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Teen Suicide Risk: A Practitioner Guide to Screening, Assessment, and Management.
By Cheryl A. King, Cynthia Ewell Foster, and Kelly M. Rogalski. Copyright © 2013.
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CHAPTER ONE

Introduction

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CHAPTER OBJECTIVES

- Describe objectives and organization of the practitioner guide.
- Discuss practitioner challenges inherent in work with suicidal teens.
- Present a classification system for suicidal and self-injurious behavior.
- Present a rationale for evidence-based, systematic approach to screening, risk assessment, and care management.

We are writing this practitioner guide to provide you with both a *clear and systematic strategy* and a *set of practical tools* for identifying and working effectively and safely with teens at elevated risk for suicidal behavior and suicide. If your practice includes teens, you almost certainly have worked with these at-risk teens. A concern about suicide risk—whether due to a suicide attempt, a text message or diary entry indicating suicidal intent, or an expression of suicidal thoughts—is the most common mental health emergency in this age group.

Our objectives for this practitioner guide are as follows:

- *To describe the challenge of teen suicide risk for practitioners*, how we *classify teens' self-harmful and suicidal behavior*, and the *value of a systematic and structured clinical approach*.
- To present an *up-to-date, evidence-based, and accessible overview of risk and protective factors* for teen suicidal behavior and suicide, with checklists and tools that can be used in your setting.
- To review the *basic principles of suicide risk screening* and provide clear guidelines for suicide risk screening in your setting.
- To describe the *key components of a comprehensive suicide risk assessment*, with specific strategies for how to conduct a specific inquiry about suicidal thoughts and impulses, how to make use of self-report questionnaires, and how to modify the assessment strategy for your setting.
- To provide an *evidence-based suicide risk formulation strategy* that incorporates an easy-to-use checklist, guidelines for integrating risk assessment findings, and guidelines for charting the formulation.
- To provide a *safety plan template (crisis response plan)*, in addition to step-by-step instructions about how to develop such a plan with the teen.
- To present *strategies for partnering with at-risk teens and their parents*, providing psychoeducation and involving them in a collaborative risk assessment, and developing safety plans, safety monitoring, and facilitating treatment adherence.
- To *provide tools and strategies for working effectively with schools*, and for assisting parents in developing a partnership with school personnel and facilitating a collaborative care approach to helping the suicidal teen.
- To describe *how to minimize your potential for legal problems* through systematic risk formulation and care management, strong documentation, and a consideration of confidentiality versus safety concerns.

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ORGANIZATION OF THIS PRACTITIONER GUIDE

We have organized this practitioner guide in a manner that allows you to access easily all of the key strategies and tools for screening, comprehensive risk assessment, risk formulation, safety planning, partnering with parents and teens, and ongoing care management. Our goal is to provide you with practical guidelines that you can turn to when needed, even if pressed for time.

Each chapter begins with a list of objectives that enable you to easily ascertain chapter topics. Then, depending on chapter content, the text is supplemented by one or more of the following: easy-to-find boxes that delineate key points, **Clinical Notes** that emphasize clinical recommendations, tables that present more detailed information, sample dialogues, and completed clinical forms. (Note: The Appendices contain blank clinical forms that are reproducible for your use.) Taken together, we provide you with *clinically relevant information* and a *wide array of clinical tools* that we believe will be helpful as you strive to diminish the suicide risk and improve the lives of at-risk teens in your practice.

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THE CHALLENGES FOR PRACTITIONERS

High Prevalence of Teen Suicide Risk

Most practitioners who work with teens will encounter suicidal teens—regardless of whether they work in an outpatient clinic, psychiatric hospital, emergency setting, or school setting. Some practitioners encounter these teens on a relatively frequent basis because the prevalence rates for suicidal thoughts and attempts in this age group are strikingly high. Based on nationally representative data from the 2011 Youth Risk Behavior Survey (YRBS), 15.8% of high school students have seriously considered attempting suicide in the preceding year, and 12.8% have made a plan about how they would attempt suicide. Moreover, 7.8% of high school students report that they have attempted suicide one or more times in

the preceding year and 2.4% report having made a suicide attempt that resulted in an injury, poisoning, or an overdose that had to be treated by a doctor or nurse (Centers for Disease Control and Prevention[CDC], 2012b). That is, one out of every 50 high school students in the United States seeks medical care each year due to a suicide-attempt injury.

Depending on your setting and position, your role may be to conduct a brief suicide risk screen and then refer the teen for a comprehensive suicide risk assessment, if needed. This may be the case if you work in a school setting. Alternatively, if you practice in an emergency department or mental health setting, your role may be to conduct the screen and the comprehensive risk assessment, arrive at a solid case formulation, and make recommendations for disposition and treatment. It is also possible that you are responsible for the ongoing treatment and care management of one or more suicidal teens. This book provides you with the clinical knowledge and tools needed to implement suicide risk screens; conduct comprehensive risk assessments; develop immediate intervention plans, including safety plans; and communicate effectively with teens, parents/guardians, and school personnel concerning suicide risk and risk management.

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Practitioner Tensions Are Common

Clinical practice with suicidal or potentially suicidal teens is challenging. One of the most common dilemmas is the tension that may develop between the clinician's desire to establish strong rapport and take a collaborative, growth-oriented, therapeutic approach, and his or her desire to take control and manage safety concerns. These are not mutually exclusive, but they can run counter to each other. Realistic fears and anxieties related to the teen's safety and possible suicide risk, in addition to liability concerns, can result in a desire for control and perhaps an overemphasis on hospitalization as a therapeutic strategy. Without clear and systematic approaches to screening, assessing, and managing the suicidal teen, the clinician may feel he or she is all alone and working to string together a

series of assessment and crisis management responses. We believe the systematic strategy described in this guide will lessen your anxiety and enable you to more easily provide high-quality care.

A second common challenge pertains to resource limitations. Our goal to provide comprehensive treatment and care management frequently runs up against limited services available in the community. It may be that the teen's family has no health insurance and a limited ability to pay out of pocket. It is also possible, however, that the community itself does not have a sufficient number of mental health professionals trained in evidence-based treatments, enough psychiatrists and pediatricians who have expertise in pediatric psychopharmacology and are willing to take on the medication management of high-risk teens, or enough space in psychiatric inpatient units. Whereas combination treatment—psychosocial and psychopharmacology treatments—may be the most effective for some suicidal teens, especially those who struggle with clinical depression, such treatment can be a costly option that is not readily available to many families. Furthermore, although such combination treatment has been associated with reduced depression severity among adolescents, we do not have evidence to suggest that it can be related directly to reductions in suicide and suicide attempt risk. It becomes even more challenging to wrap these mental health treatments into a more comprehensive package of services that includes psychoeducation for the family and community-based services to address broader parent and family needs.

This practitioner guide focuses on what you can do. The systematic, evidence-based approach that we recommend will enable you to take active, positive steps to screen adolescents; conduct well-informed risk assessments; manage the care of suicidal adolescents; and communicate effectively with parents, adolescents, and school personnel throughout the process. We provide rich background information, an up-to-date overview of clinical strategies, and practical clinical tools to enable you to approach this challenging work systematically and with confidence, consulting with others and providing stepped-up care as needed.

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CLASSIFICATION AND DEFINITIONS

Self-Injurious Behavior, Suicidal Behavior, and Suicide

Several different sets of terms have been used to refer to the spectrum of suicidal ideation and behavior. This inconsistency, sometimes found even among clinical providers who work in the same setting, can compromise communication among the teen's providers. It also hampers advancements in our field.

Fortunately, the importance of having and using a uniform classification system with standardized terminology is now widely accepted. Such classification systems have been published and widely disseminated (O'Carroll, Berman, Maris, & Moscicki, 1996; Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007). Most recently, the CDC has developed a set of uniform definitions and recommended data elements on self-directed violence (Crosby, Ortega, & Melanson, 2011). These are delineated in Table 1.1.

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TABLE 1.1. The CDC's Uniform Definitions of Suicide and Suicidal Behavior

Term	Definition
Self-directed violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. This does not include behaviors such as gambling, substance use, or other risk-taking activities, such as excessive speeding in motor vehicles.
Nonsuicidal self-directed violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent.
Suicidal self-directed violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.
Undetermined self-directed violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based on the available evidence.

(continued)

TABLE 1.1. *(continued)*

Term	Definition
Nonsuicidal self-injurious behavior	A self-inflicted, potentially harmful behavior with no intent to die as a result of the behavior, such as to affect external circumstances or internal state.
Interrupted self-directed violence—by other	A person takes steps to injure self but is stopped by another person prior to fatal injury. The interruption can occur at any point during the act, such as after the initial thought or after onset of behavior.
Interrupted self-directed violence—by self	A person takes steps to injure self but is stopped by self prior to fatal injury.
Other suicidal behavior, including preparatory acts	Acts or preparation toward making a suicide attempt, but before potential for harm has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun) or preparing for one's death by suicide (e.g., writing a suicide note).
Suicide attempt	A nonfatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
Suicide	Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.

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According to the definitions in Table 1.1, a suicide attempt is a nonfatal self-inflicted behavior that (1) had the potential to cause injury (whether or not it did), and (2) was associated with some degree of intent to die. If we have absolutely no information from a teen about suicidal intent (and no ancillary information such as a written note or a parent reporting that the teen verbalized suicidal intent), the behavior would be undetermined (intent) self-injurious behavior. Nonsuicidal self-injurious behavior (NSSI) is the appropriate term if it is clear that the teen had no suicidal intent at all. This may be the case with *some* instances of wrist cutting (scratching) as well as with behaviors such as self-inflicted burns or the carving of initials on the teen's arm or leg. Recent data indicates that NSSI is associated with elevated risk of a suicide attempt, which is discussed further in Chapter 2.

A SYSTEMATIC RISK ASSESSMENT AND CARE MANAGEMENT APPROACH

Best Practices: An Evidence-Based Approach

In this practitioner guide we emphasize the importance of evidence-based assessment and intervention, or what is more commonly referred to as evidence-based practice. In the United States, the national professional organizations in psychology, social work, and medicine have each provided definitions of such practice. The American Psychological Association (APA) endorses the following definition: "*Evidence-based practice in psychology* (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2006). Placing a similar emphasis on the role of research, the National Association of Social Workers (NASW, 2009) provides the following definition: "Evidence-based practices are interventions shown to be effective through strong scientific research." The American Medical Association (AMA) definition expands on these definitions to address the role of the provider, offering the following definition at *www.jamaevidence.com*: "The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. Evidence-based clinical practice (or evidence-based health care) requires integration of individual clinical expertise and patient preferences with the best available external clinical evidence from systematic research, and consideration of available resources" (AMA, 2012).

In this book, we present the evidence base that is currently available to guide suicide risk assessment and care management. In some areas, such as the ideal interval between suicide risk assessments, a strong evidence base for decision making is unavailable; however, some data are available to guide the recommendations (e.g., documented increase in suicide risk following psychiatric hospitalization). We provide the available evidence, understanding that your client or patient may not exactly fit the usual research subject because of a multiplicity of factors, including co-occurring mental disorders combined with severe psychosocial trauma, or a

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particular cultural background or value system. In these instances, you will need to use your clinical judgment to guide you in providing the best possible care that is grounded in the current evidence base. It is also possible that you will need to make some cultural adaptations in your communication style to facilitate a working alliance with the teen and family. These adaptations and modifications can be layered onto the existing evidence base, but should not be contradictory to or inconsistent with it.

Core Competencies: A Consensus

Several professional groups have considered practice recommendations for working with suicidal adolescents or suicidal individuals in general. In addition to practice recommendations published by the American Psychiatric Association (2003) and the American Academy of Child and Adolescent Psychiatry (2001), the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services (DHHS) funded an initiative to identify the *core competencies* needed to assess and manage suicide risk. This was a response to a recommendation in the *National Strategy for Suicide Prevention* (U.S. DHHS, 2001), which noted that many training programs for mental health professionals—social workers, counselors, psychologists, psychiatrists—provide little or inadequate training in assessing and managing suicide risk. As noted in the *National Strategy for Suicide Prevention* (U.S. DHHS, p. 79), many of these professionals are "not adequately trained to provide proper assessment, treatment, and management of suicidal clients; or to know how to refer them properly for specialized assessment and treatment." In fact, studies indicate that 90% of those who die by suicide had a diagnosable Axis I disorder (Conwell et al., 1996) and that many clients had contact with a mental health professional during the final year of their lives (Luoma, Martin, & Pearson, 2002). In their meta-analysis, Luoma and colleagues found that approximately one-fifth of those who died by suicide (19%) had contact with a mental health professional within 1 month of their suicide and approximately one-third (32%) had such contact within 1 year of their suicide.

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There is no question that adequate training for mental health professionals is one key suicide prevention strategy. With funding from the DHHS, the "Core Competencies" initiative was spearheaded by the Suicide Prevention Resource Center in collaboration with the American Association of Suicidology. A team of professionals reviewed the evidence base and reached a consensus on core competencies for training purposes. This team included Lanny Berman, Thomas Ellis, Nadine Kaslow, David Rudd, Shawn Shea, Marsha Linehan, Rheeda Walker, David Litts, Xan Young, and one of the authors of this book, Cheryl A. King. Twenty-four core competencies were established; eight of these were designated as the core competencies for the 1-day workshop, "Assessing and Managing Suicide Risk" (Suicide Prevention Resource Center, 2008), and all 24 were designated as the training competencies for the 2-day workshop, "Recognizing and Responding to Suicide Risk," sponsored by the American Association of Suicidology. The eight core competencies, essential to practice with a suicidal individual, include:

- Managing one's reactions to suicide.
- Reconciling the difference (and potential conflict) between the clinician's goal to prevent suicide and the client's goal to eliminate psychological pain.
- Maintaining a collaborative, nonadversarial stance.
- Eliciting suicide ideation, behavior, plans, and intent.
- Making a clinical judgment of the risk that a client will attempt or complete suicide in the short and long term.
- Collaboratively developing a crisis response plan.
- Developing a written treatment and services plan that addresses the client's immediate, acute, and continuing suicide ideation and risk for suicide behaviors.
- Developing policies and procedures for following clients closely, including taking reasonable steps to be proactive.

This practitioner guide builds on this core competencies approach and carefully considers and incorporates many of the recommendations from published guidelines.

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CONCLUSION

In this practitioner guide, we present the core knowledge, competencies, and skills that are essential to effective, evidence-based practice with suicidal teens. Specifically, we focus on evidence-based screening, risk assessment and formulation, and care management. This book brings together in one accessible guide the essential information, real-world examples, and useful clinical tools.

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