ADMINISTRATIVE POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Documenting Self Harm in Residential Settings-AR PASSE-AD-1436	09/01/2026
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

Individuals who self-harm in any manner are statistically at a higher risk of attempting or dying by suicide without effective intervention(s). Common examples of self-harm include cutting, severe scratching, burning, and banging or hitting body regions. Rates of self-harm are highest among adolescents and younger adults and may be higher in females. The estimated prevalence of self-harm in clinical populations is estimated at 50-70%.

Residential settings offer a variety of benefits for the treatment of behavioral health issues. 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.

The evaluation of members demonstrating self-harming behaviors or suicidal ideation 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 the treatment of behavioral health issues. Knowledge of thematic analyses of peer-reviewed literature surrounding self-harm enables practitioners to more effectively evaluate member intent to harm and to intervene to provide individualized and effective interventions. Facilities must create an environment of care fostering 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 the health and safety of a member and includes events that are reportable, requiring submission of an Incident Report to the Dept of Human Services (DHS) and CareSource.
- **Residential Setting** – Any behavioral health or substance use treatment setting with services provided under the direction of a physician, nurse practitioner, or physician assistant that includes an overnight stay.
- **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 with 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 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 any threat is removed, 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, nurse practitioner, or physician assistant to discuss assessment results, findings, and rationale for safety precautions, while obtaining any orders or other measures (ie, safety plan, 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 filed, or changes in care in the medical record and complete any additional reporting requirements, including DHS or CareSource 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 (requirements may 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. Incident Reporting and Follow-up Actions
1. All residential programs comply with State licensing and certification requirements for incident reporting including notification timelines to DHS and to CareSource.
2. After review, CareSource may request follow-up information or a follow-up report from the provider.

II. Best Practice Standards
A. Initial Screening and Assessment for Self-Harm and Suicide
1. 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, nurse practitioner, or physician assistant. Common assessment components should include, at a minimum
   a. psychiatric and medical history, including mental or physical illness and past and current medication
   b. current or recent thoughts of suicide or self-harm
   c. recent and past history of suicide attempts and self-harm, including frequency of attempts, methods, and lethality
   d. evidence of self-harm or suicide planning, intent, and access
   e. clinical presentation, including symptoms and behaviors
   f. member engagement and reliability in treatment and compliance
   g. risk formulation, including risk status, factors, and risk state (eg, mental or physical illness, substance use, recent loss, history of trauma, stress)
   h. potential triggers (eg, family or relationship issues, discord with peers, isolation, academic issues, physical health issues, discrimination)
   i. protective factors (eg, coping skills, cultural identification, perceived reasons for living, support from others, religious beliefs, strengths)
   j. changes in appetite or sleep or lack of interest in typical activities (eg, social withdrawal, low energy, flat facial expressions)
2. The admission nurse will document actions taken or precautions implemented and contact the physician, nurse practitioner, or physician assistant for appropriate orders, including an increase or decrease in level of observation based on immediacy and seriousness of risk presented. A registered nurse may initiate suicide precautions or an increased level of observation while awaiting a formal order but may not discontinue precautions or reduce the level of observation, as an 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.
3. The physician, nurse practitioner, or physician assistant 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 individualized treatment plan.

B. Reassessment of Risk
   1. Reassessment of suicidality and self-harm will occur as clinically indicated and at least every waking shift for all verbal and responsive members in acute care settings and at least weekly for members in all other residential settings. Based on disposition, the staff member may complete a more in-depth assessment, as indicated.
   2. Members rating as a moderate to high risk for self-harm or suicide attempts will be discussed with the staff physician, nurse practitioner, or physician assistant 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
      a. suicidal or self-harm statements or actions
      b. attempts to elude staff observation
      c. abrupt changes in mood, both positive and negative
      d. self-isolation
      e. psychomotor agitation
      f. prolonged insomnia
      g. attempts to gain access to items (eg, sharps, housekeeping chemicals)
      h. attempts to gain access to contraband
      i. identifying circumstantial life changes or triggers from past suicide attempts

      NOTE: For non-verbal or unresponsive patients on acute units, 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 possible increase in depression or harming behaviors. The physician, nurse practitioner, or physician assistant will assess these members for risk of self-harm during the daily visit and document such in the member's record.
   3. 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, nurse practitioner, or physician assistant 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 (not an all-inclusive list):
   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 3 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. Ask Suicide-Screening Questions (ASQ) Tool
2. Beck Scale for Suicide Ideation (BSI)
3. Beck Suicidal Intent Scale (SIS)
4. Columbia-Suicide Severity Rating Scale (C-SSRS)
5. Columbia-Suicide Severity Rating Scale-Screen (C-SSRS Screen)
6. Functional Assessment of Self-Mutilation (FASM)
7. Inventory of Statements About Self-Injury (ISAS)
8. Patient Health Questionnaire (PHQ-9)
9. Patient Safety Screener-3 (PSS-3)
10. Paykel Suicide Scale (PSS)
11. Scale for Suicidal Ideation-Current (SSI-C)
12. Self-Harm Screening Inventory (SHSI)
13. Suicidal Behaviors Questionnaire-Revised (SBQ-R)
14. Suicide Ideation Questionnaire (SIQ & SIQ-JR)

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

Behavioral Health Service Record Documentation Standards
Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	06/19/2024	New policy. Approved at Committee.
Date Revised	05/20/2026	Review: updated background, C added definition for residential setting, D.I.C updated to refer to incident reporting requirement sources, D.II updated with current best practices, D.II.D updated list of screening instruments, updated references. Approved at Committee.
Date Effective	09/01/2026	
Date Archived		

H. References

1. *2025-2026 CareSource PASSE Provider Manual*. CareSource. Updated January 14, 2026. Accessed April 20, 2026. www.caresource.com
2. Adult and Long-Term Care Facility Resident Maltreatment Act, ARK. CODE ANN. § 12-12-1701 (2025).
3. Adult Maltreatment Custody Act, ARK. CODE ANN. §§ 9-20-101 to 124 (2023).
4. Andreotti E, Ipuchima J, Cazella S, et al. Instruments to assess suicide risk: a systematic review. *Trends Psychiatry Psychother*. 2020;42(3):276-281. doi:10.1590/2237-6089-2019-0092
5. Apicella M, Pontillo M, Maglio G, et al. Non-suicidal self-injury in adolescents: a clinician's guide to understanding the phenomenon, diagnostic challenges, and evidence-based treatments. *Front Psychiatry*. 2025; 16:1605508. doi: 10.3389/fpsyt.2025.1605508
6. Burstein B, Agostino H, Greenfield B. Suicidal attempts and ideation among children and adolescents in US emergency departments, 2007–2015. *JAMA Pediatr.* 2019;173:598–600. doi:10.1001/jamapediatrics.2019.0464
7. Child Maltreatment Act, ARK. CODE ANN. §§ 12-18-101 to 1202 (2025).
8. Child Welfare Agency Licensing Act, ARK. CODE ANN. §§ 9-28-401 to 416 (2024).
9. Adult and Long-Term Care Facility Resident Maltreatment Act: Definitions, ARK. CODE ANN. § 12-12-1703 (2024).

10. Dillon C, Saab M, Meehan E, et al. Staff awareness of suicide and self-harm risk in healthcare settings: a mixed-methods systematic review. *J Affect Disord*. 2020;276:898-906. doi:10.1016/j.jad.2020.07.113
11. Division of Healthcare Improvement. *Quick Safety: Utilizing Validated Tools for Suicide Risk Screening*. The Joint Commission; 2023. Issue #68. Accessed April 20, 2026. www.jointcommission.org
12. Ellis J, Rabinowitz J, Strickland J, et al. Predictors of suicidal ideation during residential substance use treatment. *J Clin Psychiatry*. 2023;84(4):22m14611. doi:10.4088/JCP.22m14611
13. Glenn C, Nock MK. Nonsuicidal self-injury in children and adolescents: assessment. UpToDate. Updated May 7, 2025. Accessed April 14, 2026. www.uptodate.com
14. Glenn C, Nock MK. Nonsuicidal self-injury in children and adolescents: general principles of treatment. UpToDate. Updated March 2, 2026. Accessed April 14, 2026. www.uptodate.com
15. *Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Provider Manual, Section II*. Arkansas Dept of Human Services. Accessed April 20, 2026. www.humanservices.arkansas.gov
16. Home and Community Based-Services: Waiver Requirements, 42 C.F.R. §§ 441.300 -.310 (2024).
17. Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs, 42 C.F.R. §§ 441.150-.184 (2024).
18. *Inpatient Psychiatric Services for Under Age 21 Provider Manual, Section II*. Arkansas Dept of Human Services. Accessed April 20, 2026. www.humanservice.arkansas.gov
19. Intensive Residential Treatment, ARK. CODE ANN. §§ 20-46-501 to 505 (2024).
20. Kennebeck SS, Bonin L. Suicidal ideation and behavior in children and adolescents: evaluation and disposition. UpToDate. Updated February 10, 2026. Accessed April 14, 2026. www.uptodate.com
21. Liljedahl SI, Daukantaitė D, Kleindienst N, et al. The five self-harm behavior groupings measure: empirical and thematic data from a novel comprehensive self-harm assessment. *Front Psychiatry*. 2023;14:1147206. doi:10.3389/fpsyt.2023.1147206
22. Marcus SC, Hermann RC, Cullen SW. Defining patient safety events in inpatient psychiatry. *J Patient Saf*. 2021;17(8):e1452-e1457. doi:10.1097/PTS.00000000520
23. McEvoy D, Brannigan R, Cooke L, et al. Risk and protective factors for self-harm in adolescents and young adults: an umbrella review of systematic reviews. *J Psychiatr Res*. 2023;168:353-380. doi:10.1016/j.jpsychires.2023.10.017
24. Mercado MC, Holland K, Leemis RW, et al. Trends in emergency department visits for nonfatal self-inflicted injuries among youth aged 10 to 24 years in the United States, 2001–2015. *JAMA*. 2017;318:1931–1933. doi:10.1001/jama.2017.13317
25. Minimum Licensing Standards for Child Welfare Agencies – Residential, ARK. CODE ANN. §§ 9-31-101 to 1117 (2025).
26. Provider-Led Arkansas Shared Savings Entity (PASSE) Provider Agreement between CareSource PASSE and the Arkansas Dept of Human Services for the Service Delivery Period January 1, 2023 through December 31, 2026. Arkansas Dept of Human Services. www.humanservices.arkansas.gov

27. Richardson R, Connell T, Foster M, et al. Risk and protective factors of self-harm and suicidality in adolescents: an umbrella review with meta-analysis. *J Youth Adolesc*. 2024;53(6):1301-1322. doi: 10.1007/s10964-024-01969-w
28. Rouski C, Knowles SF, Sellwood W, et al. The quest for genuine care: a qualitative study of the experiences of young people who self-harm in residential care. *Clin Child Psychol Psychiatry*. 2021;26(2):418-429. doi:10.1177/1359104520980037
29. Ruch DA, Sheftall AH, Schlagbaum P, et al. Trends in suicide among youth aged 10 to 19 years in the United States, 1975 to 2016. *JAMA.* 2019;2:e193886 doi:10.1001/jamanetworkopen.2019.3886
30. Schreiber J, Culpepper L. Suicidal ideation and behavior in adults. UpToDate. Updated July 9, 2025. Accessed April 14, 2026. www.uptodate.com
31. Self-harm. National Alliance on Mental Illness. Accessed April 20, 2026. www.nami.org
32. Self-harm. Substance Abuse and Mental Health Services Administration. Accessed April 20, 2026. www.samhsa.gov
33. *Self-harm: Assessment, Management and Preventing Recurrence*. National Institute for Health and Care Excellence (London); 2022. NICE Guideline No. 225. Accessed April 20, 2026. www.ncbi.nlm.nih.gov
34. Shields M, Stewart M, Delaney K. Patient safety in inpatient psychiatry: a remaining frontier for health policy. *Health Aff*. 2018;37(11):1853-1861. doi:10.1377/hlthaff.2018.0718
35. State Plan Home and Community-Based Services for the Elderly and Individuals with Disabilities, 42 C.F.R. §§ 441.700-.745 (2024).
36. Suicide. National Institute of Mental Health. Accessed April 20, 2026. www.nimh.nih.gov
37. Suicidal behavior. Merck Manual, Professional Version. Updated January 2026. Accessed April 20, 2026.
38. Sutanaya P, Jackson D, McNamara S. Suicide: assessment and management. In: StatPearls. Updated August 2, 2025.
39. Therapeutic Communities Certification Manual, ARK. CODE ANN. §§ 20-416-101 to 801 (2025).
40. Twenge J. Increases in depression, self-harm, and suicide among US adolescents after 2012 and links to technology use: possible mechanisms. *Psychiatric Res Clin Prac*. 2020;2(1):19-25. doi:10.1176/appi.prcp.20190015
41. Twenge J, Cooper AB, Joiner TE, et al. Age, period, and cohort trends in mood disorder indicators and suicide-related outcomes in a nationally representative dataset 2005-2017. *J Abnorm Psychol*. 2019;128:185-199. doi:10.1037/abn0000410