

# Suicide Prevention in Youth and Young Adults

## Communicating With Families Saves Lives

### **A Checklist for Health Providers and Mental Health Practitioners**

**Created by the *Oregon Council of  
Child and Adolescent Psychiatry***



### **Rationale and Scope**

Preliminary statistics from Oregon indicate that 701 persons died by suicide in 2012. That was 30% greater than the number of deaths from vehicular accidents, homicide, and HIV/AIDS combined. Oregon's suicide rate in 2011, 16.9 per 100,000 persons, was far above the national average of 12.4. The rate among Oregon males ages 20-24 was a shocking 29.3. By way of comparison, the death rate from breast cancer was 12.4 per 100,000. Suicide ranks as the second leading cause of death in Oregon among people ages 15-34. But this is not for lack of care. Nationally, 35 percent of those who took their lives were being treated for mental illness at the time of their deaths and 45% of all suicide victims had contact with primary care providers within one month of taking their own lives. (Shen & Millet, 2013; Luoma et. al. 2002)

Communication between primary care providers and/or mental health practitioners and family members of patients seeking treatment for mental illness improves the quality of care provided to these patients, reduces the risk of suicide and self-harm behaviors, and encourages the use of community resources to improve overall outcomes for these patients. While confidentiality is a fundamental component of a therapeutic relationship, it is not an absolute, and the safety of the patient overrides the duty of confidentiality. Misunderstandings by clinicians about the limitations created by HIPAA, FERPA, and state laws for preserving confidentiality of patients has caused unnecessary concern regarding disclosure of relevant clinical information. Communication between providers, patients, and family members or identified significant others needs to be recognized as a clinical best practice and deviations from this should occur only in rare and special circumstances.

This checklist is intended for use by primary care providers, emergency department staff, and any professional providing mental health treatment, to include, but not be limited to, family physicians, general practitioners, pediatricians, physician assistants, nurse practitioners, social workers, counselors, psychologists, psychiatric nurse practitioners, and psychiatrists. If your professional organization does not have a preferred suicide risk assessment protocol, please see page 8 of this document.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

DOB/Medical Record #: \_\_\_\_\_

**For All Patients with Mental Health Issues, Providers Should Complete the Following:**

- Complete a comprehensive risk assessment including patient interview, record review and solicitation of information from family/parents. **If you do not feel qualified to complete a comprehensive risk assessment, refer the patient for urgent evaluation and verify completion.**
  - If the patient is 18 or older, or if you believe confidentiality is required by law or common medical practice, seek an authorization to release information for the family/parents **or** document a compelling reason not to do so. Be assertive and persuasive in obtaining this authorization.
  - Interview the family to obtain additional history about the patient and to determine what the family/parents already know about the illness/need for treatment. An authorization is not necessary to do this.
  - Obtain authorizations to obtain information from all previous treatment providers and promptly request treatment records, including psychotherapy notes, psychiatric treatment, and relevant medical records.
  - Review the medical records carefully to gain a comprehensive knowledge of risk factors for the patient.

**Where an elevated risk of suicide is identified in adult patients (or when patient is a minor in Oregon), take the following steps regardless of whether or not one has a signed authorization:**

- Following the initial evaluation, communicate with the patient and the family/parents regarding diagnoses, treatment recommendations and safety issues. Do **not** assume they know anything about the nature of mental illness, treatment, risk factors, or community resources.
- Explicitly inform the family in the presence of the patient of all safety issues, including risk factors for suicide and what steps to take if danger exists, such as ridding the home of firearms/other means of self-harm and creating a plan to monitor and support the patient.
- Discuss available community resources to help the family and patient, including resources for case management, support groups, improving mental health at home, and other relevant factors.
- Coordinate provision of care when a patient transitions from one level of care to another, or one provider to another:
  - Involve patient and family in planning process including discussion of interim safety plan.
  - Assure follow up is in place with a specific timely appointment.
  - Assure accepting provider has full knowledge of history and risk issues/records.
  - Confirm that patient has attended the follow up appointment.

**Additional Notes:**

Clinician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **Sources and Justifications**

### **Purpose:**

The basic philosophy behind this document is to always do what is in the best interest of the patient in the provider's professional judgment. OCCAP believes that in nearly all cases where the patient is at risk of self-harm, this will involve a great deal of communication with the families of patients. By "families" we include those individuals identified by the patient as significant in their life. We also believe that the perception of restrictions on communication with families is often greater than the limits imposed by law or regulation.

A common misperception by clinicians is that this communication is prohibited by law or ethical standards. The most obvious recourse is to seek authorization for release of information, and advocate with the patient to sign the authorization at an early stage in treatment (APA April 1999). However, both legal and ethical standards provide for communication with parents/family under circumstances where the patient is at risk of self harm, even without the patient's authorization.

The communication we are encouraging does not involve disclosing psychotherapy notes or other intimate details the patient may have shared with the provider. Rather, the communication should focus on the existence of a heightened risk of suicide; the diagnoses relevant to that; the provider's recommendations for treatment; the warning signs and risk factors for suicide in this specific case; actions the family can take to reduce the risk; and the community resources that might be engaged by both the family and patient to reduce the risk.

### **Key Points:**

1. Always act in the best interests of your patient, with particular attention to the safety of that individual. **If you are in doubt, it is better to violate confidentiality in the interest of protecting your patient.**
2. It is **always** better to defend allegations of an inappropriate disclosure than to defend a failure to disclose with bad outcome (e.g. injury or death). "From a liability risk standpoint, suicide claims are considered to be low frequency/high severity. The overall number of suicide-related malpractice cases is low; however, those that are filed tend to result in higher than average indemnity payments. The issue in these cases is NOT whether the physician should have been able to predict the patient would commit suicide, but, rather: was the risk of suicide foreseeable? Physicians who actively address suicide risk, and document their risk assessment and recommended treatment plan, are far less likely to be named in a lawsuit alleging improper care resulting in suicide." (Debra Davidson, American Physicians Assurance Corporation.)
3. Do not assume that confidentiality is required or that a release is necessary to communicate with parents, if it cannot be obtained. State law might indicate otherwise. (See ORS 109.650, 109.680 and 109.675 on when a provider treating a juvenile may or must disclose to parents and <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/personalrepresentatives.pdf>)
4. Where you believe that confidentiality must be required and you cannot obtain a release, communicate with the family/parents non-confidential information such as community resources available to them to help address the issue. For example, if the family knows that the patient is clinically depressed and that there has been non-suicidal self-injury (such as cutting), give the family/parents general information on depression and non-suicidal self-injury, and on community resources where they may obtain more information and support.
5. Approach safety planning and treatment as a collaborative process from the onset. Assure the patient that s/he is not alone; engage their identified support system. Recognize that family may provide information to you without the need for an authorization. Consider also non-traditional sources of information such first responders, police, ER staff.

## **Special Populations:**

There are several scenarios that will require increased scrutiny and discretion on the part of the provider prior to communicating with the family. A patient seeking care from an abusive family situation or youth seeking care only on the condition of confidentiality must be treated as a special case, as will with serious substance abuse issues. Alcohol and drug treatment have more restrictions upon them related to confidentiality and must be handled with great discretion.

For patients of a sexual or gender minority, such as LGBT patients, issues of confidentiality become even more important and limiting disclosures needs to be done with great care. Per the recommendations of the AACAP Practice Parameter on Gay, Lesbian, or Bisexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents (though equally applicable to adult patients):

“Clinicians should bear in mind potential risks to patients of premature disclosure of sexual orientation, such a family rejection or alienation from support systems, which might precipitate a crisis.”

We believe that for the vast majority of treatment scenarios, however, involvement of the family will enhance care and reduce both the risk of suicide and the risk of a malpractice suit. This checklist was created with the needs of children, adolescents, and transition-age adults (people between the ages of 17 and 24) particularly in mind. It is widely recognized that for these patients the best outcomes require the provider(s) to communicate with the family and involve them in treatment. The checklist may certainly be used beneficially with older patients as well.

## **Federal Law Regarding Disclosure of Protected Health Information for Adult Patients:**

**Federal law** permits, but does not require, a provider to disclose to family protected health information relevant to the family member’s involvement in the patient’s care without a release if the provider provides an opportunity for the patient to object and the patient does not, or the provider “reasonably infers from the circumstances, based [on] the exercise of professional judgment, that the [patient] does not object to the disclosure.” (45 CFR 164.510 [b][2])

Providers may also disclose otherwise protected information when “the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual’s incapacity or an emergency circumstance, the [provider] may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual . . .” (45 CFR 164.510 [b][3])

- "Medical professionals can talk freely to family and friends, unless the patient objects. No signed authorization is necessary. Health care workers may not reveal confidential information about a patient or case to reporters, but they can discuss general health issues." Susan McAndrew, Deputy Director of Health Information Privacy, U.S. Department of Health and Human Services, quoted in: Gross, Jane. *Keeping Patients' details private, even from kin*. New York Times, July 3, 2007.

Also, it is important to note that one cannot breach confidentiality where it does not exist, or where one is disclosing medical records or information not learned from the patient. For instance, if the family brings you prior treatment records and is familiar with them already, you may discuss the prior treatment with them and its implications for the current situation plus provide referral to community supports.

## **Oregon Laws Regarding Disclosure of Protected Health Information When Patient is a Minor:**

It may be that **state law** allows or even requires the provider to involve the family at some stage of the treatment, when the disclosure or involvement is clinically appropriate. (See ORS 109.650, 109.680 and ORS 109.675 [2] on when the provider may or must disclose.)

### **109.650 Disclosure without minor's consent and without liability.**

A hospital or any physician, nurse practitioner or dentist as described in ORS 109.640 may advise the parent or parents or legal guardian of any minor of the care, diagnosis or treatment or the need for any treatment, without the consent of the patient, and any hospital, physician, nurse practitioner or dentist is not liable for advising the parent, parents or legal guardian without the consent of the patient. [1971 c.381 §2; 2005 c.471 §8]

### **109.675 Right to diagnosis or treatment for mental or emotional disorder or chemical dependency without parental consent.**

(1) A minor 14 years of age or older may obtain, without parental knowledge or consent, outpatient diagnosis or treatment of a mental or emotional disorder or a chemical dependency, excluding methadone maintenance, by a physician licensed by the Oregon Medical Board, a psychologist licensed by the State Board of Psychologist Examiners, a nurse practitioner registered by the Oregon State Board of Nursing, a clinical social worker licensed by the State Board of Licensed Social Workers or a community mental health program established and operated pursuant to ORS 430.620 when approved to do so by the Oregon Health Authority pursuant to rule.

(2) However, the person providing treatment shall have the parents of the minor involved before the end of treatment unless the parents refuse or unless there are clear clinical indications to the contrary, which shall be documented in the treatment record. (Emphasis added.)

The provisions of this subsection do not apply to:

- (a) A minor who has been sexually abused by a parent; or
- (b) An emancipated minor, whether emancipated under the provisions of ORS 109.510 and 109.520 or 419B.550 to 419B.558 or, for the purpose of this section only, emancipated by virtue of having lived apart from the parents or legal guardian while being self-sustaining for a period of 90 days prior to obtaining treatment as provided by this section. [1985 c.525 §1; 1989 c.721 §47; 1993 c.546 §137; 1997 c.249 §38; 2009 c.442 §30; 2009 c.595 §71]

OAR 309-039-0540 General Standards: Each provider is required to meet the following administrative standards . . . (12)(a)“Providers shall provide for the **earliest feasible involvement** of the parents or guardians in the treatment plan consistent with the clinical requirement of the minor as provided under ORS 109.695.” (Emphasis added.) See also, Oregon Health Authority: Standards for the Approval of Providers of Non-Inpatient Mental Health Treatment Services implemented pursuant to ORS 109.695.

### **109.680 Disclosure without minor's consent; civil immunity.**

A physician, psychologist, nurse practitioner, clinical social worker licensed under ORS 675.530 or community mental health program described in ORS 109.675 may advise the parent or parents or legal guardian of any minor described in ORS 109.675 of the diagnosis or treatment whenever the disclosure is clinically appropriate and will serve the best interests of the minor's treatment because the minor's condition has deteriorated or the risk of a suicide attempt has become such that inpatient treatment is necessary, or the minor's condition requires detoxification in a residential or acute care facility. If such disclosure is made, the physician, psychologist, nurse practitioner, clinical social worker licensed under ORS 675.530 or community mental health program shall not be subject to any civil liability for advising the parent, parents or legal guardian without the consent of the minor. [1985 c.525 §2; 1989 c.721 §48; 2009 c.442 §31; 2009 c.595 §72]

Also note, if a parent seeks access to medical records of an un-emancipated minor, federal law (HIPAA) defers to any state law which specifically permits or prohibits disclosure, e.g. Oregon statutes. (45 CFR 164.502 (g)(3)(ii); see also State of Oregon, Legislative Counsel Committee, *Disclosure of protected health information to a parent*, 10/18/2011, and OMA Legal/Regulatory Briefing on Specially Protected Records, page 5.)

### **Ethical Standards for Exemptions from Confidentiality Due to Safety Concerns:**

Generally accepted ethical standards also promote greater communication with families and/or significant others.

The **American Medical Association's** Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, 2013 Edition specifies in Section 4 "A physician shall respect the rights of patients, colleagues and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law." Annotation 8 interprets and expounds upon section 4 by adding "When, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient." (Emphasis added.)

The **American Psychological Association's** Ethical Principles of Psychologists and Code of Conduct specifies in Standard 4: Privacy and Confidentiality "Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship." Section 4.05 titled Disclosures indicates "(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to ... (3) protect the client/patient, psychologist, or others from harm..." (Emphasis added.)

The **National Association of Social Workers'** Code of Ethics Standard 1.07(c) states that the general obligation to maintain client confidentiality "does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person." (Morgan, 2013)

The **American Nurses Association** Code of Ethics for Nurses, Provision 3 discusses the duty of nurses to promote, advocate for, and strive to protect the health, safety, and rights of the patient. Section 3.2 specifically addresses Confidentiality, noting:

"Associated with the right to privacy, the nurse has a duty to maintain confidentiality of all patient information. The patient's well-being could be jeopardized and the fundamental trust between patient and nurse destroyed by unnecessary access to data or by the inappropriate disclosure of identifiable patient information. The rights, well-being, and safety of the individual patient should be the primary factors in arriving at any professional judgment concerning the disposition of confidential information received from or about the patient, whether oral, written or electronic. The standard of nursing practice and the nurse's responsibility to provide quality care require that relevant data be shared with those members of the health care team who have a need to know. Only information pertinent to a patient's treatment and welfare is disclosed, and only to those directly involved with the patient's care. Duties of confidentiality, however, are not absolute and may need to be modified in order to protect the patient, other innocent parties and in circumstances of mandatory disclosure for public health reasons." (Emphasis added.)

### **Generally Accepted Standards of Practice:**

Generally accepted practice standards recognize a need for communication with families and/or significant others to protect patients' safety or to promote the best interests of the patient.

*For Adult Patients:*

#### **American Psychiatric Association Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors (2003):**

Section V: Documentation and Risk Management, *C. Communication With Significant Others*

The confidential nature of the doctor-patient relationship is a fundamental aspect of the psychotherapeutic process. Consequently, the psychiatrist will need to manage the tension between this requirement and the wish to act in the patient's best interest (Emphasis added.) The default position is to

maintain confidentiality unless the patient gives consent to a specific intervention or communication. However, in maintaining a safe environment for the patient, significant others may need to be contacted to furnish historical information or carry out specific tasks such as removing firearms from the home. If the psychiatrist determines that the patient is (or is likely to become) dangerous to him- or herself or to others and the patient will not consent to interventions that aim to reduce those risks, then the psychiatrist is justified in attenuating confidentiality to the extent needed to address the safety of the patient and others. (Emphasis added.)

The **American Psychiatric Association** has said “Disclosures can sometimes be justified on the grounds that they are necessary to protect the patient. For instance, it is generally acceptable for a psychiatrist to warn a patient’s family or roommate when the patient is very depressed and has voiced suicidal thoughts.” (Practice Management Handbook for Early Career Psychiatrists, Office of Healthcare Systems and Financing, American Psychiatric Association, June 2010; also see 34 CFR 99.36 as regards educational institutions.)

The **Oregon Medical Association** has said as regards communication with other providers, that “It is important to keep in mind that, while it is sound practice to evaluate what information needs to be disclosed, it is also important not to be too restrictive. If the appropriate information is not disclosed for treatment purposes, it can lead to adverse consequences for the patient... Some of the more restrictive practices that have been adopted by some physicians represent a barrier to efficient and quality health care.” (Oregon Medical Association HIPAA Privacy Rule Overview, accessed through <http://www.theoma.org/practice-help-center/practice-management/privacy-security/hipaa/hipaa-privacy-rule-overview> on 9/16/2011)

The **American Association of Suicidology** (AAS) has prepared “Recommendations for Inpatient and Residential Patients Known to be at Elevated Risk for Suicide”. Recommendation number 7 states, “Both the patient and the family or significant others should be given instruction regarding suicide and its associated risk, including, but not limited to the following: warning signs of suicide, the increased risk for suicide during pass or following discharge; the need for medication and other treatment adherence; explanation of how psychiatric symptoms may impair judgment; explanation of the need for the patient to avoid use of intoxicants and how intoxicants increase risk; the need for the removal of the means for suicide, and the particular risk associated with firearms.” This reasoning is equally valid to out-patient care. ([http://www.suicidology.org/c/document\\_library/get\\_file?folderId=231&name=DLFE-106.pdf](http://www.suicidology.org/c/document_library/get_file?folderId=231&name=DLFE-106.pdf))

Specifically related to college students, the **American Psychiatric Association** has said, “Parents also have a strong interest in being involved in their children’s health care—even when their child might legally be an adult...The perceived impediments to disclosures by college officials in situations in which the health or safety of students may be endangered seem often to be the result of a misunderstanding of FERPA and other relevant laws and regulations.” The paper notes that suicide is the second leading cause of death among American college students, and the third leading cause among all American youth, aged 10-24. (American Psychiatric Association, College Mental Health and Confidentiality, June 2009)

*For Juvenile Patients:*

### **American Academy of Child and Adolescent Psychiatry Practice Parameter on Depressive Disorders (2007):**

**Recommendation 1.** The Clinician Should Maintain a Confidential Relationship With the Child or Adolescent While Developing Collaborative Relationships With Parents, Medical Providers, Other Mental Health Professionals, and Appropriate School Personnel [MS\*].

At the outset of the initial contact, the clinician should clarify with the patient and parents the boundaries of the confidential relationship that will be provided. The child’s right to a confidential relationship is determined by law that varies by state. Each state has mandatory child abuse reporting requirements. Parents will expect information about the treatment plan, the safety plan, and progress toward goals of treatment. The child should expect that suicide or violence risk issues will be communicated to the parents. (Emphasis added.) The clinician should request permission to communicate with medical providers, other mental health professionals involved in the treatment, and appropriate school personnel. Clinicians should provide a mechanism for parents to communicate concerns about deterioration in function and high-risk behaviors such as suicide threats or substance use.

**Recommendation 7.** Each Phase of Treatment Should Include Psychoeducation, Supportive Management, and Family and School Involvement [MS\*]...

*Family Involvement.* Even in the absence of formal family therapy, it is virtually impossible to successfully treat a child or adolescent patient without the close involvement of parents. (Emphasis added.) First, the clinician has to recognize that motivation for treatment comes often from the parents, and therefore the treatment contract must involve them. Second, the parents may observe aspects of the child's functioning or symptoms that the child either is not aware of or does not wish to share, and this information is vital to the development of a realistic and effective treatment contract. Third, the parents are able to monitor their child's progress and serve as a safety net. As described in the section about psychotherapies (Recommendation 9), despite the scarce and weak empirical evidence, knowledge of risk factors suggests that interventions with families are an important part of clinical management. (Emphasis added.) These interventions should take into account the family's cultural and religious background and focus on strengthening the relationship between the identified patient and caregiver(s), provide parenting guidance (e.g., management of conflicts), reduce family dysfunction, and facilitate treatment referral for caregivers or siblings with psychiatric disorders and for marital conflict (Asarnow et al., 1993 [rct]; Birmaher et al., 2000 [ut]; Diamond et al., 2002 [ut]; Garber et al., 2002; Hammen et al., 2004; Nomura et al., 2002; Sanford et al., 2006)...

\* The AACAP Practice Parameters specify the strength of the underlying clinical and/or empirical data of the recommendations; the [MS] designation reflects a "Minimal Standard" described in the practice parameters as: "Minimal Standards are applied to recommendations that are based on rigorous empirical evidence (e.g., randomized controlled trials) and/or overwhelming clinical consensus. Minimal standards apply more than 95% of the time (i.e., in almost all cases)."

## **Suicide Risk Assessment Resources for Clinicians**

1. An excellent review of suicide prevention and screening resources can be found at <http://www.stopasuicide.org>
2. SAFE-T (Suicide Assessment Five-step Evaluation and Triage) available to download at [www.sprc.org](http://www.sprc.org). Go to the library and resources section, browse the library, search for SAFE-T, or copy and paste this: [http://www.sprc.org/sites/sprc.org/files/library/safe\\_t\\_pcktrd\\_edc.pdf](http://www.sprc.org/sites/sprc.org/files/library/safe_t_pcktrd_edc.pdf)
3. An excellent screening resource developed specifically for PCPs can be found at: <http://prevention.mt.gov/suicideprevention/PrimaryCarePhysiciansMasterFile.pdf> . The Master File has many other easy to use tools on suicide prevention and is simple to access.
4. One of the most complete and accurate methods of suicide assessment is the CASE Method developed by Sean C. Shea and discussed at length in his book, The Practical Art of Suicide Assessment: A Guide for Mental Health Professionals and Substance Abuse Counselors, Mental Health Presses, 2002/2011. See also his: Psychiatric Interviewing: the Art of Understanding, A Practical Guide for Psychiatrists, Psychologists, Counselors, Social Workers, Nurses, and Other Mental Health Professionals, 1998.



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## **Publication Data**

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The checklist and resource material are available for downloading and printing on the Internet at [www.aacap.org/occap](http://www.aacap.org/occap) or [www.occap.org](http://www.occap.org) as Communication Checklist for Mental Health Practitioners. Requests for reprints may be made to OCCAP, PO Box 21571, Keizer, OR 97307.

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