Suicide Assessment and Intervention: Working with the Crisis Adolescent

Katherine S. Arnold, MA, LPC-S, LMFT-SC, CFRC, Certified Psychological Autopsy Clinician
Present Hope Counseling, LLC

Steve Wilkison, *Captain Baton Rouge Police Department; Captain, Health &Safety; Commander of Negotiations Squad*

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Learning Objectives

- Increased confidence to assess and intervene in suicide
- Increased understanding of the responsibility of the therapist and the client
- Increased awareness of the ethical requirements (Duty to Report and Do No Harm)

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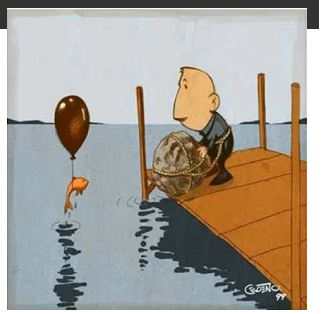
Overview

- Introduction
- Learning Objectives
- Self-Awareness Check
- Statistics
- Ethical Requirements
- Assessment
- Intervention
- Documentation
- Self-Awareness Review



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Self-Check

Working with Crisis Clients
Self-check

1. How often do you work with clients who report suicide ideation?
   ☐ Never ☐ Sometimes ☐ Often ☐ Very Often
2. Have you ever worked with a client who choose to die by suicide? ____ Yes ____ No
3. How comfortable are you working with clients who report suicide ideation?
   Not comfortable ←---------- Extremely Comfortable
4. What is your greatest fear in working with a client who is suicidal?
   _____
   _____
5. How knowledgeable do you believe that you are in suicide assessment?
   Not very ←---------- Extremely
6. How knowledgeable do you believe that you are in suicide intervention?
   Not very ←---------- Extremely
7. How familiar are you with the ethical requirements regarding suicide?
   Not very ←---------- Extremely
8. How comfortable do you believe you are in understanding your responsibility as a therapist and the client's responsibility?
   Not comfortable ←---------- Extremely Comfortable

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Ethical Requirements

- AAMFT: 1.8 **Client Autonomy in Decision Making**: …respect the rights of clients to make decisions and help them to understand the consequences of these decisions. (ACA Code of Ethics Preamble)
- AAMFT: 1.10 **Referrals…**. assist persons in obtaining appropriate therapeutic services if the therapist is unable or unwilling to provide professional help. (Title 46.2103.11.b; ACA Code of Ethics A.11.a)
- AAMFT: 1.11 **Non-Abandonment…**. do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of treatment. (Title 46.2103.11.a; ACA Code of Ethics A.12)
- AAMFT: **2.1 Disclosing Limits of Confidentiality…**. disclose to clients and other interested parties at the outset of services the nature of confidentiality and possible limitations of the clients' right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures. (Title 46.2105.2.a; 4707.B; ACA Code of Ethics A.2.b; A.12; B.1.d.;)
- AAMFT **3.1 Maintenance of Competency**. Marriage and family therapists pursue knowledge of new developments and maintain their competence in marriage and family therapy through education, training, and/or supervised experience.
- AAMFT: 3.5 **Maintenance of Records**: …maintain accurate and adequate clinical and financial records in accordance with applicable law.
- ACA Code of Ethics A.4. **Avoiding Harm and Imposing Values**: Counselors act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm.

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Test your Knowledge (True or False)

- It is estimated that in 1 in 20 psychotherapist will lose a client to suicide within their career.
  - False: 1 in 5 psychotherapist (1); 1 in 6 psychiatric patients will die while in treatment(2)
- Suicide Malpractice is the leading cause of legal action against behavioral healthcare providers.
  - True
- Suicide is the 10th cause of death in the United States.
  - True
- Asking a person if they are having thoughts about suicide will raise the risk.
  - False
- Suicide is the 1st cause of death of adolescents in the United States.
  - False

(1)Task Force study of community therapists, McIntosh, J. L., Talcott, L., & Jones, F. A., Jr. (1999, April 16). "Therapists as survivors of client suicide." Presentation made at the annual meeting of the American Association of Suicidology, Houston, TX. Summary appears in M. Weishaar (Ed.), (2000). *Suicide '99: Proceedings of American Association of Suicidology 32nd annual conference* (pp. 75-78). Washington, DC: AAS.
(2) Bongar, Bruce. 1991. The Suicidal Patient: Clinical and Legal Standards of Care. Washington, DC: American Psychological Association
(3) Multiple studies summarized by Marsicki, Eve K. 1999, in *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco: Jossey-Bass, Inc., Publishers. Jacobs, Editor.

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Definitions and Terminology

- Suicide – death caused by self-directed, injurious behavior with intent to die
- Suicide Ideation – any self-reported thoughts in engaging in suicide related behavior
- Suicide Attempt – self-directed, non-lethal behavior with intent to die
- Self-harming – self-directed, injurious behavior without intent to die

Center for Disease and Prevention
Rudd, M. David. (2006). *The Assessment and Management of Suicidality*. Professional Resource Press.

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Terminology to Avoid

CAMH. (2021). Words Matter. https://www.camh.ca/-/media/files/words-matter-suicide-language-guide.pdf

INSTEAD OF THIS...	...SAY THIS	WHY
commit/committed suicide	died by suicide / death by suicide / lost their life to suicide	"commit" implies suicide is a sin or crime, reinforcing the stigma that it's a selfish act and personal choice using neutral phrasing like "died by suicide" helps strip away the shame/blame element
successful/unsuccessful suicide completed/failed suicide	died by suicide / survived a suicide attempt / lived through a suicide attempt fatal suicidal behaviour / non-fatal suicidal behaviour fatal suicide attempt / non-fatal suicide attempt	the notion of a "successful" suicide is inappropriate because it frames a very tragic outcome as an achievement or something positive to be matter-of-fact, a suicide attempt is either fatal or not
epidemic, skyrocketing	rising, increasing	words like "epidemic" can spark panic, making suicide seem inevitable or more common than it actually is by using purely quantitative, less emotionally charged terms like "rising", we can avoid instilling a sense of doom or hopelessness
<Name> is suicidal	<Name> is facing suicide / is thinking of suicide / has suffered through suicidal thoughts / has experienced suicidal thoughts	we don't want to define someone by their experience with suicide; they are more than their suicidal thoughts
He's suicidal They're a schizophrenic She's bipolar The mentally ill <Substance> addicts	he is facing suicide / thinking of suicide / experiencing suicidal thoughts they have schizophrenia / are living with schizophrenia people with mental illness people addicted to <substance>, people with addiction	putting the condition before the person reduces someone's identity to their diagnosis—people aren't their illness; they have an illness people-first language shows respect for the individual, reinforcing the fact that their condition does not define them

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2019 Statistics

- **Second** leading cause of deaths between the ages of 10 and 34, where the leading cause being accidents (unintentional injury).
- Highest rates by race/ethnicity are **American Indian/Alaska Native** and **non-Hispanic** populations
- More youth/adolescents who identify as lesbian, gay, or bisexual have **higher rates** of suicide ideation than their peers
- For every death by suicide there are 25 attempts; 1 death every 11 minutes (**8 people** will take their life before this training is over)
- Each suicide intimately effects at least six other people (estimated) – **ripple** effect
- The most commonly reported means of completing suicide, across all groups, was by **firearm** (49.8%), followed by suffocation or **hanging** (26.8%), **poisoning** (15.4), cutting (1.7%) and drowning (1.2%)
- Most common Dx for those who die by suicide are **MDD**
- 1 in 8 report correlation to negative perception of **body-image**

Center for Disease Control
https://wmich.edu/suicideprevention/basics/facts

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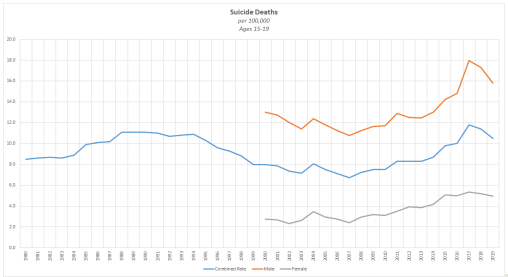
Statistics



Resource: CDC

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Assessment

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Warning Signs

- Noticeable changes in eating or sleeping habits
- Significant and unexplained change in behavior – increased anger, agitation, and rebellion
- Withdrawal from family or friends
- Sexual promiscuity
- Noticeable personality change
- Agitation, restlessness, distress, or panicky behavior
- Talking or writing about suicide, even jokingly
- Giving away possessions important to them
- Securing weapons
- Change in interest, attendance, and/or performance in school

https://www.stanfordchildrens.org/en/topic/default?id=teen-suicide-learning-to-recognize-the-warning-signs-1-1696

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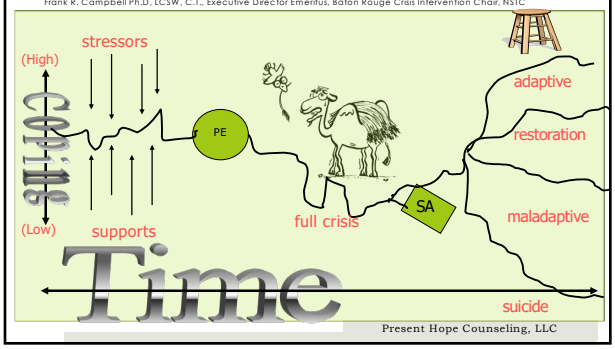
Crisis Theory

Frank R. Campbell Ph.D, LCSW, C.T., Executive Director Emeritus, Baton Rouge Crisis Intervention Chair, NSTC



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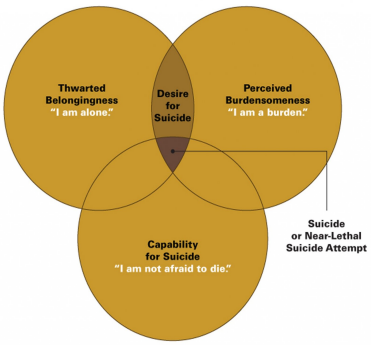
JOINER'S THEORY OF SUICIDE



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Risk Factors

Critical

- Mental Heath Illness
- Past Suicide Attempts: single vs multiple
- Substance Abuse
- Lack of Support System
- Significant Loss
- Isolation – lack of belonging
- Psychological Pain
- Self-harming behaviors
- Negative perspective of body image
- Impulsivity
- Health/Pain Problems
- Sleep Problems
- Legal or Financial Issues
- Shame/Burden
- Agitation (need to take action)
- Stress
- Hopelessness
- Family History
- Means to Lethality

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Protective Factors

- Supportive social network (friend(s), family, etc.)
- Responsible to Family and Others
- Engaged in Work/Career
- Ability to Overcome difficult circumstances/events in the past
- Spirituality
- Healthy Coping Strategies
- Engaged in Interest/Hobbies
- Frustration Tolerance
- Ambivalence w/ Strong desire to live life
- Fear of Dying
- Good Therapeutic Relationship
- Commitment to Treatment

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Are you afraid to ASK??!!

Ask the Question

- Ask directly
- Ask about a plan
- Ask about lethality
- Ask about access
- Ask about availability

Be aware of your Non-verbal language!!!

"Sometimes people in your situation, with so much hurt and pain, think about suicide."

"It sounds like your burden is heavy, I am wondering if you are having thoughts of suicide."

"I'm wondering if taking your life is something you are considering."

"You think there is no way out. You don't see how this situation will get any better. I am curious….are you thinking suicide is a solution?"

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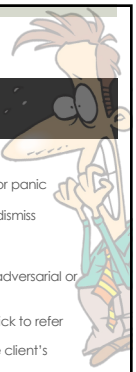
Do's and Don'ts



- **DO** empathize
- **DO** Normalize
- **DO** reflect
- **DO** sit with them in the emotional suffering
- **DO** remind them of your duty to protect them
- **DON'T** freak out or panic
- **DON'T** ignore or dismiss
- **DON'T** shame
- **DON'T** become adversarial or judgmental
- **DON'T** be too quick to refer
- **DON'T** restrict the client's autonomy
- **DON'T** pull out a "No Suicide Contract"

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Risk Assessment

- Ask the client directly: Plan, Method, Means
- Determine the Risk Factors
- Determine the Protective Factors
- Evaluate the relationship: Risk Factors to Protective Factors
- Determine motivation
- Document Assessment

- High Risk:

  Desire, Intent, Plan, Access, Availability, Rehearsal, MI, Substance use, Previous attempts, RFL/RFD, Low Ratio of PF:RF
- Moderate Risk:

  Desire, Intent, Plan, No access, No availability, MI, occasional Substance use, Single previous attempt, RFL/RFD, Equal Ratio of PF:RF
- Low Risk:

  Desire, Intent, No Plan, No access, No availability, RFL/RFD, How Ratio of PF:RF

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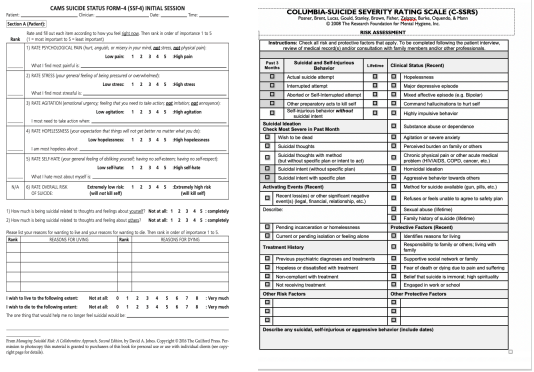
Examples of Assessments



CAMS SUICIDE STATUS FORM–4 (SSF-4) INITIAL SESSION

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (Patient)

Rank Rate and fill out each item according to how you feel right now. Then rank in order of importance 1 to 5 (1 = most important to 5 = least important)

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, not stress, not physical pain)
Low pain 1 2 3 4 5 High pain
What I find most painful is _____

2) RATE STRESS (your general feeling of being pressured or overwhelmed)
Low stress 1 2 3 4 5 High stress
What I find most stressful is _____

3) RATE AGITATION (emotional urgency, feeling that you need to take action; not irritation, not annoyance)
Low agitation 1 2 3 4 5 High agitation
I most need to take action when _____

4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do)
Low hopelessness 1 2 3 4 5 High hopelessness
I am most hopeless about _____

5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect)
Low self-hate 1 2 3 4 5 High self-hate
What I hate most about myself is _____

N/A 6) RATE SUICIDAL RISK OF SUICIDE
Extremely low risk (will not kill self) 1 2 3 4 5 Extremely high risk (will kill self)

1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 4 5 : completely
2) How much is being suicidal related to thoughts and feelings about others? Not at all: 1 2 3 4 5 : completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much
I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be _____

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COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann
© 2008 The Research Foundation for Mental Hygiene, Inc.

RISK ASSESSMENT

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Past 1 Months	Suicidal and Self-Injurious Behavior	Lifetime	Clinical Status (Recent)
☐	Actual suicide attempt	☐	☐ Hopelessness
☐	Interrupted attempt	☐	☐ Major depressive episode
☐	Aborted or Self-Interrupted attempt	☐	☐ Mixed affective episode (e.g. Bipolar)
☐	Other preparatory acts to kill self	☐	☐ Command hallucinations to hurt self
☐	Self-injurious behavior without suicidal intent	☐	☐ Highly impulsive behavior
Suicidal Ideation Check Most Severe in Past Month			☐ Substance abuse or dependence
☐	Wish to be dead		☐ Agitation or severe anxiety
☐	Suicidal thoughts		☐ Perceived burden on family or others
☐	Suicidal thoughts with method (but without specific plan or intent to act)		☐ Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
☐	Suicidal intent (without specific plan)		☐ Homicidal ideation
☐	Suicidal intent with specific plan		☐ Aggressive behavior towards others
Activating Events (Recent)			☐ Method for suicide available (gun, pills, etc.)
☐	Recent (resolved) or other significant negative event(s) (legal, financial, relationship, etc.)		☐ Refuses or feels unable to agree to safety plan
Describe:			☐ Sexual abuse (lifetime)
			☐ Family history of suicide (lifetime)
☐	Pending incarceration or homelessness		Protective Factors (Recent)
☐	Current or pending isolation or feeling alone		☐ Identifies reasons for living
Treatment History			☐ Responsibility to family or others; living with family
☐	Previous psychiatric diagnoses and treatments		☐ Supportive social network or family
☐	Hopeless or dissatisfied with treatment		☐ Fear of death or dying due to pain and suffering
☐	Non-compliant with treatment		☐ Belief that suicide is immoral, high spirituality
☐	Not receiving treatment		☐ Engaged in work or school
Other Risk Factors			Other Protective Factors
☐			☐
☐			☐
☐			☐

Describe any suicidal, self-injurious or aggressive behavior (include dates)

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https://www.ruidesearing.com/blog/the-power-of-active-listening/

Intervention

In the Office

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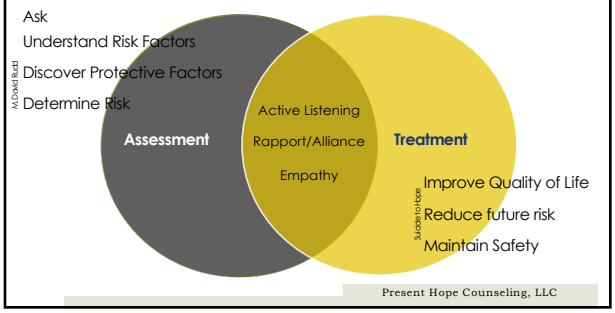
Intervention is BOTH



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Treatment

- Join collaboratively
- Actively listen
- Employ empathy and valuing
- Build and maintain rapport & connection - Therapeutic Alliance
- Clearly inform duty to protect, legal statutes for "imminent danger"
- Include the family system (determine the level of inclusion)
- Communicate Options for Tx
- Connect in ambivalence
- Clearly define roles and responsibilities
- Collaborative Stabilization Planning (Jobes), Crisis Response Plan(Rudd), or Safety Plan (S2H)
- Employ clinical Interventions to promote change
- Continuation of Care
- Consult
- Refer as needed
- DO NO HARM
- Document

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Options for Treatment

- Join together in the journey
- Intensive Out-Patient Care
- Hospitalization, Inpatient care
- Refer to another Mental Health provider
- Client's Right of Refusal for Treatment

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Connect in Ambivalence

"If someone is in the clinician's office talking about suicide, he or she is ambivalent. Suicidal people who are not ambivalent about living or dying are not talking to clinicians; they are dead."[1]

Reasons for Living

- Family/Others
- Enjoyable Things/Interest
- Hopefulness
- Plans and Goals
- Beliefs
- _____ (let them fill in the blank)

Reasons for Dying

- Relationship Distress
- Loneliness
- Hopelessness
- Negative perspective of Self
- Escape (general, past, pain, relationships)
- Unburdening Others
- To end their Pain and Suffering

1. Jobes, David A., (2016) *Managing Suicide Risk, A Collaborative Approach*. 2nd Ed., 24.

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"Despite best efforts at suicide assessment and treatment, suicides can and do occur in clinical practice."[1]

Responsibilities - Therapist

- Competency in Assessment and Treatment Interventions
- Limits of confidentiality
- Number, location, time, length, and cost of session
- Client autonomy
- Non-abandonment & Referrals
- Follow-up
- Documentation
- Do no Harm
- KNOW YOUR OWN BIASES AND VALUES – DO NOT IMPRESS THESE ON YOUR CLIENT

1. Rudd, M. David, (2007). *Suicide Assessment & Management Standard of Care Strategies.*

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Responsibilities - Client

- Commitment to Treatment
  - Compliance to Appointments
  - Motivation
- Collaboratively approach to Stabilization or Crisis Plan
- Application of Stabilization or Crisis Plan
- Autonomy – They have the choice to live or die

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Stabilization Planning

- Builds on a Collaborative relationship – manner of developm
- Honors and Values rather than restricts the client's rights
- Individualized
- Identifies roles and responsibilities for both the therapist and the client
- Plan to reduce or remove access and availability to lethal means
- Details coping strategies and enhances skill-building
- Promotes self-management and social support
- Includes a Crisis Response Plan (moves from self-management to external intervention)
- Active and living document – Commitment to treatment and self

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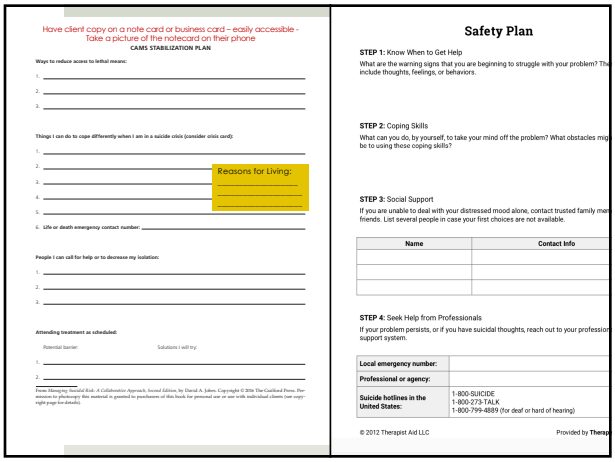

Have client copy on a note card or business card – easily accessible - Take a picture of the notecard on their phone

CAMS STABILIZATION PLAN

Ways to reduce access to lethal means:

1. _____
2. _____
3. _____

Things I can do to cope differently when I am in a suicide crisis (consider crisis card):

1. _____
2. _____
3. _____
4. _____
5. _____
6. **Life or death emergency contact number:** _____

Reasons for Living:
_____
_____
_____

People I can call for help or to decrease my isolation:

1. _____
2. _____
3. _____

Attending treatment as scheduled:

Potential barrier: Solutions I will try:

1. _____
2. _____

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Safety Plan

STEP 1: Know When to Get Help

What are the warning signs that you are beginning to struggle with your problem? The include thoughts, feelings, or behaviors.

STEP 2: Coping Skills

What can you do, by yourself, to take your mind off the problem? What obstacles mig be to using these coping skills?

STEP 3: Social Support

If you are unable to deal with your distressed mood alone, contact trusted family mem friends. List several people in case your first choices are not available.

Name	Contact Info

STEP 4: Seek Help from Professionals

If your problem persists, or if you have suicidal thoughts, reach out to your professiona support system.

Local emergency number:	
Professional or agency:	
Suicide hotlines in the United States:	1-800-SUICIDE 1-800-273-TALK 1-800-799-4889 (for deaf or hard of hearing)

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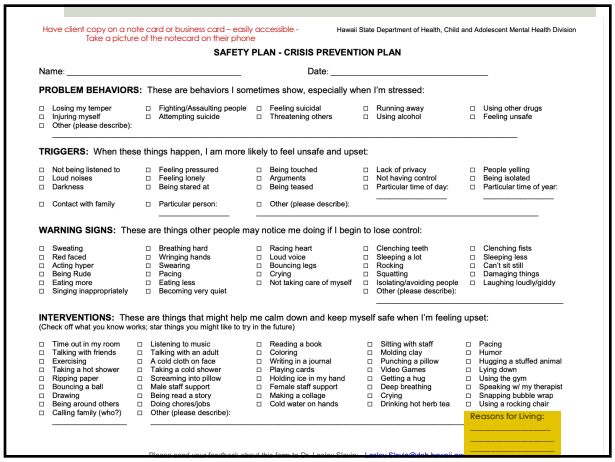

Have client copy on a note card or business card – easily accessible - Take a picture of the notecard on their phone

Hawaii State Department of Health, Child and Adolescent Mental Health Division

SAFETY PLAN - CRISIS PREVENTION PLAN

Name: _____ Date: _____

PROBLEM BEHAVIORS: These are behaviors I sometimes show, especially when I'm stressed:

☐ Losing my temper ☐ Fighting/Assaulting people ☐ Feeling suicidal ☐ Running away ☐ Using other drugs
☐ Injuring myself ☐ Attempting suicide ☐ Threatening others ☐ Using alcohol ☐ Feeling unsafe
☐ Other (please describe): _____

TRIGGERS: When these things happen, I am more likely to feel unsafe and upset:

☐ Not being listened to ☐ Feeling pressured ☐ Being touched ☐ Lack of privacy ☐ People yelling
☐ Loud noises ☐ Feeling lonely ☐ Arguments ☐ Not having control ☐ Being isolated
☐ Darkness ☐ Being stared at ☐ Being teased ☐ Particular time of day: _____ ☐ Particular time of year: _____
☐ Contact with family ☐ Particular person: _____ ☐ Other (please describe): _____

WARNING SIGNS: These are things other people may notice me doing if I begin to lose control:

☐ Sweating ☐ Breathing hard ☐ Racing heart ☐ Clenching teeth ☐ Clenching fists
☐ Red faced ☐ Wringing hands ☐ Loud voice ☐ Sleeping a lot ☐ Sleeping less
☐ Acting hyper ☐ Swearing ☐ Bouncing legs ☐ Rocking ☐ Can't sit still
☐ Being Rude ☐ Pacing ☐ Crying ☐ Squatting ☐ Damaging things
☐ Eating more ☐ Eating less ☐ Not taking care of myself ☐ Isolating/avoiding people ☐ Laughing loudly/giddy
☐ Singing inappropriately ☐ Becoming very quiet ☐ Other (please describe): _____

INTERVENTIONS: These are things that might help me calm down and keep myself safe when I'm feeling upset:
(Check off what you know works; star things you might like to try in the future)

☐ Time out in my room ☐ Listening to music ☐ Reading a book ☐ Sitting with staff ☐ Pacing
☐ Talking with friends ☐ Talking with an adult ☐ Coloring ☐ Molding clay ☐ Humor
☐ Exercising ☐ A cold cloth on face ☐ Writing in a journal ☐ Punching a pillow ☐ Hugging a stuffed animal
☐ Taking a hot shower ☐ Taking a cold shower ☐ Playing cards ☐ Video Games ☐ Lying down
☐ Ripping paper ☐ Screaming into pillow ☐ Holding ice in my hand ☐ Getting a hug ☐ Using the gym
☐ Bouncing a ball ☐ Male staff support ☐ Female staff support ☐ Deep breathing ☐ Speaking w/ my therapist
☐ Drawing ☐ Being read a story ☐ Making a collage ☐ Crying ☐ Snapping bubble wrap
☐ Being around others ☐ Doing chores/jobs ☐ Cold water on hands ☐ Drinking hot herb tea ☐ Using a rocking chair
☐ Calling family (who?) _____ ☐ Other (please describe): _____

Reasons for Living:
_____
_____
_____

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When NOT to rely on Stabilization Planning

- Imminent Risk to Self
- Lack of commitment to Collaborative Care
- Lack of commitment to Treatment
- Treatment refusal

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Employ Clinical Interventions that promote Change

- Build resources and systems support
- Build healthy coping strategies
- Determine Suicide "drivers" (direct and indirect)
- Working to alleviate or decrease drivers
- Help them narrate their story of suicide
- CBT, Solutions-focused, Art therapy….

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Documentation

"…maintain accurate and adequate clinical and financial records in accordance with applicable law."

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When to Document

- within a reasonable timeframe that represents REAL time

- Assessment at intake
- Warning signs or clinical change
- Reported thoughts of suicide
- Treatment – case notes, progress notes
- Consultations/Coordination of Care
- Termination/ Planned or unplanned
- Upon hospitalizations, discharge

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What to document

- Pertinent information that offers you the ability to provide the BEST LEVEL of care

- Reported suicide ideation
- Risk and protective factors
- Risk assessment and rationale, "as evidenced by…"
- Evening and weekend emergency arrangements/emergency contacts
- Pertinent Contact/Follow-up
- Input or attempts to employ social support
- Consultations/ Coordination of Care
- Rational for or against hospitalization
- Hospitalizations/ discharge papers
- Treatment plan and safety plan
- Changes in care – increases or decreases in treatment
- Special precautions taken, or arrangements made
- Referrals to other Medical or mental health

Present Hope Counseling, LLC

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Application

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