is to provide people who have experienced a suicidal crisis with a specific set of coping strategies and resources to use in order to decrease the risk of suicidal behavior.

- **Warning Signs for Suicide**
- **Safety Plan: Rationale, Respond, Remove, Review & Revise (5 R's)**
- **Suicide Severity Screener/Assessment**
- **Patient Safety Plan**
- **Suicide Risk Curve: Case Example**
- **Suicide Intervention Resources**
- **FBANHC-Behavioral Health Referral Form**
- **FBANHC-Behavioral Health Consent/ROI Form**
- **Suicide Severity Assessment Procedures**

Aaniiih-Nakoda Integrated Behavioral Health: 406-353-8392
Local IHS Emergency Department: 406-353-3222
National Suicide Prevention Hotline: 1-800-273-TALK (1-800-273-8255)
National Hope Line Network: 1-800-SUICIDE (1-800-784-2433)
LGBTQ+ and Questioning Youth: 1-800-4-UTREVOR (1-800-488-7386)
24/7 Crisis Text Line: TEXT "HOME" to 741-741

Warning Signs for Suicide

Immediate Risk

- Talking about wanting to die or kill oneself
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Talking about feeling hopeless or having no reason to live
- Physically in the moment of despair
- Isolation, loneliness, withdrawal limited ability to identify reasons for living, and limited or no sense of belonging
- A recent loss, such as a breakup, failure, trouble with authorities, death of a loved one
- Giving away personal/meaningful possessions to others

Serious Risk

Other behaviors may also indicate a serious risk- especially if the behavior is new; has increased; and/or seems related to a painful event, loss, or change.

- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

Aaniiih-Nakoda Integrated Behavioral Health Safety Plan: Rationale, React, Respond, Review & Revise (5 R's)

Rationale for Safety Plan

Explain:

- How suicidal crises come and go and identify warning signs (link to individual's own experience)
- How the Safety Plan helps to prevent acting on suicidal feelings
- How the Safety Plan is a series of steps – go to the next step if the current step is not helpful

Respond to the Crisis to Decrease Suicide Risk

Collaborate to:

- Understand the reasons for each step
- Brainstorm ideas for each coping strategy or resource
- Be specific
- Improve feasibility/remove barriers

Remove Access to Lethal Means

Work together to develop an action plan to:

- Limit access to preferred method or plan for suicide
- Limit access to firearms

Review the Safety Plan to Address Concerns

Obtain feedback to assess:

- Helpfulness and likelihood of using Safety Plan
- Where to keep the Safety Plan and when to use it

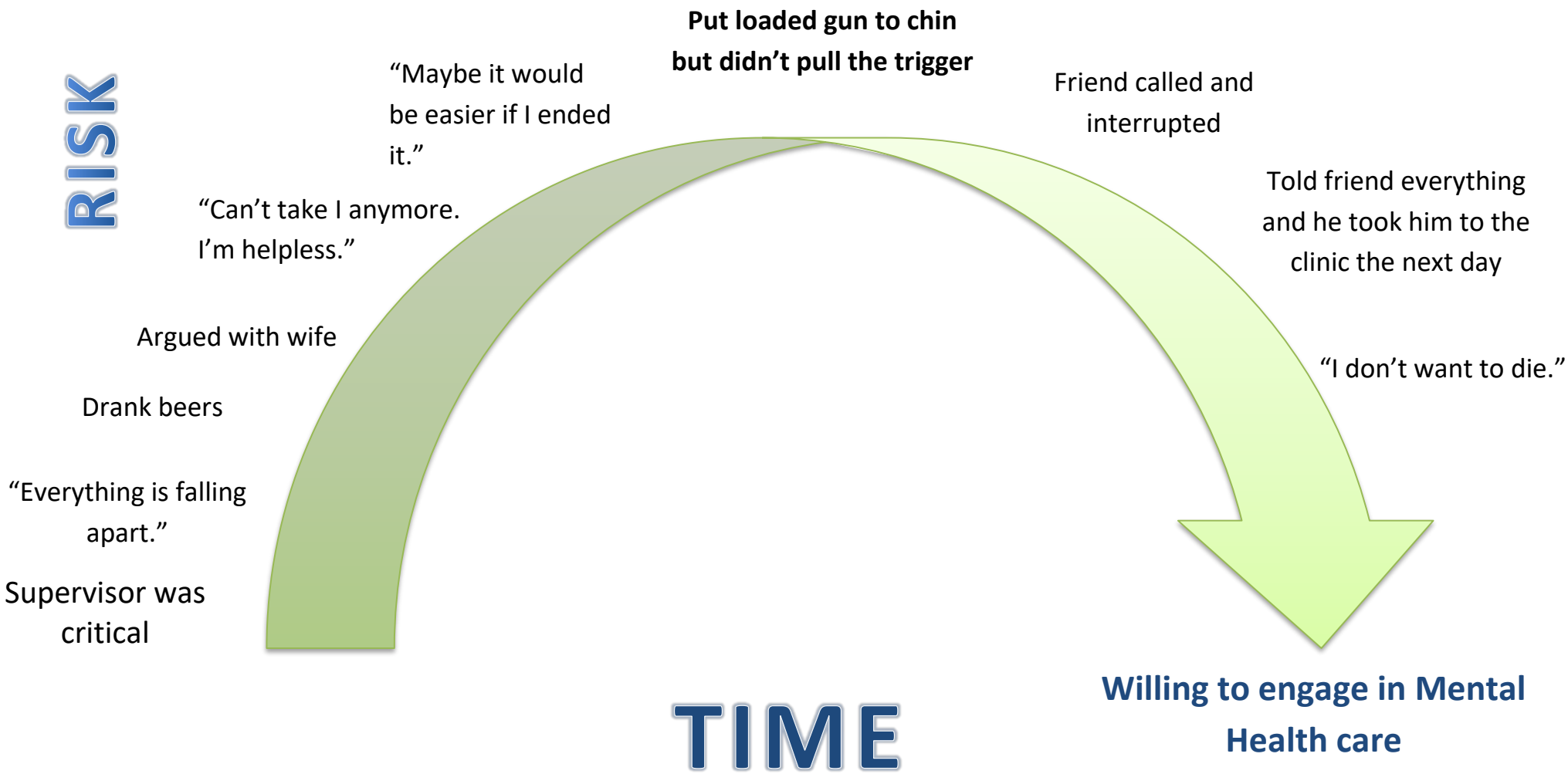
Revise at Follow-up Visits

Ask:

- Do you remember the last Safety Plan you developed?
- Have you actually used your Safety Plan?
- Was the Safety Plan helpful for preventing you from acting on suicidal urges? If not, why not?
- How can the Safety Plan be revised to be more helpful?

Aaniiih-Nakoda Integrated Behavioral Health

Suicide Risk Curve: Case Example



Suicide Hotlines

If you feel suicidal or you're in a crisis situation and need immediate assistance, people at these hotlines in the U.S. are there to help.

- 1-800-273-TALK (1-800-273-8255)
  NATIONAL SUICIDE PREVENTION HOTLINE
- 1-800-SUICIDE (1-800-784-2433)
  NATIONAL HOPE LINE NETWORK
- 1-800-4-UTREVOR (1-800-488-7386)
  LBGTQ AND QUESTIONING YOUTH
- 406-353-3222
  THE LOCAL IHS EMERGENCY DEPARTMENT
- 24/7 CRISIS TEXT LINE: TEXT "MT" TO 741-741
- CALL 911

Tribal Health Employees

Individuals and Availability (*)

Dr. Regina S Ertz 406-399-0121 (24/7)

Jen Strzelczyk 406-399-1914 (24/7)

Dr. Jessica Brody 406-399-3437 (24/7)

Monica Williams 406-399-0302 (24/7)

Terri Mitchell 406-399-0256 (24/7)

Rickey Whisenhunt 406-399-3687 (24/7)

Hannah Has Eagle 406-399-0140 (24/7)

Aaniiih-Nakoda Integrated Behavioral Health Suicide Severity Assessment

Patient Name: _____ DOB: _____

Advocate Name: _____ Assessment Date: _____

1 **Support Patient** for discussing their thoughts

"I'm here to follow-up on your responses to the suicide screening risk questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 **Screen the Patient** using the Columbia-Suicide Severity Rating Scale-Screen Version-Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past Month	
Ask Questions 1 and 2	**YES**	**NO**
1.) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2.) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, asked questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3.) ***Have you been thinking about how you might do this?*** E.g., *"I thought about taking an overdose, but I never made a specific plan as to when were or how I would actually do it … and I would never go through with it."*		
4.) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to, *"I have the thoughts, but I definitely will not do anything about them"*		
5.) ***Have you started to work out or worked out the details of how to kill yourself?*** ***Do you intend to carry out this plan?***		

	YES	NO
6.) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from you hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cute yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past three months?***		

New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu
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- Low Risk
- Moderate Risk
- High Risk

If the patient rates in the moderate-high risk, continue with assessing for suicide severity

"Based on your answers to the suicide severity screener, I'm going to ask you some further questions related to your current thoughts."

Personal Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies- Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Place: _____ 4. Place: _____

Step 4: People whom I can ask for help:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____

Step 5: Professional or agencies I can contact during crisis:

1. Name_____ Phone: _____ Emergency Contact #: _____
2. Name_____ Phone: _____ Emergency Contact #: _____

Local IHS Emergency Department: 406-353-3222
National Suicide Prevention Hotline: 1-800-273-TALK (1-800-273-8255)
National Hope Line Network: 1-800-SUICIDE (1-800-784-2433)

Step 6: Making the environment safe:

1._____

2._____

The one thing that is most important to me and worth living for is:

_____

FORT BELKNAP Aaniiih-Nakoda Integrated Behavioral Health
Patient Referral Notice

Instructions: Information of this form must remain confidential. This form is a tool to be utilized to refer patients to services.

Referring Department _____

Name _____ **Phone** _____

Patient Name _____ **Date** _____

Date of Birth _____ **Phone** _____

Parent(s)/Guardian Name _____

Mailing Address _____

Directions to Home _____ Pediatric Patient **Yes/No**

Type of Service Requested/Behavioral Health Concern

___ Therapy Services (individual/family)	___ Depression	___ Autism Spectrum
___ Suicide Assessment/Intervention	___ Anxiety	___ ADHD
___ Psychodiagnostic Evaluation (testing)	___ Suicidality	___ Intellectual Disability
___ Chemical Dependency	___ Bipolar Disorder	___ Learning Disorder
___ Tobacco Prevention	___ Delusions/Hallucinations	___ Auditory Processing
___ Crisis Intervention	___ Alcohol/Drug Use	___ Developmental Delay
___ School Problems	___ Personality Issues	___ Language/Speech
___ IEP/504 Plan Request	___ Major Life Stressors	___ Behavior Problems
___ Employment Problems	___ Inappropriate Sexual Bx	___ Physical Violence
___ Domestic Abuse	___ Abuse/Neglect	___ Trauma
___ Mental Disability	___ Adjustment Issues	___ LGBTQ+ Issues
___ Dementia Concerns	___ Grief/Loss	___ Other

Brief Description of Problem _____

_____

_____

List all actions taken by Integrated Behavioral Health Program and send form back to referring department (if applicable) _____

_____

Behavioral Health fax number 406-353-2884 Jaada Main 406-353-8392

Fort Belknap Aaniiih-Nakoda Integrated Behavioral Health
CONSENT FOR SERVICES

Application is hereby made by the undersigned for voluntary admission for services at the Fort Belknap Aaniiih-Nakoda Health Center (FBANHC) Program, as a voluntary patient. Please refer to the FBANHC Program Overview for a description of the services offered.

Voluntary admission may be made for any person eighteen (18) years of age. Any person at least sixteen (16) years of age may be admitted with the consent of such person without parental consent, unless under special circumstances. This includes a minor who is legally separated from their parent/legal guardian, married, has a child, or graduated from high school (MCA; 41-1-402, 2021). I have read, or had read to me, the following information about my rights.

1. I consent to behavioral health treatment with the FBANHC Program for myself/minor child/designee. I understand all patients of the FBANHC Program are eligible to receive a range of services addressing all areas of concern outlined in the Program Overview.

2. All persons shall have the rights guaranteed by the Notification of Patient Rights, unless these standards, or an order of a court of competent jurisdiction, specifically authorizes an exception.

3. I have been given a summary, or a full copy of my rights, as a patient and fully understand the content of this document. I understand that my treatment records may be subject to review by funding sources and accrediting bodies to verify and evaluate the services rendered.

4. I understand that data collection will be completed as part of my initial intake assessment to assist my provider in determine the most appropriate diagnosis and treatment recommendations; follow-up appointments to track treatment progress and evaluate symptom severity; and suicide assessment and intervention. I understand that this data collection may be subject to review and use for funding sources and accrediting bodies.

5. I understand that, as a patient of the FBANHC Program, my behavioral health services will include suicide assessment and intervention as part of our commitment to Zero Suicide within the Fort Belknap Indian Community.

6. I understand that I have the right to ask any questions I may have about the process, methods, duration, and goals of my behavioral health treatment; the right to discuss any concerns I may have about my progress in my behavioral health treatment; and the right to terminate my behavioral health treatment at any time. This includes the development of an individualized treatment plan through a collaborative treatment team effort.

7. I understand the various behavioral health treatment offered provide significant benefits and may pose risks, which can be discussed with my designated behavioral health provider. I understand the process of behavioral health recovery may include relapse. I understand the success of my behavioral health treatment is dependent upon motivation to change with the therapeutic support of the FBANHC Program professional staff.

8. I understand that one of my most important rights involves privacy and confidentiality. I understand that a confidential psychological record of the care and services I receive will be securely and privately maintained in order to provide quality care and to comply with certain legal and ethical requirements. I also understand that an electronic record will be maintained. I understand that the medical doctors, nurse practitioners, and staff associated with the Indian Health Service (IHS) Clinic will NOT have access to my behavioral health records without my written consent. Also, I understand the professionals and staff associated with the FBANHC Program WILL have access on a need-to-know basis should services be billed, I sign a ROI, or if a complaint I

shared requires clinic administration to investigate. I have received a copy of the Notice of Practices to Protect the Privacy of Health Information and I have been provided an opportunity to review the legal duties, privacy practices, and my rights regarding the use and disclosure of my confidential psychological information. I understand that the use and disclosure of my psychological information will not be permitted without my specific written authorization. I understand that any specific written authorization I provide may be revoked at any time by writing to this office. I understand there are certain legal and emergency situations in which it is required by law and/ or professional ethics that specific information obtained during treatment may be used and disclosed. The use and disclosure of specific psychological information have been described in the Notice of Practices to Protect the Privacy of Health Information. My signature below acknowledges that I have read and understand the Notice of Practices to Protect the Privacy of Health Information and that this signature page will be kept in my psychological record.

9. I understand that the FBANHC Program does not require any financial responsibility from the patient for care and treatment services outlined in the Program Overview. I understand that, if a referral is made for needed or desired service not provided by the FBANHC Program, you may or may not be personally responsible financially for the additional service.

10. The goal of behavioral health treatment is to reduce psychological distress and improve interpersonal conflict, and that process depends on trust and openness during treatment. Therefore, the patient agrees to not to use information given to the treatment professional for the patient's own purposes in a legal proceeding of any kind. If the treatment professional is somehow legally compelled to attend a legal proceeding of any kind, the patient agrees and understands that: a) the professional will not render an opinion on the issues of divorce, parental fitness, child custody, disability, or any other legal or medical conclusion; and b) the professional will not render any testimony or make any statement of any kind absent an express, written waiver of confidentiality executed by the patient.

11. I understand that, by signing this document, I certify that I give my written consent for behavioral health services, as defined in the Program Overview, data collection, and suicide assessment/intervention for the duration of individual treatment plan established with my provider upon my initial intake assessment. I understand that this form is valid for one year from the signature date and will be reviewed/resigned on a yearly basis. I understand that I can revoke my consent for treatment, verbally, to my provider or other FBANHC professional staff at any time. In the event that I choose to verbally revoke my consent for treatment, I understand that this will be documented in my psychotherapy notes by my provider. I understand that, if I choose to return for services after verbally revoking my consent for treatment, I will be required to review and resign this document to provide/validate my written consent for ALL behavioral health services.

12. I certify that I understand the contents of this document, I have read the Notice of Practices to Protect the Privacy of Health Information, and I give my written consent for behavioral health services.

_____	_____	_____	_____
Patient Signature (age ≥14 years)	Date	Parent/Guardian if minor	Date

_____	_____
Provider Signature	Date

Fort Belknap Aaniiih-Nakoda Integrated Behavioral Health
HIPAA AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ SSN: _____

I authorize the following using or disclosing party; Fort Belknap Aaniiih-Nakoda Health Center **to use or disclose the following health information:** (check all that apply)

☐ All my Behavioral Health records pertaining to _____.
☐ Release records covering the period beginning on _____ (date) and ending on _____ (date).
☐ Treatment Reports/Progress and Attendance Verification.
☐ Verbal/written communications to_____.
☐ Other (e.g., school behavior/academic progress/etc.): _____.

These records will be used for (e.g., continuity of care/follow-up care) _____.

The purpose of this authorization is: (check all that apply) ☐ At my request. ☐ Other: _____.

The above party may disclose this health information to the following recipient:

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Release records or information including: to have verbal and written communication with Fort Belknap Aaniiih-Nakoda Health Center including access to medical/behavioral health records and insurance needs with a Benefit Specialist.

This authorization expires on _____, or one year from today's date. I understand that I have the right to revoke this authorization, in writing, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party) and that I may have the right to refuse to sign this authorization. I understand I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Additional Consent for Certain Conditions: I understand that my medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or behavioral health treatment**. This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. With this knowledge, I freely consent to release the information in my medical records specified above, including information related to my identity. I release the Aaniiih-Nakoda Integrated Behavioral Health as well as their agents and employees from any liability in connection with the release of information to which I have consented.

_____	_____	_____
Patient Signature	Date	Expiration Date From Above

The patient named above is unable to sign this consent because _____. Patient is a minor: _____ years of age.

_____	_____	_____	_____
Signature of Parent/Legal Guardian	Date	Witness Signature	Date

*This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Aaniiih-Nakoda Integrated Behavioral Health Suicide Severity Assessment

Patient Name: _____ DOB: _____

Advocate Name: _____ Assessment Date: _____

1 **Support Patient** for discussing their thoughts

"I'm here to follow-up on your responses to the suicide screening risk questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

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4.) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to, *"I have the thoughts, but I definitely will not do anything about them"*		
5.) ***Have you started to work out or worked out the details of how to kill yourself?*** ***Do you intend to carry out this plan?***		

	YES	NO
6.) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from you hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cute yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past three months?***		

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- Low Risk
- Moderate Risk
- High Risk

If the patient rates in the moderate-high risk, continue with assessing for suicide severity

"Based on your answers to the suicide severity screener, I'm going to ask you some further questions related to your current thoughts."

Personal Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies- Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Place: _____ 4. Place: _____

Step 4: People whom I can ask for help:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____

Step 5: Professional or agencies I can contact during crisis:

1. Name_____ Phone: _____ Emergency Contact #: _____
2. Name_____ Phone: _____ Emergency Contact #: _____

Local IHS Emergency Department: 406-353-3222
National Suicide Prevention Hotline: 1-800-273-TALK (1-800-273-8255)
National Hope Line Network: 1-800-SUICIDE (1-800-784-2433)

Step 6: Making the environment safe:

1._____

2._____

The one thing that is most important to me and worth living for is:

_____

FORT BELKNAP Aaniiih-Nakoda Integrated Behavioral Health
Patient Referral Notice

Instructions: Information of this form must remain confidential. This form is a tool to be utilized to refer patients to services.

Referring Department _____

Name _____ **Phone** _____

Patient Name _____ **Date** _____

Date of Birth _____ **Phone** _____

Parent(s)/Guardian Name _____

Mailing Address _____

Directions to Home _____ Pediatric Patient **Yes/No**

Type of Service Requested/Behavioral Health Concern

___ Therapy Services (individual/family)	___ Depression	___ Autism Spectrum
___ Suicide Assessment/Intervention	___ Anxiety	___ ADHD
___ Psychodiagnostic Evaluation (testing)	___ Suicidality	___ Intellectual Disability
___ Chemical Dependency	___ Bipolar Disorder	___ Learning Disorder
___ Tobacco Prevention	___ Delusions/Hallucinations	___ Auditory Processing
___ Crisis Intervention	___ Alcohol/Drug Use	___ Developmental Delay
___ School Problems	___ Personality Issues	___ Language/Speech
___ IEP/504 Plan Request	___ Major Life Stressors	___ Behavior Problems
___ Employment Problems	___ Inappropriate Sexual Bx	___ Physical Violence
___ Domestic Abuse	___ Abuse/Neglect	___ Trauma
___ Mental Disability	___ Adjustment Issues	___ LGBTQ+ Issues
___ Dementia Concerns	___ Grief/Loss	___ Other

Brief Description of Problem _____

_____

_____

List all actions taken by Integrated Behavioral Health Program and send form back to referring department (if applicable) _____

_____

Behavioral Health fax number 406-353-2884 Jaada Main 406-353-8392

Fort Belknap Aaniiih-Nakoda Integrated Behavioral Health
CONSENT FOR SERVICES

Application is hereby made by the undersigned for voluntary admission for services at the Fort Belknap Aaniiih-Nakoda Health Center (FBANHC) Program, as a voluntary patient. Please refer to the FBANHC Program Overview for a description of the services offered.

Voluntary admission may be made for any person eighteen (18) years of age. Any person at least sixteen (16) years of age may be admitted with the consent of such person without parental consent, unless under special circumstances. This includes a minor who is legally separated from their parent/legal guardian, married, has a child, or graduated from high school (MCA; 41-1-402, 2021). I have read, or had read to me, the following information about my rights.

1. I consent to behavioral health treatment with the FBANHC Program for myself/minor child/designee. I understand all patients of the FBANHC Program are eligible to receive a range of services addressing all areas of concern outlined in the Program Overview.

2. All persons shall have the rights guaranteed by the Notification of Patient Rights, unless these standards, or an order of a court of competent jurisdiction, specifically authorizes an exception.

3. I have been given a summary, or a full copy of my rights, as a patient and fully understand the content of this document. I understand that my treatment records may be subject to review by funding sources and accrediting bodies to verify and evaluate the services rendered.

4. I understand that data collection will be completed as part of my initial intake assessment to assist my provider in determine the most appropriate diagnosis and treatment recommendations; follow-up appointments to track treatment progress and evaluate symptom severity; and suicide assessment and intervention. I understand that this data collection may be subject to review and use for funding sources and accrediting bodies.

5. I understand that, as a patient of the FBANHC Program, my behavioral health services will include suicide assessment and intervention as part of our commitment to Zero Suicide within the Fort Belknap Indian Community.

6. I understand that I have the right to ask any questions I may have about the process, methods, duration, and goals of my behavioral health treatment; the right to discuss any concerns I may have about my progress in my behavioral health treatment; and the right to terminate my behavioral health treatment at any time. This includes the development of an individualized treatment plan through a collaborative treatment team effort.

7. I understand the various behavioral health treatment offered provide significant benefits and may pose risks, which can be discussed with my designated behavioral health provider. I understand the process of behavioral health recovery may include relapse. I understand the success of my behavioral health treatment is dependent upon motivation to change with the therapeutic support of the FBANHC Program professional staff.

8. I understand that one of my most important rights involves privacy and confidentiality. I understand that a confidential psychological record of the care and services I receive will be securely and privately maintained in order to provide quality care and to comply with certain legal and ethical requirements. I also understand that an electronic record will be maintained. I understand that the medical doctors, nurse practitioners, and staff associated with the Indian Health Service (IHS) Clinic will NOT have access to my behavioral health records without my written consent. Also, I understand the professionals and staff associated with the FBANHC Program WILL have access on a need-to-know basis should services be billed, I sign a ROI, or if a complaint I

shared requires clinic administration to investigate. I have received a copy of the Notice of Practices to Protect the Privacy of Health Information and I have been provided an opportunity to review the legal duties, privacy practices, and my rights regarding the use and disclosure of my confidential psychological information. I understand that the use and disclosure of my psychological information will not be permitted without my specific written authorization. I understand that any specific written authorization I provide may be revoked at any time by writing to this office. I understand there are certain legal and emergency situations in which it is required by law and/ or professional ethics that specific information obtained during treatment may be used and disclosed. The use and disclosure of specific psychological information have been described in the Notice of Practices to Protect the Privacy of Health Information. My signature below acknowledges that I have read and understand the Notice of Practices to Protect the Privacy of Health Information and that this signature page will be kept in my psychological record.

9. I understand that the FBANHC Program does not require any financial responsibility from the patient for care and treatment services outlined in the Program Overview. I understand that, if a referral is made for needed or desired service not provided by the FBANHC Program, you may or may not be personally responsible financially for the additional service.

10. The goal of behavioral health treatment is to reduce psychological distress and improve interpersonal conflict, and that process depends on trust and openness during treatment. Therefore, the patient agrees to not to use information given to the treatment professional for the patient's own purposes in a legal proceeding of any kind. If the treatment professional is somehow legally compelled to attend a legal proceeding of any kind, the patient agrees and understands that: a) the professional will not render an opinion on the issues of divorce, parental fitness, child custody, disability, or any other legal or medical conclusion; and b) the professional will not render any testimony or make any statement of any kind absent an express, written waiver of confidentiality executed by the patient.

11. I understand that, by signing this document, I certify that I give my written consent for behavioral health services, as defined in the Program Overview, data collection, and suicide assessment/intervention for the duration of individual treatment plan established with my provider upon my initial intake assessment. I understand that this form is valid for one year from the signature date and will be reviewed/resigned on a yearly basis. I understand that I can revoke my consent for treatment, verbally, to my provider or other FBANHC professional staff at any time. In the event that I choose to verbally revoke my consent for treatment, I understand that this will be documented in my psychotherapy notes by my provider. I understand that, if I choose to return for services after verbally revoking my consent for treatment, I will be required to review and resign this document to provide/validate my written consent for ALL behavioral health services.

12. I certify that I understand the contents of this document, I have read the Notice of Practices to Protect the Privacy of Health Information, and I give my written consent for behavioral health services.

_____	_____	_____	_____
Patient Signature (age ≥14 years)	Date	Parent/Guardian if minor	Date

_____	_____
Provider Signature	Date

Fort Belknap Aaniiih-Nakoda Integrated Behavioral Health
HIPAA AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ SSN: _____

I authorize the following using or disclosing party; Fort Belknap Aaniiih-Nakoda Health Center **to use or disclose the following health information:** (check all that apply)

☐ All my Behavioral Health records pertaining to _____.
☐ Release records covering the period beginning on _____ (date) and ending on _____ (date).
☐ Treatment Reports/Progress and Attendance Verification.
☐ Verbal/written communications to_____.
☐ Other (e.g., school behavior/academic progress/etc.): _____.

These records will be used for (e.g., continuity of care/follow-up care) _____.

The purpose of this authorization is: (check all that apply) ☐ At my request. ☐ Other: _____.

The above party may disclose this health information to the following recipient:

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Release records or information including: to have verbal and written communication with Fort Belknap Aaniiih-Nakoda Health Center including access to medical/behavioral health records and insurance needs with a Benefit Specialist.

This authorization expires on _____, or one year from today's date. I understand that I have the right to revoke this authorization, in writing, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party) and that I may have the right to refuse to sign this authorization. I understand I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Additional Consent for Certain Conditions: I understand that my medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or behavioral health treatment**. This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. With this knowledge, I freely consent to release the information in my medical records specified above, including information related to my identity. I release the Aaniiih-Nakoda Integrated Behavioral Health as well as their agents and employees from any liability in connection with the release of information to which I have consented.

_____	_____	_____
Patient Signature	Date	Expiration Date From Above

The patient named above is unable to sign this consent because _____. Patient is a minor: _____ years of age.

_____	_____	_____	_____
Signature of Parent/Legal Guardian	Date	Witness Signature	Date

*This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.