



**DEPARTMENT OF MENTAL HEALTH
POLICY/PROCEDURE**

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SUICIDE RISK ASSESSMENT AND MITIGATION	302.13	07/11/2016	1 of 8
APPROVED BY: <i>Robin Kay, M.D.</i> Acting Director	SUPERSEDES N/A	ORIGINAL ISSUE DATE 07/11/2016	DISTRIBUTION LEVEL(S) 1

PURPOSE

- 1.1 To establish policy and procedures related to the use of a standardized suicide risk assessment for Directly-Operated providers.
- 1.2 To establish procedures for reviewing and mitigating suicide risk.

DEFINITION

Suicide Screening and Assessment Descriptors:

- 2.1 **Suicide Assessment:** An assessment that includes the completion of the Columbia-Suicide Severity Rating Scale (C-SSRS), current mental status report, synopsis of any active psychiatric symptoms, identified protective factors, acute and chronic risk factors, and clinician judgment.
- 2.2 **Columbia-Suicide Severity Rating Scale (C-SSRS):** An evidence-based suicide risk screening tool that assesses the full range of ideation and behavior items with recommendations for next steps (e.g., referral to mental health professionals).
 - 2.2.1 **C-SSRS (Lifetime/Recent Full Version):** Assesses lifetime history of suicidality as well as any recent suicidal ideation and/or behavior in the last three (3) months (Attachment 1).
 - 2.2.2 **C-SSRS (Since Last Visit/Full Version):** Assesses for suicidality since the client’s last visit. Designed to assess clients who have completed at least one Lifetime/Recent C-SSRS assessment (Attachment 2).
 - 2.2.3 **C-SSRS (Recent/Screen Version):** Provides a truncated form of the Full Version. Screens for suicidality in a potential client (Attachment 3).



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- 2.2.4 **C-SSRS (Since Last Visit/Screen Version):** Provides a truncated form of the Full Version. Screens for suicidality since the client’s last visit during which the C-SSRS was administered. Designed to assess clients who have completed at least one Lifetime/Recent C-SSRS assessment. The ‘Since Last Visit’ version of the C-SSRS asks about any suicidal thoughts or behaviors the patient/participant may have had since the last time the C-SSRS was administered (Attachment 4).
- 2.2.5 **C-SSRS Pediatric/Cognitively Impaired (Lifetime/Recent Full Version):** Assesses lifetime history of suicidality in children and cognitively impaired clients as well as any recent suicidal ideation and/or behavior in the past three months. **Note:** This version is included for use in children in the age range of 6-11 or individuals with impaired cognition depending upon their level of understanding (i.e., if the individual is unable to understand the questions on the adult Lifetime/Recent Screen). It has been used in clients as young as five and can be asked of the parent or caregiver (Attachment 5).
- 2.2.6 **C-SSRS Pediatric/Cognitively Impaired (Since Last Visit/Full Version):** Assesses for suicidality since the child’s last visit. Designed to assess children who have completed at least one Pediatric/Cognitively Impaired Lifetime/Recent C-SSRS assessment. Also see **“Note”** in Section 2.2.5 (Attachment 6).
- 2.3 **Moderate Suicide Risk:** A client who indicates upon response to the C-SSRS:
- 2.3.1 Suicidal ideation with method occurring in the past month (“Yes” to Item 3 in the C-SSRS Ideation Section); and/or
- 2.3.2 Suicidal intention with or without a specific plan, but not occurring within the past one month (“Yes” to Item 4 and/or 5 in the C-SSRS Ideation Section); and/or
- 2.3.3 Actual, interrupted, or aborted suicide attempt(s) or preparatory behavior, but not occurring within the past three months (“Yes” to the Behavior Question(s) on the C-SSRS or to Item 6 on the C-SSRS screen versions).



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- 2.4 **High Suicide Risk:** A client who indicates upon response to the C-SSRS:
- 2.4.1 Suicidal intention with or without a specific plan occurring in the past month (“Yes” to Item 4 and/or 5 in the C-SSRS Ideation Section); and/or
 - 2.4.2 Actual, interrupted, or aborted suicide attempt(s) or preparatory behavior occurring within the past three months (“Yes” to the Behavior Question(s) on the C-SSRS or Item 6 on the C-SSRS screen versions).

Common Terminology of Suicide Behaviors:

- 2.5 **Aborted Attempt:** An act committed by an individual in an effort to cause his or her own death that was deliberately not completed.
- 2.6 **Interrupted Attempt:** Steps taken by an individual to injure self that is stopped by something or someone before the potential for harm has begun.
- 2.7 **Preparatory Behavior:** Any act of preparation for an imminent suicide attempt occurring before potential for harm has begun. This can include anything that goes beyond the verbalization or thought of self-harm, such as obtaining the elements of the intended method (e.g., buying a gun, collecting pills) or preparing for one’s death by suicide (e.g., writing a suicide note, giving away belongings).
- 2.8 **Suicide:** A death of an individual by a deliberate self-inflicted injury.
- 2.9 **Suicide Attempt:** An act committed by an individual in an effort to cause his her own death.

Client Status Descriptors in the Los Angeles County Department of Mental Health System of Care:

- 2.10 **Inactive LACDMH Client:** A client, in the LACDMH System of Care with a Clinical Record, who has had no activity for one hundred eighty plus (180+) days or service(s) terminated per LACDMH Policy No. 312.01, Mutual and Unilateral Termination of Mental Health Services (Reference 1).



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- 2.11 **Newly Active Client:** A new client requiring the opening of a new clinical record or an existing client returning for services after the termination of services per LACDMH Policy No. 312.01, Mutual and Unilateral Termination of Mental Health Services, or an existing client returning for services after one hundred eighty plus (180+) days of inactivity requiring the resumption of documentation in an existing clinical record.
- 2.12 **Potential Client:** An individual or his/her representative who is seeking mental health services.

POLICY

- 3.1 A suicide assessment, including the appropriate components of the C-SSRS, must be completed for all clients and potential clients six years of age or older at all service contacts (whether by phone or face to face with the client/potential client) including screening, triage, and assessment in accordance with the procedures below.
- 3.1.1 For children under the age of six, a suicide assessment should be completed as clinically appropriate.
 - 3.1.2 If there are multiple contacts with the client/potential client on the same day by the same practitioner, the suicide assessment only needs to be completed once. If the contacts are by different practitioners, each practitioner must complete a suicide assessment.
 - 3.1.3 If the contact is with a significant support person, the applicable elements of a suicide assessment are recommended. Information gathered from a significant support person should be included when determining the risk.
- 3.2 Clinicians shall take specific actions to report and mitigate moderate or high suicide risk.



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PROCEDURE

- 4.1 For all potential clients being screened or triaged, a Suicide Screening, which includes the use of the C-SSRS (Recent/Screen Version), shall be completed (Attachment 3).
 - 4.1.1 If the Suicide Screening is positive, a Suicide Assessment, which includes the use of the C-SSRS (Lifetime/Recent Version), shall be completed (Attachment 1).
- 4.2 For all newly active clients, an initial Suicide Assessment, which includes the use of the C-SSRS (Lifetime/Recent Full Version), shall be completed as a baseline assessment (Attachment 1).
 - 4.2.1 If an existing client does not have an initial suicide assessment, which includes the use of the C-SSRS (Lifetime/Recent Full Version), the C-SSRS (Lifetime/Recent Full Version) shall be completed at the next service contact (Attachment 1).
 - 4.2.2 If a newly active client has a C-SSRS (Lifetime/Recent Version) present in the record, then the C-SSRS (Since Last Visit/Full Version) shall be completed (Attachment 2).
- 4.3 For existing clients without evidence of moderate to high suicide risk and for whom a C-SSRS (Lifetime/Recent Full Version) has been completed, a Suicide Screening, which includes the administration of Question 2, "**Have you actually had any thoughts of killing yourself?**" and Question 6, "**Have you done anything, started to do anything, or prepared to do anything to end your life?**" from the C-SSRS (Since Last Visit/Screen Version) (Attachment 4) shall be completed and documented in the progress note at each service contact.
 - 4.3.1 If the response to either question 2 or question 6 above is "Yes," a Suicide Assessment, which includes the use of the C-SSRS (Since Last Visit/Full Version), shall be completed (Attachment 2).
- 4.4 For existing clients with moderate to high suicide risk, a Suicide Assessment which includes the use of the C-SSRS (Since Last Visit/Full Version) shall be completed at each visit until the client is no longer considered moderate to high



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suicide risk, e.g., ninety (90) days free of suicidal ideation or behavior (Attachment 2).

- 4.5 For any client who is determined to be at moderate to high suicide risk, the practitioner making the determination shall:
- 4.5.1 Document the notification of the Clinical Supervisor and, if applicable, the treating Psychiatrist/Psychiatric Mental Health Nurse Practitioner (PMHNP) on the same business day or sooner depending on the risk level in order to inform him/her of the risk and to determine if a medication consultation prior to the next scheduled consultation is advised.
 - 4.5.2 Notify the Program manager/supervisor to schedule a treatment team review of the client's case including, as applicable, stressors, diagnosis, substance use implications, inclusion of family involvement or other indicators of risk, interventions and plan of communication until the risk has dissipated.
 - 4.5.3 Consider and document actions taken, including but not limited to:
 - 4.5.3.1 Conduct an evaluation of the client by Lanterman-Petris-Short (LPS) designated staff to determinate if he/she meets the criteria of danger to self and, if applicable, initiating an application for involuntary detention in accordance with California Welfare and Institutions Code (WIC) Sections 5150/5585.
 - 4.5.3.2 Develop a Safety Plan with the client and significant others to identify and monitor current stressors that may serve as risk factors and identify protective factors (Attachment 7) including, but not limited to:
 - Considering past suicide attempts and triggers to the attempts.
 - Considering risk of modeling, e.g., from exposure to a recent death by suicide event for an adolescent client or a



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client who has a history of a family member who has died by suicide.

- Considering current risk factors/stressors such as age (adolescent), pending custody proceedings, school, relationships, job, legal or financial issues.
- Considering past or current substance use and obtaining consultations as needed regarding concurrent co-occurring disorders interventions.
- Considering current medical conditions such as pain or psychiatric symptoms that may decrease coping or increase ideation/plans, such as psychosis.
- Considering recommendation of psychotherapy or psychoeducation for maximizing social, coping, or stress management and/or other indicated skills.
- Encouraging inclusion of family, friends, or significant others in order to contribute to and support the safety plan (Reference 2).
- Assisting individual and family/friends involved in treatment in planning the removal of immediately available or preferred methods of self-harm.
- Identifying resources to contact in the event of crises.
- Determining level of client and/or significant other engagement in increasing protective factors and reducing identified risk and seeking consultation if there is insufficient engagement for the level of risk determined (Reference 3).

4.5.4 After ninety (90) days, if suicidal ideation, plan, or behavior is not indicated on the C-SSRS or other components of the Suicide Assessment, any Moderate or High Risk Status will be downgraded to a Low or Moderate Risk status with corresponding documentation as to the rationale.

4.5.4.1 Factors in making the decision to change moderate or high risk level determinations shall be clearly documented in the progress note.



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4.6 Any recent suicide attempt(s) identified during the Suicide Screening/Suicide Assessment shall immediately be reported to the clinical supervisor and program manager.

AUTHORITY

1. LACDMH Office of the Medical Director Clinical Directive

ATTACHMENT (HYPERLINKED)

Please note: Attachments 1-6 below referenced in this policy have been incorporated into the Integrated Behavioral Health Information System (IBHIS). While the format and structure may be slightly different, the nature of the questions and the content has been maintained.

1. [C-SSRS \(Lifetime/Recent Full Version\)](#)
2. [C-SSRS \(Since Last Visit/Full Version\)](#)
3. [C-SSRS \(Recent/Screen Version\)](#)
4. [C-SSRS \(Since Last Visit/Screen Version\)](#)
5. [C-SSRS Pediatric/Cognitively Impaired Version \(Lifetime/Recent Full Version\)](#)
6. [C-SSRS Pediatric/Cognitively Impaired Version \(Since Last Visit/Full Version\)](#)
7. [APPENDIX A Safety Planning: Barbara Stanley and Gregory K. Brown, Introduction, Sample, and Template](#)

REFERENCE

1. [LACDMH Policy No. 312.01, Mutual and Unilateral Termination of Mental Health Services](#)
2. [LACDMH 4.16 Parameters of Family Engagement and Inclusion for Adults](#)
3. [LACDMH 4.17 Parameters for the Determination of Insufficient Client Engagement of Adults at Risk for Suicide](#)

RESPONSIBLE PARTY

LACDMH Office of the Medical Director