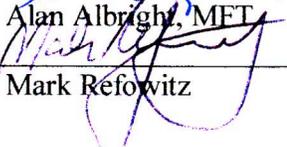


**Practice Guideline  
Health Care Agency  
Behavioral Health Services**

<b>Approvals</b>	<b>SIGNATURE</b>	<b>DATE</b>
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## **Suicide Assessment and Management with Children and Adolescents**

### **I. Initial Contact**

**A. Initial Clinical Contact** Screening for suicidal intent should be part of every initial clinical telephone or face-to-face contact.

**B. Screening** Upon first telephone or face-to-face contact, O.D. clinicians should make efforts to determine the urgency for clinical contact based upon the client's:

1. Level of emotional distress,
2. Recent behavior,
3. Content of statements e.g., suicidal, homicidal thoughts, and/or
4. Nature of situation described.

**C. Information Provided by an Informant** Statements by an informant about a client's suicidal ideation, statements or behavior should always be considered seriously and thoroughly assessed even though they may contradict the client's statements or be denied by the client.

- D. Initial assessment**      The designated clinician should perform and document an emergency assessment in order to ascertain the presence of significant suicide risk and need for emergency management.

**II. EMERGENCY SUICIDE RISK ASSESSMENT**

- A. Components**      The Emergency Suicide Risk Assessment should include the:
1. Exact reason the client has contacted the agency or otherwise came to the agency’s attention
  2. Presence of any acute stressors (e.g. runaway, homeless, significant loss, school difficulties or stresses)
  3. Specific nature of help the client desires (or refusal of help.)
  4. Degree to which the client experiences hopelessness
  5. Type of suicidal thoughts, statements or plans, (including assessment of suicidal ideation by asking questions related to not wanting to live, courting danger, attempting to hurt self, thinking about killing self)
  6. Practicality and lethality of plans (including availability of firearms or lethal medication, note that children and adolescents usually overestimate the lethality of methods so do not judge intent by objective lethality)
  7. Nature of previous attempts
  8. Potential for harm to others
  9. Presence or absence of external incentives for suicidal statements
  10. Acute risk factors, e.g. new onset insomnia, anxiety, acute alcohol or drug use (which may be disinhibiting and raise the risk level for suicide); irritability, agitation, delusional behavior. Threatening, violent persons or those with hallucinations that voice a persistent wish to die are at greater risk.
  11. Evidence of substance-related pathology
  12. Evidence of other mental disorders (disorders known to raise the risk for suicide include depression, mania or hypomania, mixed states or rapid cycling, substance abuse, borderline personality), and
  13. Availability of responsible and concerned significant others.

- B. Determination of Level of Risk**      The emergency risk assessment should clearly document:
1. The estimated degree of suicide risk present, stated as Low, Moderate or High risk (based on the following variables)
    - Presence of recent suicidal ideation or gesture
    - Previous suicide attempt
    - Presence of acute stressors
    - Presence of hopelessness
    - Pattern or history of reckless, dangerous behavior
    - Presence of firearms or lethal medication
    - Presence of current drug or alcohol use
- Low:** No urgent risk, client may be scheduled for next available routine appointment
- Moderate:** No imminent risk, but need for additional

assessment/intervention is urgent and client will be scheduled for first available appointment within 1 day of initial contact

**High:** Imminent risk necessitating immediate intervention. Meets Criteria as a danger to self, danger to others, or gravely disabled minor

High risk primary or secondary diagnosis (see A.12. above)  
Lack of external incentive for suicidal statements  
Lack of responsible or concerned others  
Resistance to mental health intervention

Note that level of risk is not based on simply the number of risk variables present, since severity of each variable needs to be taken into account

2. The basis for determination, e.g. history, behavioral observations, statements of the client or significant others.

**C. Emergency Risk Assessment Follow-Up**

After an emergency risk assessment, the clinician will determine the level of care needed.

**Low Risk:**

1. Client may be scheduled for next available routine appointment (should be within 5 business days or less).
2. Client may be referred to a Community Clinic for mental health services if they do not meet medical necessity criteria.
3. In addition, Client may be referred to other appropriate, non-mental health community resources depending on their needs.

**Moderate Risk**

1. Initiate a full clinical assessment within 1 day of initial contact.
2. In addition, arrange a safety plan with the family, which includes close monitoring of the child (See D.1). Let family know that if minor begins to show an increase in symptoms, another risk assessment should be requested immediately.
3. If the child and family are amenable, they may be referred to intensive in-home crisis services or referred to a short-term crisis residential home. These programs are designed to provide crisis services and divert from unnecessary hospitalization as well as providing linkage to ongoing post-crisis services.

**High Risk**

1. Client should be hospitalized voluntarily if possible. If family/client not willing proceed with involuntarily hospitalization under 5585.5 (Child and Adolescent).

All Risk categories should be given the phone number of the nearest county clinic and the ETS phone number in case of emergency. For life threatening emergencies they should call 911.

Minors at Orangewood Children's Home: Follow the Intensive Supervision Protocol, which includes all risk categories and hospitalize under 5585.5 if minor meets criteria.

Minors at Juvenile Hall: Follow the Crisis Protocol, which includes all risk categories. If minor meets criteria, hospitalize

under 5585.5.

**D. Involvement of Others/  
Confidentiality/  
Safety Issues**

1. Significant others should be notified and engaged to provide support and remove means for suicide as clinically indicated and permitted by statutes, policies and procedures regarding confidentiality. Note that significant others or caretakers, when possible, should verify the absence of firearms or lethal medications in the client's environment.
2. When consent is not possible and a client is at imminent risk of suicide, the clinician should limit the disclosure of confidential information to only that which is necessary to obtain emergency intervention in order to save life.
3. Other agencies, e.g., law enforcement, public health, should be notified depending on the nature and acuteness of risks to others.

**III. COMPREHENSIVE SUICIDE RISK ASSESSMENT**

**A. Indications**

1. Comprehensive Suicide Risk Assessment should be completed for clients:
  - a. Who have recently made a suicide attempt,
  - b. Complain of suicidal thoughts
  - c. Admit to suicidal thoughts when questioned, and/or
  - d. Who demonstrate suicidal behavior.
2. In addition to clients who express suicidal ideas or intent, clients presenting with history of prescribed or illicit drug overdose, single-car auto accidents, "risk taking behavior", and "accidental" self-inflicted trauma should be routinely evaluated for suicidal thoughts.
3. Comprehensive clinical assessment for clients believed at risk for suicidal behavior should be expeditiously initiated, and should be ongoing for as long as clinically indicated.

**B. Documentation**

The comprehensive assessment should be completely documented in the medical record, and suicide-related components of the assessment should be easily found and prominently noted when significant risk is present.

**C. Components**

1. Assessment should at minimum include the complete evaluation for mental disorders and acute stressors performed at the agency in which the client has sought and been offered services.
2. Exact reason the client has contacted the agency or otherwise came to the agency's attention, including the:
  - a. Presence of any acute stressors (e.g. runaway, homeless, significant loss, school difficulties or stresses, medical problems, relationship conflict or loss)

- b. Specific nature of help the client desires (or refusal of help.)
- c. Degree to which the client experiences hopelessness,
- d. Type of suicidal thoughts, statements or plans, (including assessment of suicidal ideation by asking questions related to not wanting to live, courting danger, attempting to hurt self, thinking about killing self)
- e. Practicality and lethality of plans (including availability of firearms or lethal medication, note that children and adolescents usually overestimate the lethality of methods so do not judge intent by objective lethality)
- f. Nature of previous attempts,
- g. Potential for harm to others
- h. Presence or absence of external incentives for suicidal statements,
- i. Acute risk factors, i.e. new onset insomnia, anxiety, (acute alcohol or drug use, which may be disinhibiting and raise the risk level for suicide; irritability, agitation, delusional or threatening, violent persons or those with hallucinations that voice a persistent wish to die are at greater risk)
- j. Evidence of substance-related pathology
- k. Evidence of other mental disorders (disorders known to raise the risk for suicide include depression, mania or hypomania, mixed states or rapid cycling, substance abuse, borderline personality),
- l. Pattern or history of reckless, dangerous behavior and
- m. Availability of responsible and concerned significant others. Other factors that indicate an increased risk such as intoxication, preparations made for death, i.e. the giving away of prized possessions, agitation, feeling a pressure to decisively act, expressing suicidal thoughts in writing, anniversary of a loss.

**D. Assessment of Lethality**

Assessment should include, to the extent possible, factors in the client's physical and psychosocial environment that may increase suicidal risk, e.g., presence of weapons or potentially lethal medications, loss of significant others especially due to suicide.

**E. Assessment Summary**

The assessment should clearly document the estimated degree of suicide risk present, stated as Low, Moderate or High risk and the basis for determination, e.g. history, behavioral observations, statements, related to the components of the assessment:

**F. Treatment Plan Documentation**

The treatment plan derived from the assessment should document the manner in which the estimation was derived, the manner in which the degree of suicide risk has influenced the treatment plan, and any specific measures taken to decrease the risk of suicide.

**G. Measurement of Risk**

Specific instruments to measure suicide risk should be interpreted by qualified clinicians, and should not be used in absence of additional competent clinical assessment. Self – report suicide scales are primarily useful in screening and their usefulness in evaluating a client who has

already presented with a suicide threat is questionable. They cannot substitute for a clinical assessment, and their tendency is to be oversensitive and under specific, yielding false positives but few false negatives. A client who scores positive on a suicide scale should always be assessed clinically. When the assessment of suicide risk differs from a previous assessment of suicide risk, the change should be explicitly noted, the reasons determined, and the manner in which the change affects treatment (or why treatment remains unchanged) should be documented.

**H. Involvement of Others/  
Confidentiality**

1. Within the limits of confidentiality, significant others should be notified of assessed suicide risk and their help enlisted when clinically indicated.
2. Other agencies, e.g., law enforcement, healthcare systems, should be notified depending on the nature and acuteness of suicide risk and risks to others.

**IV. MANAGEMENT OF CLIENTS AT RISK FOR SUICIDE**

**A. Reassessment**

1. Clients at risk for suicide should be regularly reassessed to determine changes in the degree of risk, and treatment plans should be adjusted accordingly.
2. The client's environment should be continually reassessed to the extent practical to detect and mitigate risk factors, e.g., guns, lethal medications. Note that it is not sufficient to ask the client about these variables and significant others or caretakers, when possible, should verify the absence of firearms or lethal medications in the client's environment

**B. Safety Contract Considerations**

1. A "Safety Contract" should not be considered in and of itself as a strategy to lower the risk for suicide and is not a mandated part of treatment of high-risk clients.
2. An individual's willingness to "contract" not to commit suicide (safety contract) should not be considered in and of itself to lower the risk of suicide.

**C. For Clients at Orangewood Children's Home**

If a child or adolescent presents a suicide risk, follow the protocol for Intensive Supervision.

**D. Involuntary Hospitalization**

Involuntary hospitalization should be considered and, where appropriate, immediately implemented for clients at significant risk for suicide. In addition to clients who present a clear-cut imminent risk of suicide, clients who are at risk and whose unstable condition makes their behavior unpredictable are candidates for hospitalization. Prior to deciding to hospitalize a client, intensive in-home crisis services or short-term crisis residential services should be considered as a possible alternative to involuntary hospitalization.

**E. Engagement of Support System**

Within the limits of confidentiality, the client's support system should be kept apprised of the client's suicide risk, and their help should be enlisted whenever clinically appropriate. Significant others and caregivers can be particularly important in "sanitizing" the environment to reduce exposure to firearms and lethal medications, to monitor medications, and to be alert to the presence of known stressors and the dangerousness of the disinhibiting effects of alcohol and drugs.

**F. Therapeutic Interventions**

Provision of hope and motivation to live should be an essential psychotherapeutic intervention for clients at risk for suicide. Cognitive Behavioral Therapy, Interpersonal Therapy, Dialectical Behavior Therapy, and Family Therapy have all been shown to be effective with suicidal patients.

**G. Medication Considerations**

Prescription of psychiatric medication should be undertaken with caution in clients at risk for suicide because of the risk of intentional overdose. The risks versus benefits assessment involved with such a decision should be explicitly documented, along with any steps taken to mitigate risk factors, e.g., having others keep medication for the client. Having a third party monitor medication effects and side effects may be helpful, and is particularly recommended for children and adolescents. Prescribing an SSRI in the treatment of a depressed adolescent requires systematic inquiry about suicidal ideation before and after such treatment is started.

**H. Emergency Support System**

Clients at risk for suicide should be provided with a 24/7 method of establishing contact with mental health resources that can effectively intervene when necessary to decrease suicide risk.

**V. Follow-up services**

In addition to offering supportive services to the families/significant others of a victim of suicide, referrals to the unique services tailored to the survivors of suicide should be considered, e.g. the "Survivors After Suicide" group. Therapists and staff who experience the suicide of a client may receive support services through the HCA Employee Assistance Program.