Behavioral Health Services (BHS)

Guidelines for Suicide Assessment and Treatment Practice

2019

Approval	Signature	Date
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Introduction

Purpose

The purpose of the Suicide Assessment and Treatment Practice Guideline is to help BHS Providers make informed decisions about assessing and providing ongoing treatment to individuals experiencing suicidal ideation, those at higher risk for suicide, and individuals exhibiting warning signs of danger to self. This Guideline will provide BHS Providers with information about evidence-based and clinically sound interventions which can be used to assess suicide risk factors and warning signs, and help minimize potential for self-harm, suicide attempts, and death by suicide.

This Practice Guideline is intended to address the assessment and treatment of suicidality experienced by individuals of all ages, and integrates the recommendations previously outlined in the *Suicide Assessment and Management with Children and Adolescents Practice Guidelines* developed in 2006 by the Health Care Agency (HCA).

Intended Audience

Behavioral Health Services (BHS) Providers offering services to children, adults, and older adults within HCA's County or County-contracted behavioral health programs are the primary audience for this guideline. The following practice guidelines are intended to help the BHS Provider make informed decisions about assessing children, adolescents, adults, and older adults who may be experiencing suicidality, and to provide guidance about how to support the individual through this crisis.

Definition of Terms

Minor is any individual under the age of 18 who is not married or divorced, currently in active military duty, or legally emancipated by the court.[1]

Safety Plan is a prioritized written list of coping strategies and sources of support that individuals can use during or preceding a suicidal crisis. It is a predetermined set of coping strategies, social support activities, and help-seeking behaviors identified by the individual, which they feel will be most effective with preventing and managing exacerbation of symptoms and/or suicidality.[2]

Self-Inflicted Injuries are suicidal and non-suicidal behaviors such as self-mutilation or deliberate self-harm, which is the willful self-inflicting of painful, destructive, or injurious acts.[3,4]

Suicidality is comprised of the thoughts, plans, behaviors, and/or intent to die by suicide.

Suicide is self-inflicted death with evidence (either explicit or implicit) that the person intended to die.[4]

Suicide attempt is a self-injurious behavior with a nonfatal outcome accompanied by evidence (either explicit or implicit) that the person intended to die.[4]

Suicide Contagion is an increase in suicide and suicidal behaviors, especially in adolescents and young adults, when people are exposed to suicidal behaviors within one's family, peer groups, or through media reports.

Suicidal Ideations are thoughts of serving as the agent of one's own death. Ideation may vary in seriousness depending on the specificity of suicidal plans and the degree of suicidal intent.[4]

Background

Development of Guideline

This Practice Guideline was developed by the Behavioral Health Services (BHS) Practice Guidelines Workgroup, which is a committee of clinicians, supervisors, psychiatrists, and BHS managers who represent all BHS areas (i.e., Adult and Older Adult Behavioral Health (AOABH), Children, Youth and Prevention Behavioral Health (CYPBH), and Authority and Quality Improvement Services (AQIS)). The Practice Guidelines Workgroup was developed to create and standardize clinical practice guidelines within BHS. The Guideline was developed based on a review of the literature and other popular research sources (e.g. internet websites) in the field. Workgroup Leads oversaw all aspects of the development of the practice guideline, including bringing the team together to discuss and review, delegate sections, set timelines, and develop all initial, intermediate, and final drafts of the practice guideline. The workgroup also included BHS Clinicians and Service Chiefs with experience providing direct service to individuals, including those with suicidal ideation. These workgroup members provided review and feedback on the working practice guideline document, assisted in identifying best practices from the research to be included in the practice guideline, assisted with summarizing the evidence, and developed quick guides once the full practice guideline was finalized. The Workgroup also included researchers, who reviewed and commented on the practice guideline outline and drafts, identified relevant research to support the documentation of need, and gathered and summarized evidence to support suggested practices.

Selection of Evidence

Evidence for this practice guideline was gathered from literature published in peer-reviewed journals and information published on the websites of government and professional organizations that provide information on mental health. Evidence was excluded if it was not published in a peer-reviewed journal or on the website of a reputable government or professional organization.

A formal literature search was conducted to identify relevant peer-reviewed publications through the PubMed, EBSCOhost, and Google Scholar databases. The literature search included publications published through January of 2018. No sources published prior to 2000 were included. Keywords used in the literature search included: “suicide”, “suicidality”, “suicidal ideation”, “suicidal thoughts”, “prevalence of suicide”, “prevalence of suicidality”, “prevalence of suicidal ideation”, “suicide treatment recommendations”, “suicide assessment tool”, “suicide screening”, “suicide warning signs”, “suicide risk factors”, “impact of suicidal thoughts”, and “impact of suicidality”. Publications returned through the literature search were screened using titles and abstracts; publications that passed initial screening were subsequently thoroughly reviewed for relevant evidence.

In addition, informal searches for relevant evidence were conducted using websites of government and professional organizations, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institutes of Mental Health (NIMH), the Centers for Disease Control and Prevention (CDC), and the American Psychiatric Association (APA). Searches from the websites of these organizations yielded previously published practice guidelines, as well as statistics and facts that were used as evidence for the current practice guideline.

Documentation of Need

BHS recognizes the prevalence and significance of suicidality experienced by participants treated by our County and County-contracted programs. Suicidality can be experienced on a spectrum ranging in severity from suicidal thoughts or ideations, to planning suicide attempts, to completing suicide. At each of these points on the suicidality spectrum there are opportunities for behavioral health providers to intervene. The following data provides the rates of individuals experiencing suicidal thoughts, planning, and death by suicide in children, adolescents, and adults.

National Rates: Nationally, suicide is the third leading cause of death among children 10-14 years old, and second among individuals 15-34 years old.[3] Suicide was the tenth leading cause of death for people of all ages in 2015.[5] Each of these suicides has a profound and devastating impact on family, friends, and the community.

A survey conducted in 2013 indicated that 17% of children in 9th-12th grades had seriously considered attempting suicide in the preceding 12 months, and 13.6% had made a suicide plan.[3] Eight percent of these children had attempted suicide one or more times in the previous 12 months (10.6% of females and 5.4% of males).[3] Among Hispanic children in this age group, 18.9% had seriously considered attempting suicide; 15.7% had made a plan about how they would attempt suicide, and 11.3% had attempted suicide.[3] All of these rates for Hispanic children were consistently higher than their non-Hispanic white or Black counterparts.[3]

Suicidality in children is predictive of later suicidal ideation and attempts in adulthood. There exists a positive correlation between suicidal ideation and anxiety and mood disorders.[6] A 15-year study tracked the development and functioning of adolescents after an onset of suicidal ideation at age 15 years, and found that individuals with suicidal ideation were twice as likely to have a behavioral health diagnosis, and nearly 12 times more likely to have attempted suicide by age 30 years old.[7] These individuals also reported lower self-esteem, fewer coping skills, and poor interpersonal relationships.[7]

As noted above, these suicidal thoughts, plans, and attempts in children and adolescents place individuals at greater risk for suicidality later in life. The percentage of adults who experience serious thoughts about suicide is highest among young adults, age 18-25 years old (7.4%), and these young adults are the most likely age group to develop a plan for suicide compared to other adults.[3] From 2014-2015, the age-adjusted suicide death rate increased by 8% among the Transitional-Age-Youth (TAY) population, aged 15-24 years old.[5]

In 2013, an estimated 9.3 million adults, or 3.9% of the adult U.S. population, reported experiencing suicidal thoughts during the previous year.[3] One quarter of adults who experience serious thoughts of suicide make suicide plans, and nearly two-thirds of individuals who make plans actually attempt suicide.[8] An estimated 1.3 million adults over the age of 18 years old attempted suicide in 2014.[3] Each of these stages –contemplation, planning, and attempting – is an opportunity for BHS Providers to intervene and help individuals maintain safety.

Orange County Rates: Taking a closer look at Orange County, over 2,800 residents intentionally harm themselves seriously enough to require medical treatment each year.[9] It is difficult to determine exactly how many of these individuals intend to end their life when self-harming, but consistent with the national findings mentioned above, women are more likely to intentionally injure themselves or use less lethal means to attempt suicide, such as poisoning, which results in the need for medical attention.

In addition to the prevalence of self-injurious behaviors, there were 1,571 reported suicide deaths of Orange County residents between 2012 and 2016.[9] Seventy-five percent of suicides in Orange County were among men, as they were more likely to use highly lethal means, such as firearms, hanging, or strangulation.[10] Suicide death rates were higher for middle-aged and older adults in Orange County compared to younger adults. Older adults, age 75-84 years old, had an age-adjusted rate of suicide that was almost double that of young adults aged 25 to 34 years old.[10]

County and County-contracted BHS Providers often encounter individuals experiencing suicidal ideation, and the assessment and treatment for the potential crisis of an individual attempting suicide can be stressful and complex. It becomes the BHS Provider's role to properly assess the severity of these thoughts and any imminent self-inflicted harm that might come to the individual sitting in front of them. There is a need for BHS Providers to be up-to-date with evidence-based practices in screening and assessing suicidality as it is within our professional legal and ethical responsibilities, as well as knowing how to effectively provide ongoing treatment to prevent future crises. There is a need for BHS Providers to be up-to-date with evidence-based practices in screening and assessing suicidality, as well as how to effectively provide ongoing treatment to prevent future crises.

Justification

This guideline was developed because of the high-risk and subsequent mortality if suicidality is not addressed. As stated above, suicidality can be present in people of all ages, genders, ethnicities, and socioeconomic groups within our community, and suicides impact a significant number of people when considering the family, friends, and communities impacted by each individual death.

The intended goal of the following guideline is to ensure accurate and effective tools and resources are available to BHS Providers to assist with accurately assessing and treating suicidality, and thereby maximizing the opportunity to reduce suicide attempts and deaths by individuals served by Health Care Agency Behavioral Health Services. The following guideline will focus on the specific recommendations for clinical practice when screening, assessing, and treating those experiencing suicidality in the community.

Consistency with Policies, Regulations, Laws, and Professional Standards

The primary purpose of this Practice Guideline is to educate professional staff and to identify well-supported practices to help guide the provision of high-quality services. The Guideline is designed to educate about desirable professional practices and to recommend specific professional behavior.

The Guideline differs from a Professional Standard in a few meaningful ways. Where a Standard is mandatory and, thus, may be accompanied by an enforcement mechanism, a Guideline is not mandatory, definitive, or exhaustive. This Guideline is intended to be aspirational, with the intent to facilitate continued development of professional practices and to promote high quality services. This set of guidelines may not apply to every professional or clinical situation within the scope of the guideline. As a result, the guideline is not intended to take precedence over professional judgment and the specific program policies.

This guideline is meant to provide consistency with other HCA policies, the Office of Compliance, and any state or federal regulations to which HCA is already adhering. Federal and State laws supersede this Guideline, and for reference about the laws governing assessing and treating an individual who is determined to be a danger to themselves, please refer to:

Lanterman-Petris-Short (LPS) Act

Welfare and Institutions Code (WIC)

Health Insurance Portability and Accountability Act (HIPAA)

Scope of Practice

Practicing BHS Providers may have some fundamental skills in establishing therapeutic rapport and assessing for suicidal ideation and risk for suicide, however, being mindful of scope of practice and level of expertise is imperative when encountering an individual voicing suicidal ideation or who is at risk for suicide. Maintaining ethical standards of practicing within scope and expertise is required to keep individuals safe, and consulting with team members and supervisors, or contacting crisis programs to complete further assessments may be needed.

Guideline

Guideline Statement

This guideline is meant to provide general information about providing assessment, intervention, and care that is evidenced-based and has been found to be effective in situations where a person expresses suicidality. As with any guideline, the purpose is to aid BHS Providers in responding to a crisis or high-risk situation. Clinical judgment, training, and experience, as well as consultation with supervisors and colleagues is always warranted if there are questions that arise in a particular situation. The guideline will outline steps for BHS Providers to identify risk factors and warning signs, screen for suicidality, complete a full evaluation if warranted, provide ongoing treatment for individuals expressing suicidal ideation, and document encounters with individuals being treated for suicidality. Throughout the document, BHS Providers are encouraged to refer to their Division/Agency/Program Policies and Procedures (P&Ps) and/or consultation with direct supervisors for further clarification about how to address issues or instances that might arise within your specific programs or with the specific population served.

Application

When to Assess for Suicide

Suicide screening should always be conducted upon initial phone or in-person clinical contact, and with any subsequent suicidal or self-harming behavior, expressed ideation, pertinent clinical change, or perceived crisis. Screenings should occur after specific stressors, such as hospitalizations, however, significant life stressors can occur at any moment and may indicate a need to perform routine screening and prevention for those who have experienced suicidal ideation in the past. Statements by individuals or other informants (i.e. families/parents/guardians/foster parents) about a person's suicidal ideation, statements, or behavior should always be considered seriously and thoroughly screened. When possible, caregivers should be involved in the assessment and crisis intervention process for minors.[1]

How to Assess for Suicide

Therapeutic Rapport

Essential to building therapeutic rapport is first ensuring safety of both the BHS Provider and individual being assessed for suicidality. If a BHS Provider is able to establish a safe space in which to interview, then attention can be paid to building therapeutic rapport and trust to increase comfort, openness, and a positive interpersonal experience for the individual being assessed. Establishing a therapeutic rapport allows for a collaborative approach to intervention so the individual can be an active participant in any screening, assessment, or short/long-term treatment plans.[11] Therapeutic rapport will help uphold the respect and rights of the individual being assessed, as well as increase recognition of the individual preferences, needs, and activities of the person at risk.[12]

Suicide Screening Tools

Specific instruments to measure suicide risk should be interpreted by qualified BHS Providers, and should not be used without additional competent clinical assessment. Self-report suicide scales are primarily useful in screening, and their usefulness in evaluating a person who has already presented with a suicide threat is questionable.

Brief screening tools and specific instruments to assess suicide risk alone do not substitute a thorough clinical assessment, and their tendency is to be over-sensitive and under-specific, yielding false positives but few false negatives.[11] A person who scores positively on a suicide scale should always be further assessed clinically. When a suicide risk score differs from a previously administered suicide risk assessment score, the change should be explicitly noted in documentation; the reasons determined, and the manner in which the change affects treatment (or why treatment remains unchanged) should also be documented.

BHS Providers should refer to their individual Program/Division/Agency P&Ps and/or their supervisors for direction as to what screening tools are recommended for use with the individuals you serve.

Determining Risk for Suicide

Determining an individual's risk for suicide should encompass a thorough assessment of the individual's risk-, protective-factors and warning signs, integrated with an assessment of suicidality (ideation, plan, means, and intent). Per the Welfare and Institutions code, the BHS Provider who is completing the risk assessment shall not be limited to considering only the danger of *imminent* harm.[1]

While assessing for suicide risk, it is important to synthesize both risk and protective factors in the development of individualized short- and long-term interventions for the individual.[12] Screening and examining all risk and protective factors are intended to prompt BHS Providers to consider a myriad of complex factors in determining an individual's risk for suicide. *A list of the Risk Factors, Protective Factors, and Warning Signs can be found in the **Quick Guide** section of this Practice Guideline.*

Risk factors are the demographics or more enduring attributes of an individual, and should signal the BHS Provider to increase awareness of a higher potential for suicidality.[13,14] Risk factors may include, but are not limited to, a person's age, gender, ethnicity, psychiatric diagnosis, trauma or sexual abuse history, physical illness, and substance abuse history. Having a clear screening process to gather this information is imperative when assessing and providing treatment to individuals experiencing suicidality.

Conversely**, protective factors** can mitigate risk and act as a barrier to following through with suicidal ideation or plans. These may include a person's engagement with treatment, connection to a support network and/or a supportive family, or identification with a meaningful role (i.e. friend, neighbor, or co-worker) within their community.[11,14]

In addition, imminent **warning signs** act as red-flags of suicide or suicidal behaviors in the immediate future. These include current emotional states, behaviors, symptoms, statements, or current stressful life events. Identifying risk factors and imminent warning signs will be an integral part of more effective assessments and treatment for individuals experiencing suicide.[11,14]

Assessing for Suicidality

The other component needed to determine suicide risk is the actual assessment of the suicidality itself. The following section outlines the elements of the suicide assessment that BHS Providers conduct when an individual is experiencing suicidality utilizing open-ended questions. Depending on the situation, these questions can be asked of the individual experiencing suicidality, as well as family or significant others as BHS Providers gather collateral information as appropriate.

Suicidal Ideation – This includes asking questions related to not wanting to live, courting danger, attempting to hurt oneself, thinking about killing oneself or dying, and the degree to which he/she is hopeless about living. Ideation can be experienced as "passive" or "active" thoughts about death or dying. **Passive suicidal ideation** may include: "I hope I don't wake up," "people would be better off without me," or "I wish I was dead." These are typically more fleeting and there is no active planning for suicide. These thoughts may also be more ambivalent than active suicidal ideation. **Active suicidal ideation** may sound like: "I'm going to kill myself," "I will hang myself," "You won't be seeing me anymore." These are typically more severe and decisive about ending one's life, and often contain a component of planning for action. Be mindful of the ambivalent suicidal individual who may experience facets of both active and passive suicidal ideation. Please remember to consult supervisors regarding preventative interventions and safeguards concerning ambivalent suicidal individuals.

Suicide Plan – Ask questions assessing the practicality and lethality if a plan for suicide is mentioned, even transiently. This also includes determining the immediacy or timeframe for the plan. It is important to note that children and adolescents often overestimate the lethality of methods, therefore, thorough assessment of even seemingly non-lethal plans in this population should be completed. Some questions to assess for and about suicide plans may include "Have you thought about *when* you would do it?" "Do you have a plan to take your life?" "Tell me more about your plan," "What other ways have you thought of killing yourself?" or "What type of methods have you thought about using?"

Means to Act on the Plan – This includes determining the presence or accessibility to methods he/she plans to use to harm him/herself or die by suicide. For example, "How/when do you have access to [a gun, medications, knife, etc.]?"

Intent to Follow Through with the Plan – Assess the individual's level of determination to act on the plan for suicide. For example, did the individual mean what they said when they expressed suicidal ideation to a family member? This portion of questioning should include assessing for the presence or absence of external incentives for suicidal statements, such as someone who indicates they are suicidal in order to get a benefit of some sort, such as being hospitalized or accessing crisis residential programs, or someone who is attempting to prevent a break-up.

Effective evaluation for suicide risk will also include using open-ended questions to assess the following in order to gather a more comprehensive picture of the individual and their current environment: [1,12,14]

- The presenting problem that brought the person to your current attention
- The presence of acute stressors (i.e. runaway, homeless, significant loss, school/work/ relationship difficulties or stresses)

- Collateral information provided by family/other/3rd party regarding the historical course of the person's behavioral health , including any recent history of reckless or dangerous behavior, and determining if there are responsible or concerned others to support the individual through the crisis
- Substance use history, including any recent overdoses
- Current signs or symptoms of intoxication
- Medical problems/medical consults
- Current behavioral health diagnosis
- Current acute behavioral health symptoms
- Current medications
- Grave disability/self-neglect risk indicators
- Danger to others risk factors
- Individual strengths

Conducting a complete assessment incorporating all of these factors will help BHS Providers formulate an accurate clinical picture of the individual and make clinically informed judgements about their level of risk for suicide. Risk can be determined to be either *Low*, *Medium*, or *High*. BHS Providers may then provide interventions based upon that determined risk.

Interventions Based upon Level of Risk

Interventions for individuals experiencing suicide are as varied as each distinct individual, and should be tailored to fit the person's unique strengths, stressors, support network, and severity of suicidality. All interventions, however, should be as collaborative as possible with the individual being assessed in order to increase the likelihood of the intervention being effective.[15] The following is an outline of the best practice recommendations for intervening with individuals based upon their level of risk.

Low Risk

This means that although some suicidal thinking may exist, there is no urgent risk of harm. The person may be provided counseling or scheduled for the next available routine appointment. Interventions may include:

- **Therapeutic interventions**, such as crisis interventions, provision of hope and motivation to live, or Motivational Interviewing about current stressors or situations. Cognitive Behavioral Therapy (CBT), Interpersonal Therapy, Dialectical Behavioral Therapy (DBT), and family therapy have all been found to be effective with individuals experiencing suicidality.[14]
- **Shared decision-making** with the individual can empower him/her to feel in control of his/her situation and result in use of natural resources and supports to address symptoms or suicidal thinking.

- **Engagement of support systems**, including peer mentor support if available. Any engagement of support systems needs to continue to comply with HIPAA protections of the individual's right to privacy practices and confidentiality.
- **Provision of resources**, referrals, and/or linkage. Each BHS Program or Clinic should have a list of Crisis and Supportive Resources prepared to provide to individuals and families/supports to assist with managing a behavioral health crisis, such as hotlines or crisis assessment teams contact information. Any coordination of services continues to require compliance with HIPAA and appropriate disclosures of the least amount of information necessary to address the individual's current needs.
- **Safety planning** if symptoms or suicidal ideation increase. This can be both a discussion with the individual and/or a written document that the individual can take with him/her to remind him/her about how to maintain safety. An individual's willingness to "contract" not to attempt suicide (safety contract) should not be considered in and of itself an intervention to lower the risk of suicide or self-harm. Common elements in written safety plans typically include:[2]
    - Recognition of triggers
    - Red-flags/warning signs
    - Symptoms that indicate the individual requires increased support
    - Identification and use of coping skills the individual can use to manage symptoms or feelings brought on by triggers
    - Identification and utilization of support networks to stay safe with natural supports
    - Contacting behavioral health providers; and
    - Reducing the potential use of lethal means.

Medium Risk

This means that there is no imminent risk, but there is need for additional assessment to determine the appropriate treatment level for the individual's safety to mitigate the developing behavioral health crisis. A person presenting with medium risk for suicide may or may not be able to maintain safety in their current environment, depending on their unique circumstance. In addition to the interventions listed above for low risk individuals, also consider:

- **Discussing access** to lethal means or self-injurious behavior, and developing a plan to remove or disable these means of harm.
- Developing a more comprehensive **safety plan** with the individual and his/her family/support network. In addition to the suggested elements of the safety planning listed in the previous "low risk" section, safety planning for moderate risk of suicide should also include, at a minimum:
    - Shared decision-making regarding agreeing to maintain safety
    - Removal or disabling of the means of harm
    - Connection with emergency resources
    - Establishment of frequency of contact. There may be increased contact between the BHS Provider and at-risk individual as clinically indicated based upon his or her unique clinical presentation, support network, and severity of suicidal ideation.

  - Plans for the at-risk individual to increase connectedness by contacting his/her family, community, social institutions, and natural support system
  - Protective activities and use of coping skills
- Consulting and triaging the individual following your Program and/or Agency P&Ps. This may include consulting with supervisors, initiating a 5150/5585.5 evaluation, or contacting the AOABH or CYPBH Crisis Assessment Teams (CAT) to begin 5150/5585.5 evaluation if your program is not LPS Designated.
- Gathering more clinical information to determine the least restrictive treatment options available to provide increased intervention and safety to support the individual through the potential crisis, such as Crisis Residential Programs or In-Home Crisis Stabilization Programs.

High Risk

These individuals are at high risk for suicide, necessitating immediate intervention through either:

- **Voluntary Hospitalization**, if clinically appropriate. For children and adolescents, the parent/guardian should be asked to approve voluntary hospitalization if hospitalization is required. If this is the case, complete the County WIC 6000 Form, which includes most of the same information as an involuntary hold, but includes the parent/guardian signature.[1] If the minor's parent/guardian is unwilling to sign for voluntary hospitalization, then proceed to the Involuntary Hospitalization.
- **Involuntary Hospitalization** - This should be considered and, where appropriate, immediately implemented for individuals at significant risk for suicide. In addition to people who present a clear-cut imminent risk of suicide, individuals who are at-risk and whose unstable condition makes their behavior unpredictable should be considered for hospitalization. Involuntary hold criteria include that the person:[1]
  - Has a behavioral health diagnosis,
  - Is a danger to him/herself (and/or others, and/or gravely disabled), and
  - Is unwilling or unable to accept voluntary services

Documentation of the Suicide Assessment and Interventions

Thorough documentation of the suicide risk assessment will allow BHS Providers to not only account for their comprehensive clinical work, but will also pass on as much information to subsequent providers regarding the person's suicidality, allowing these providers to have more information when/if formulating their own risk assessments.[15] Within the BHS Electronic Health Record (EHR), the *BH Hospital Assessment Progress Note* or *BH Crisis Service Progress Note* will be used to document the assessment, interventions, and disposition after the assessment. BHS and County-contracted providers should refer to Program or Division/Agency P&P's regarding the specifics of how to document these crisis and hospitalization assessments.

Documentation should include all components in the "Determining Risk for Suicide" section above, as well as the determined level of risk, and any formal screening or assessment tools utilized. This means documentation will include:

- The exact reason or presenting problem that prompted risk assessment
- Presence of acute stressors
- Specific nature of help the person desires (or the refusal of help)
- Description of previous suicide attempts or overdoses, if applicable
- Risk and protective factors
- Imminent warning signs or red-flags indicating high risk for self-harm or suicide
- Potential for harm to others
- The individual's determined level of risk (Low, Medium, High)
- The plan for care that was determined through shared decision-making after the risk assessment
- If used, brief screening and suicide assessment tools need to be documented in the individual's chart as part of the risk assessment
- Any consultation or collaboration with other providers or treatment team members

Consultation and Clinical Supervision

During the course of a suicide assessment, it is important to seek consultation with other BHS Providers and/or Supervisors, especially when there is ambiguity about aspects of the individual's risk for self-harm or suicide. Additionally, BHS Providers may not always find consensus with other providers or members of the treatment team when determining a person's level of risk, therefore thorough documentation of the risk assessment and collaboration or consultation with Supervisors becomes all the more important.

As part of good self-care, and to prevent secondary-trauma and burn-out, it is important to seek clinical supervision or consultation after conducting risk assessments for suicide.

Ongoing Treatment and Potential Follow-Up

After assessing and providing clinical interventions or linkage to the most appropriate and least restrictive treatment setting available, it is best practice to provide individuals experiencing suicidality with the opportunity for ongoing long-term treatment or follow-up care. What is required of the BHS Provider for follow-up care or ongoing treatment will be determined within individual programs. Ongoing treatment and/or follow-up may include:

- **Engagement of his/her natural support system**. This may include providing the individual's family/support network with education, therapy, and/or supportive community resources as appropriate so they may provide support to the individual at-risk of suicide
- Linkage to **therapy and/or medication services** if the individual is not already linked. If your program is providing the ongoing behavioral health services after the suicide assessment, recommended evidence-based therapeutic interventions to address suicidal ideation include:[14,16]
    - Dialectical Behavioral Therapy (DBT)
    - Cognitive Behavioral Therapy (CBT)
    - Family therapy
- **Re-assessment for safety** issues and danger-to-self at clinically appropriate follow-up times based upon clinical assessment that includes his/her current presentation, support system, and risk factors. Individuals who are at-risk for suicide should be regularly re-assessed to determine

changes in the degree of risk, and treatment plans should be adjusted accordingly. Likewise, if safety plans have been developed with the individual to help him/her cope with suicidality, these should be periodically reviewed and discussed, as well as possibly revised by the BHS Provider and individual after each time it is used.[2]

In addition to engaging natural supports, linking to ongoing services, and re-assessing for safety, the BHS Provider should consult with supervisors to ensure that expectations are met in regards to program requirements for follow-up and required documentation after the evaluation. This is especially important after the immediate crisis has ended as a lack of follow-through and missing documentation can lead to lapses in the individual's continuity of care.

Deaths by Suicide

If an individual who was receiving services dies by suicide, the BHS Provider should consult with supervisors to determine what next steps are required by their program. These next steps may include notifying other agencies or providers who may also have been working with the individual while continuing to abide by privacy laws outlined by HIPAA, such as requiring an active Authorization to Disclose information. BHS Providers may want to also consider seeking consultation and support from team members or supervisors, if death by suicide of a client does occur, to manage any vicarious trauma or stress response.

In addition to offering supportive services to the families or significant others of a victim of suicide, referrals to the unique services tailored to the survivors of suicide should be considered. BHS Providers and programs who experience the suicide of a client may receive supportive services through the Disaster Response Team or HCA's Employee Assistance Program. Contracted Providers can also utilize the Disaster Response Team or their company's employee support systems.

Special Incident Reporting

A special incident is any incident or situation that could expose the County to possible liability, including incidents involving death, injuries and illnesses, or the loss or destruction of property including client medical records or documents. For information regarding the Special Incident Reporting (SIR) P&Ps and documentation, please go to http://intranet/safety/sir and discuss with your supervisor.

Mandated Reporting

BHS Providers are professionally and legally responsible for reporting child abuse, elder abuse, and/or dependent adult abuse, if, during the course of the assessment, information that indicates a suspicion of abuse is disclosed or uncovered. Refer to HCA BHS P&Ps listed on the BHS website, http://www.ochealthinfo.com/bhs/pnp, for detailed information regarding *Mandated Child Abuse Reporting* and *Mandated Dependent Adult/Elder Abuse Reporting.* These P&Ps contain information regarding filing reports with the appropriate agency within the mandated timelines, as well as how to document that the mandated report was made.

Special Populations

The LGBTQIA+ Community

Please note that the utilization of *LGBTQIA+* is the most inclusive and modern term of identification for this population. However, research obtained for this practice guideline is representative of the lesbian, gay, and bisexual (LGB) population as there is a lack of research representing transgender, queer/questioning, and intersex communities.

LGBTQIA+ youth seriously contemplate suicide at almost three times the rate of heterosexual youth, and are almost five times as likely to have attempted suicide compared to heterosexual youth.[17] As stated above, suicidal ideation or attempts in youth are risk factors for adults to also experience suicidality. LGBTQIA+ youth who come from highly rejecting families are 8.4 times as likely to have attempted suicide as LGBTQIA+ peers who reported no or low levels of family rejection, so BHS Providers will need to consider the family dynamics of any LGBTQIA+ community members to whom they provide risk assessments.[18] Additionally, transgender people report higher prevalence of suicide attempts over their lifetime than LGB or heterosexual people.[19] Higher prevalence of suicidality in the LGBT community has been attributed to a variety of factors, which include: social isolation, low self-esteem, substance abuse, depression, anxiety, and other mental health issues often resulting from or worsened by stigma and discrimination; experiences of prejudice and discrimination, including family rejection, bullying, cyberbullying, harassment and mistreatment; and laws and public policies that encourage stigma and discrimination, as well as a lack of laws and policies that protect against discrimination.[19]

Despite this population being at high-risk, relatively little attention has been given to develop best-practices and LGBTQIA+ -specific suicide assessment strategies or interventions.[20] Suicide prevention interventions designed for the general public rarely address suicidal behavior or risk within LGBTQIA+ groups, and no evidence-based interventions currently exist to reduce suicide risk with this special population.[20] [21]

Although not evidence-based practices, LGBTQIA+ advocacy and behavioral health groups have outlined suggested practices for providers to help this population. These namely include emphasizing resilience, not just as a factor that can help protect against suicide, but also as a crucial part of developing emotional and psychological well-being among LGBTQIA+ people.[19] Working on factors that can help to strengthen resilience against suicidality in LGBTQIA+ people include facilitating family acceptance and support, connections to people who care, a sense of safety, increasing coping skills to manage stressors, and a positive sense of identity as an LGBTQIA+ person.[19] Other protective measures can include reducing anti-LGBTQIA+ stigma and prejudice, reducing bullying and other forms of victimization, increasing access to LGBTQIA+ affirming physical and behavioral health care, and legal protections from discrimination.[19]

Veterans

As military personnel return to civilian life, many experience symptoms of post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), depression, substance use disorders, or social withdrawal.[22] This may be compounded by difficulties meeting basic needs, such as housing. Approximately 18.5% of service members returning from Iraq or Afghanistan have post-traumatic stress disorder (PTSD) or depression.[23] Veterans who screened positive for PTSD were 4 times more likely to report suicidal ideation than veterans who did not, and the likelihood of suicidal ideation is 5.7 times greater in veterans who screened positive for PTSD and two or more comorbid disorders, such as substance abuse or depression.[24] Additionally, 19.5% of veterans report experiencing a traumatic brain injury (TBI) during deployment, which has been shown to increase risk of dying by suicide compared with veterans without brain injuries.[25] Additionally, a history of trauma (i.e. child abuse, sexual trauma) or suicidality prior to enlistment is linked to higher rates of suicide among military personnel and veterans when coping with combat or multiple deployments.[26]

In Orange County, the suicide rate among military veterans is three times higher than that of non-veterans, and they are more likely to use firearms to commit suicide than the rest of the county population.[27] Core components to assisting the veteran population experiencing suicidality include: reducing the stigma of accessing behavioral health care, increasing behavioral health care access, providing culturally competent and trauma-informed interventions, and providing adequate support and emphasis on reintegration to civilian life to ensure basic needs (such as housing) are met.[23]

Children and Adolescents

Compared to other age groups, children and adolescents may experience suicidality as a result of more external or social stressors, such as family discord or violence, isolation, bullying, disciplinary problems, interpersonal losses, or physical and sexual abuse.[28,29] These types of external stressors or traumas frequently contribute to suicidality, especially in circumstances when youth also experience behavioral health issues.[29] Depression, bulimia, anxiety, oppositional defiant disorder, Attention-Deficit/Hyperactivity Disorder (ADHD), anorexia, autism, and intellectual disability have all been found to be risk factors for suicidality in children ages 6-18 years old.[30] Studies have found that most adolescents who experience suicidality have typically received some form of behavioral health or school-based treatment for these other behavioral health issues prior to the onset of suicidality. [31] Therefore, it is a recommended best practice that BHS providers screen adolescents (12 – 18 years old) for major depressive disorder to provide adequate resources and treatment to improve depression severity and symptoms, reducing risk for suicidality.[32] In addition, it is important to note the developmental differences that make adolescents unique from children and adults with respect to suicidal ideation and death by suicide, including increased impulsivity and less attention to long-term consequences when making decisions.[33]

To address external factors that may be contributing to a child/adolescent's risk of suicidality, BHS Providers can partner with schools and parents to address these environmental factors as well as improve children/adolescents' coping skills.[28] Additionally, CBT, DBT, and family therapy have all been found to be effective with addressing suicidality in children and adolescents.[16]

Individuals with Developmental Disabilities

Developmental disabilities encompass a diverse range of conditions, however, most can cause problems with communication, mobility, learning, self-help, and independent living. Like all other populations, this group is vulnerable to the psychological, social, and environmental factors that increase risk of suicidality, especially feelings of isolation, depression, and history of trauma.[34] Specific studies examining suicidality causes and prevention for people with Autism or other developmental disabilities remains poorly understood and under-researched. [35,35]

Adolescents and young adults with intellectual disability often focus on peer acceptance and not being seen as "different," however, social rejection, bullying, and stigma may be encountered in school and the community; and individuals living with mild intellectual disability recognize that they may misunderstand social norms and consequences of their behavior, all of which may contribute to increased social isolation.[34] Strong support to improve behavioral health, to mitigate factors leading to secondary depression (i.e. lack of social support, social isolation, poor access to support after disability diagnosis or health care), and improving quality of life, can reduce risk of suicidality.[35]

Co-occurring conditions and issues which are common in Autism Spectrum Disorders, such as anxiety, depression, ADHD, impulsivity, aggression, conduct problems, sleep disturbance, and self-injurious behavior, can predispose individuals to suicidality as well.[37]

Assessing suicide risk in individuals with some developmental disabilities may be challenging as intellectual disability may impair language skills and the ability to accurately describe feelings and experiences.[34,35] A tendency to acquiesce, to please those in authority, and to give the "desired" response may also bear on an evaluative interview. In some cases, out of necessity, the assessment may rest heavily on third party collateral information.[34]

There is limited research on interventions for suicidality for individuals in this population, and recommendations within the literature focus on consideration of the risk factors for suicide in this population, and to intervene in relation to those factors, such as reducing stress, increasing coping skills in response to stress, or improving social and/or familial support.[36] Like all other populations, if individuals with developmental disabilities experience suicidality, a safety plan should be developed in collaboration with the individual and his/her social support, and be tailored to specific needs.[36] Lastly, part of the intervention for these individuals should include understanding the function of suicidal behavior.[36] There may be the possibility that self-harming or suicidal behaviors may be, in part, attention-seeking or a means of escaping stressful demands, and developing alternative behaviors to gain attention or increasing coping with stress might assist with reducing suicidal thoughts or behaviors.[36] This is by no means the case with every individual, and any suicidal thought or behavior should still be taken seriously and addressed as part of clinical interventions tailored to the individual and the risk factors or causes of suicidality. Good practice indicates that special care should be taken when safety planning is required, especially when the individual lacks a supportive environment, and coordinating care with the Regional Center is recommended.

Older Adults

Depression is associated with higher rates of suicidal ideation and death by suicide, and depression is one of the most common behavioral health issues experienced by older adults.[38] As noted above in the

introduction, the rates of suicide are higher in older adult men compared to any other age group, however, older women experience higher rates of depression and suicidal ideation than their male counterparts. Symptoms of depression in older adults may appear as memory problems, confusion, social withdrawal, loss of appetite, weight loss, vague complaints about pain, inability to sleep, irritability, delusions, or hallucinations.[39] Somatic complaints are more common in older adults experiencing depression.

It is important to differentiate grief from depression in this cohort. Older adults often experience normal, temporary sadness and grief in the face of life changes, such as leaving a home of many years, losing a loved one, or coping with a loss in capacities.[39] Clinical depression is different in that it will last for months, and requires behavioral health interventions to reduce duration and intensity of symptoms.[39]

Another consideration when working with older adults is the extent to which behavioral health has an impact on physical health and vice versa.[40] Older adults with physical health conditions, such as heart disease, have higher rates of depression compared to healthy older adults.[40] Additionally, untreated depression in an older person with heart disease can negatively affect the medical issue's outcome.[40]

Additional risk factors for depression and suicidality in older adults include chronic medical illness (i.e. cancer, diabetes, or heart disease), being diagnosed with a disability, sleeping poorly, or being lonely or socially isolated.[41] Family history of depression, certain medications, brain disease, substance abuse, and stressful life events or loss also increase an older adult's risk for depression and suicidality.[41]

Pharmacotherapy and several versions of psychotherapy, including interpersonal and brief psychodynamic therapy significantly reduce depressive symptoms for older adults.[41] Research also shows that CBT, including a version called problem-solving therapy, may be an especially useful type of psychotherapy for treating older adults and improving their quality of life.[41]

Cultural Considerations

A BHS Provider must examine his/her own culture and how personal values, beliefs, and norms influence worldviews, prejudices, biases, understanding of families and communities, religious/spiritual beliefs, political views, and economic understandings and status. BHS Providers must be willing to engage in reflection regarding how cultural beliefs and understandings can manifest in one's work during a crisis assessment and intervention. There are many immediate demands placed upon a BHS Provider during a crisis situation, and therefore factors of culture and cultural identity are often neglected.[42] However, the BHS Provider and the individual in crisis often come from different cultures.[42] Crisis intervention often requires an immediate development of trust between two people from different cultures for the purpose of restoring hope and the person's coping-strategies to a pre-crisis level of functioning.[42] The quick development of rapport and trust between people of different cultures often requires the professional to communicate, both verbally and nonverbally, a demeanor that one is knowledgeable about and accepting of cultural differences.[42] Cultural considerations should be made when understanding a person or community's perspective or perception of mental health symptoms, understanding of the behavioral health or legal system, stigma about seeking help, how a trauma is experienced or trauma response is expressed, and the interpretation of a "crisis."

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This section contains a list of all research citations, laws/regulations, etc. that are referenced in the guideline. Please use standard APA style in your referencing, for consistency.

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