ADOLESCENT SUICIDE ASSESSMENT PROTOCOL-20

William J. Fremouw, Ph.D., Julia M. Strunk, B.A., Elizabeth A. Tyner, B.S.,
Robert Musick, MSW/LCSW

Youth suicide is the third leading cause of death, behind accidents and homicide, among young people from 15 – 24 years old (National Center for Health Statistics, 2000). Adolescent suicide is increasing at an alarming rate. From 1980 – 1992, completed suicides by adolescents increased over 28 percent. Fortunately, this rate has slightly decreased from 1994 to 2000 but is still 10.4 suicides per 100,000 among 15 – 24 year olds (Miniño, Arias, Kochanek, Murphy & Smith, 2002). In 2001, 3,409 males and 562 females between the ages of 15 – 24 committed suicide (Anderson & Smith, 2003).

Young males and females complete suicide at a comparable rate between the ages of 10 – 14. However, teenage boys ages 15 – 19 commit suicide 3.6 times more often than teenage girls. This gender difference further increases through ages 20 – 24. While more boys complete suicide, girls have a much higher rate of attempting suicide (Center for Disease Control; CDC, 1995).

In just one year, almost 3,000,000 teenagers in the United States attempted or seriously considered suicide (Substance Abuse and Mental Health Services Administration, 2002). Bell and Clark (1998) estimate that there are 15 to 20 nonfatal suicide attempts for each adolescent who commits suicide. Attempting suicide is one of the strongest predictors of completed suicide. The CDC (1998) reported that 10.3% of white female adolescents and 3.2% of white male adolescents attempted suicide with 2.6% and 1.5%, respectively, requiring medical attention for this attempt.

Litman (1990) defined any suicide contemplation, attempt, and completion as forming a SUICIDE ZONE of risk. While the exact classification of suicidal behaviors remains a challenging area for researchers (O'Carroll, Berman, Maris, Moscicki, Tanney & Silverman, 1996), the identification of adolescents who are in this SUICIDE ZONE of risk is the essential task of the clinician. The second task is then to respond appropriately to reduce this risk (Rudd & Joiner, 1998).

The purpose of this chapter is to describe a suicide assessment protocol for use by mental health intake workers, hotline workers, school counselors, and other gatekeepers who interact with adolescents who may be in the SUICIDE ZONE of risk. Goldston (2003) reviewed over 50 suicide assessment instruments ranging from four item questionnaires to multi-level intensive clinical assessments. Most of these instruments require an adolescent to complete

extensive written measures of ideation, mood, and history and to cooperate with an in-depth clinical interview. Unfortunately, there is not a "gold standard" assessment procedure for the initial screening of adolescents who may be at risk for suicide that can be used easily by professionals conducting intake interviews.

This chapter presents the rationale and guidelines for a brief, user-friendly, structured clinical interview called the Adolescent Suicide Assessment Protocol-20 (ASAP-20). It is intended for use by mental health workers and/or school counselors to provide an initial objective assessment of adolescent suicidal risk. The ASAP-20 is organized based on a risk assessment model. An adolescent will be classified as either low, medium, or high risk upon completion of the assessment. If an individual is classified as medium or high risk for suicide, then a more intensive evaluation should be conducted with prevention and treatment interventions implemented immediately.

RISK ASSESSMENT AND GUIDED CLINICAL INTERVIEW

Historically, risk assessment has been conducted by two distinctive procedures:

a. the unstructured clinical judgment, or

b. the actuarial risk assessment database procedure. McNeil, Borum, Douglas, Hart, Lyon, Sullivan, and Hemphil (2002) reviewed the risk assessment procedures. The authors criticized unstructured clinical interviews and also examined the limitations of actuarially based assessments. They identified the guided clinical interview as an innovative synthesis of the unaided clinical judgment and pure actuarial prediction methods. This approach has been used in other areas of clinical-forensic assessments such as competency to stand trial. A structured or semi-structured clinical interview is developed based on research findings from actuarial and/or clinical research. McNeil and colleagues (2002) conclude that guided clinical assessments can perform equal to or even better than some actuarial predictions.

The ASAP-20 is modeled after the HCR-20 guided clinical interview developed by Webster, Douglas, Eaves, and Hart (1995) which assesses future risk of violence by forensic or psychiatric inpatients. A 20-item guided interview was developed and organized into three domains: historical, clinical, and risk management. Their manual provided a research rationale and coding instructions for each item. HCR-20 is not a test; instead it is presented as a guide to the assessment of violence for mental health professionals. This

instrument guides the interviewer to assess the most relevant areas, based on empirical research, prior to coming to a clinical judgment about an individual's level of risk for violence. Douglas and Webster (1999) reported that prisoners with high HCR-20 scores above the medium range were associated with **four** times the rate of violence than prisoners who scored below the median. In a follow-up study of civilly committed psychiatric patients two years after discharge, Douglas, Ogloff, Nichols, and Grant (1999) reported that scores above the median on the HCR-20 had rates of violence more than **six** times that of the group that scored below the median.

RATIONALE FOR THE ASAP-20

The ASAP-20 was developed from a careful review of the adolescent suicide risk literature to identify both static and dynamic factors associated with both adolescent attempted and completed suicides. In 1990, Fremouw, DePerczel, and Ellis wrote *Suicide Risk Assessment Response Guidelines*, which identified and addressed risk factors of both adults and adolescents. The authors identified demographic factors, historical factors, and current clinical factors which were relevant to the assessment of suicidal risk. The book provided treatment guidelines for individuals at different levels of suicidal risk. The assessment of contextual factors, such as availability of weapons, was not included in this work. This empirical review of adolescent literature served as the starting point for the development of the ASAP-20. ASAP-20 items were generated based on this work, current research summarized in Spirito and Overholser (2003), and empirical articles such as the New York State Adolescent Autopsy Study of 120 suicides completed by individuals under 20 years of age and 147 control subjects (Gould, Fisher, Parides, Flory, & Shaffer, 1996) and the Pittsburgh Autopsy Study of 67 adolescent suicide victims and 67 control participants (Brent, Perper, Kolko, & Zelenak, 1988; Brent, Perper, Moritz, Allman, Friend, Roth, Schweers, Balach, & Baugher, 1993).

Twenty-four items were generated based on the literature review. These items were piloted with mental health intake workers who evaluated 100 adolescents using the preliminary scale and coding guidelines. Based on these data, items were eliminated or refined to be more sensitive and helpful. ASAP-20 presents the 20 items most discriminating of ratings of low, medium, and high risk of suicide by mental health professionals of adolescents who are presenting for initial evaluation.

ASAP-20 is organized into four domains: **Historical, Clinical, Contextual, and Protective. Historical** items include a history of prior suicide attempts or history of family suicide attempts/completions. **Clinical** items consist of the presence of hopelessness, depression, or anger, and *specific* clinical items such as current suicidal ideation and communication of suicidal wishes. **Contextual** or environmental factors include recent losses, access to firearms, or the absence of family, and peer support. **Protective** factors are the presence or the

existence of current treatment and of reasons for living. Protective factors are an emerging area in the risk assessment literature. In general, protective factors are those variables which reduce the likelihood of violence or suicide by reducing the negative impact of the risk factors. Eggert, Thompson, and Herting (1994) included the assessment of protective factors such as social support, self-esteem, and spirituality in their model of adolescent suicide risk.

While courts do not expect mental health professionals to perfectly predict future behavior, courts do expect the mental health professionals to demonstrate reasonable care and judgment in their predictions and clinical decision making (Fremouw, DePreczel, & Ellis, 1990). The use of the guided clinical instrument, such as the ASAP-20, would ensure that a professional is conducting a thorough clinical assessment prior to concluding the risk level of the respondent. In short, it is just good clinical practice to use such an instrument and should become the "best practice" for mental health intake workers to guarantee a minimum level of thoroughness in these important evaluations.

ASAP-20 MANUAL

The following sections describe the empirical basis, coding guidelines, and suggested questions for the 20 items. The ASAP-20 protocol is in Appendix A. The scoring ranges from 0 to 3 and the end points are defined in the coding guidelines. The clinician must use judgment for the intermediate levels of each item, such as mild or moderate ratings.

HISTORICAL FACTORS

Historical factors in adolescent suicide risk assessment include past experiences that are static, or unchangeable, at the time of assessment. Previous experiences, especially of suicide or violence, are strong predictors of future risk (Fremouw et al., 1990).

1. History of Suicide Attempts

Fremouw, de Perczel, and Ellis (1990) state that "the history of an individual's prior suicide attempts is the most significant historical factor that must be considered in assessing current suicide risk" (p. 39). Research indicates that 25 to 33 percent of adolescents who completed suicide made prior attempts. Furthermore, boys who have a history of prior suicide attempts are especially at risk (30-fold increase); girls are slightly less at risk (3-fold increase) of completing suicide (Gould & Kramer, 2001). A suicide attempt is defined as an intentional, self-harming act with greater than zero probability of death (O'Carroll, et al., 1996).

Coding Guidelines / Suggested Questions

1. Have you ever tried to kill yourself?

2. Describe what you did.

Any suicide attempt significantly raises the risk of future suicide behavior and death.

CODING:

0 = No previous suicide attempt(s) (SCORES OF 1 AND 2 ARE NOT USED)
3 = Suicide attempt(s)

2. History of Physical/Sexual Abuse

According to Brent (2001) "ongoing physical or sexual abuse is a particularly ominous precipitant… (p. 109)" for suicidal behavior. The risk of suicide becomes greater as the length and frequency of the abuse increases (Kaplan, 1996) and may be more likely to result in completed suicide (Brent, 2001).

Coding Guidelines / Suggested Questions

1. Have you ever been physically or sexually abused?

2. If so: When did the abuse occur?

3. If so: How often did the abuse occur?

The rating of physical and sexual abuse of the adolescent should involve three dimensions: frequency, duration, and intensity. A high number of occurrences of the abuse will increase the risk of suicide attempt. Additionally, ongoing abuse qualifies as a higher risk factor than abuse that has ceased. Finally, high intensity abuse will predict a more severe risk for the adolescent.

CODING: 0= No history of physical and/or sexual abuse
1= History of mild physical and/or sexual abuse
2= History of moderate physical and/or sexual abuse
3= History of severe physical and/or sexual abuse

3. History of Antisocial Behavior

Adolescents displaying antisocial behaviors have an increased risk of suicide attempts. The risk is particularly high if these individuals have encounters with the law (Marttunen et al., 1998). Data from the New York Autopsy Study revealed that the rate of suicide in boys with antisocial behavior is 35 per 100,000, as compared to a base rate of 11 per 100,000; and for girls with antisocial behavior the risk is 7 per 100,000 (Gould, Shaffer, Fisher, Kleinman, & Morishima, 1992).

Coding Guidelines / Suggested Questions

1. Have you ever been in any fights at school/in neighborhood? Describe.

2. Have you ever been arrested or PLACED in jail? Explain.

3. Have you ever been on probation or had any legal conflicts? Explain.

Consider the frequency and seriousness of the antisocial behavior when scoring.

CODING: 0= No history of antisocial behavior
1= History of mild antisocial behavior
2= History of moderate antisocial behavior
3= History of severe antisocial behavior with legal conflicts

4. History of Family Suicide Attempts/Completions

Numerous studies have found that suicidal behavior in family members significantly increases the risk for adolescents attempting or completing suicide (Gould & Kramer, 2001; Goldman & Beardslee, 1999). Gould, Shaffer, Fisher, Kleinman, and Morishima (1992) report that in the New York Psychological Autopsy Study, "approximately 40% of the suicide completers had a first- or second-degree relative who had previously attempted or committed suicide" (p.138). Although genetic factors or general family dysfunction may contribute to this pattern of suicidal behavior, Gould and Kramer (2001) report that family histories "increase suicide risk even when studies have controlled for poor parent-child relationships and parental psychopathology" (p. 9).

Coding Guidelines / Suggested Questions

1. Have any of your close family members ever attempted suicide?

2. Have any of your close family members ever completed suicide?

"Family" should include relatives outside the immediate family unit, such as grandparents. Due to the prevalence of extended families living in the same household, aunts, uncles, and cousins should also be considered if interaction with the adolescent is frequent and significant to him/her. Score 3 if either attempts or completions have occurred.

CODING: 0=No history of family suicide attempts or completions
(SCORES OF 1 AND 2 ARE NOT USED)
3=History of family suicide attempts or completions

CLINICAL FACTORS

Clinical items address the current psychological condition of an individual. These factors are dynamic, or changeable, and represent potential areas for change and treatment. Regardless of an individual's history, suicide risk assessment should include an examination of one's current clinical state, including specific thoughts or plans of suicide.

5. Depression

Brent et al. (1993) state that in the Pittsburgh Autopsy Study, "affective disorder, most specifically, major depression, was the single most significant risk factor for completed suicide in adolescents" (p. 524). Other research has revealed that among suicide attempters, depression is the most prevalent psychological disorder (Brent, 2001; Gould & Kramer, 2001). The New York Psychological Autopsy Study found that 61% of the suicide completers met criteria for mood disorder, 52% for major depressive disorder (Shaffer et al., 1996). The Pittsburgh Autopsy Study found depressive disorders in 49% of suicide completers (Brent et al., 1993). While these studies examined suicide completers, studies of suicide attempters reveal even higher estimates of the prevalence of a mood disorders. Pfeffer et al. (1991) found mood disorders in 80% of adolescents who had attempted suicide following hospitalization (cited in Wolfsdorf et al., 2003).

Coding Guidelines / Suggested Questions

1. Do you feel depressed or sad?

2. Have there been any changes in sleeping/eating?

3. Have you lost interest in previously enjoyable activities?

In addition to direct inquiries about depressed mood and feelings of hopelessness, several symptoms of depression seen in adolescents can be addressed when rating this item. Disturbances in sleep and eating patterns are characterized by reversal of normal sleep patterns (retiring early or rising early) and loss of interest in food and eating. Adolescents often appear complacent or lethargic and become socially withdrawn when depressed. The cognitive components of depression include feelings of worthlessness, self-condemnation, impaired self-defense, and pronounced self-deprecation (Fremouw et al., 1990). Questions about feeling in control of the future and the likelihood of making future plans can address the hopelessness component (see next item).

CODING: 0=No depression
1=Mild levels of depression
2=Moderate levels of depression
3=Severe levels of depression

6. Hopelessness

One aspect of depression is the cognitive state of hopelessness, which Fremouw et al. (1990) state is "especially indicative of suicide risk" (p. 65). As a construct, hopelessness includes "feelings of despair, lack of control, and pessimism about the future" (Fremouw et al., 1990). Hopelessness is a dominant characteristic of adolescent suicide attempters (Esposito, Johnson, Wolfsdorf, & Spirito, 2003; Brent, 2001) and should be considered as an indication of the severity of depression and increased risk of suicide (Fremouw, 1990). In the New York Psychological Autopsy Study, 44% of boys and 35% of girls who met criteria for an Axis 1 disorder expressed hopelessness, with mood disorder being the most common criteria met (Shaffer et al., 1996).

Coding Guidelines / Suggested Questions

1. How do you feel about your future: okay, slightly negative, discouraging, or clearly hopeless?

2. What are your future plans: next week? next year?

In scoring hopelessness, answering that the future is okay and he/she has plans for this weekend, next week, or next year would indicate a score of 0. Feeling that the future is slightly negative or discouraging indicates a score of 1. Feeling that the future is bleak indicates a score of 2, and feeling completely hopeless about the future indicates a score of 3.

CODING: 0=No hopelessness
1=Mild levels of hopelessness
2=Moderate levels of hopelessness
3=Severe levels of hopelessness

7. Anger

Anger is prevalent in most adolescents, and many studies demonstrate that anger is correlated significantly with adolescent suicide, especially in non-institutionalized adolescents who have attempted suicide (Wolfsdorf, et al., 2003). The emotion of anger can be externalized and displayed as aggression. Conversely, anger can be internalized and manifested as depression (Myers et al, 1991). This emotion is a risk factor, as Negron et al. (1997) suggest that adolescent suicide "may function as an outlet for their anger" (p. 103).

Coding Guidelines / Suggested Questions

1. How often do you feel angry or lose your temper?

2. Would people describe you as "hot-headed"?

3. Have you ever threatened or assaulted anyone when you were angry?

Some characteristics of anger are resistance and lack of self-control. Some behavioral

indicators of anger are temper tantrums and making threats or assaults. Score 1 if there is some, less serious characteristics or display of anger. Score 2 if the adolescent frequently expresses anger. Score 3 if there are physical manifestations of anger such as threats and assaults.

CODING: 0=No anger
1=Mild anger
2=Moderate anger
3=Severe anger

8. Impulsivity

Research consistently recognizes impulsivity as a psychological characteristic that is highly correlated with adolescent suicidal behavior. In a study examining adolescent suicidal inpatients, nonsuicidal inpatients and high school controls, Kashden et al. (1993) found suicidal inpatients to be more impulsive than both groups. The authors suggest that impulsivity may cause problem-solving deficits in suicidal adolescents. Poor problem solving skills do not allow for thorough evaluation of suicidal acts, including their potential lethal consequences (Brent, 2001). Furthermore, research by Horesh, Gotheif, Ofek, Weizman, and Apter (1999) demonstrate that impulsivity is a stronger risk factor of adolescent suicide for males than females.

Coding Guidelines / Suggested Questions

1. Do you act on whim/do things without thinking first?

2. Are you impatient?

3. Have you been told that you have ADHD?

Impulsivity may be manifested as a personality trait or as a behavior. Impulsive behavior may be difficult to define as it overlaps with other suicidal behaviors such as aggression and violence. Some indicators of impulsivity are impatience, acting without thinking, becoming easily frustrated, and lack of ability to plan ahead. Additionally, a clinical diagnosis of ADHD indicates an increased risk.

Score 1 if there is less serious impulsive characteristics or behavior. Score 2 if the individual has some impulsivity in one setting (e.g., school, home, or work). Score 3 if the individual has encountered multiple problems across settings because of impulsivity. Also, a previous or current prescription of medication for ADHD indicates a severe risk.

CODING: 0=No impulsivity
1=Mild impulsivity
2=Moderate impulsivity
3=Severe impulsivity

9. Substance Abuse

Substance abuse is a strong risk factor for suicide (Brent, 2001). Fremouw et al. (1990) state that "chronic and excessive use of such substances substantially increases the risk of self-destructive behaviors" (p. 67). Gould and Kramer (2001) suggest that substance abuse is the most significant difference between those who actually attempt suicide and those with suicidal ideation. Suicide completions are the result of a combination of factors; however, studies have found that the most deadly combinations involve an element of substance abuse. Shaffer et al. (1996) report in the New York Psychological Autopsy Study that 42 of the 119 suicide completers had a diagnosis of substance abuse, 39 of which were male, indicating that substance abuse is more of a significant risk factor for males than females. In the Pittsburgh Psychological Autopsy Study (Brent et al., 1993), substance abuse was found to be a significant risk factor as well, particularly when comorbid with an affective disorder. Of the 67 suicide completers in this study, 27 were estimated to have a substance abuse diagnosis.

Coding Guidelines / Suggested Questions

1. How often do you indulge in alcohol and/or drugs?

2. How often are you intoxicated?

3. What type(s) of drug do you use?

4. What is your "drug of choice?

Substance Abuse involves illicit and prescription drugs, as well as alcohol and toxins (fuel, paint, glue). Toxin use is indicative of severe abuse. A score of 1 may be given for occasional, recreational drug use or experimentation. When abuse is moderate and causes some impairment or problems a score of 2 should be given. A score of 3 indicates regular abuse and/or addiction with serious impairment or problems, such as arrests for underage drinking, drug treatment, or school/family problems.

CODING: 0=No substance abuse
1=Mild substance abuse
2=Moderate substance abuse
3=Severe substance abuse

10-12. Suicidal Ideation Items

Overholser and Spirito (2003) state that "suicidal ideation is an important precursor to attempted suicide" (p. 19). While not all adolescents who think about suicide actually attempt it, most of those who do attempt or complete suicide have ideation in the preceding days or weeks before (Brent et al., 1993; Overholser & Spirito, 2003). Levels of severity range from mere thoughts of dying to wishing one was dead to creating an active plan, and frequency can range from occasional thoughts to those that are persistent and intrusive (Brent, 2001). In the Pittsburgh Autopsy Study (Brent et al., 1993), 77% of suicide victims had suicidal ideation and a

plan within a week of death. This same study found that "past suicidal ideation with a plan was at least as strongly associated with completed suicide as was a past attempt" (p. 526). Andrews and Lewinsohn (1992) report that 90% of a community sample of suicide attempters had suicidal ideation before the attempt (cited in Overholser & Spirito, 2003).

Coding Guidelines / Suggested Questions

See ASAP-20 items 10 (frequency), 11 (specificity of plan), and 12 (intention).

CONTEXTUAL FACTORS

Contextual factors are external to the individual and can significantly raise or lower the probability of suicidal behavior. These factors can be static or dynamic.

13. Recent Losses

Interpersonal loss and conflict with peers or family may trigger adolescent suicide (Overholser & Spirito, 2003). Interpersonal loss is operationalized as death of a loved one, the abandonment, divorce or separation of a parent, or a breakup from a romantic relationship. Conflict refers to turmoil in a peer, significant other, or family relationship (Fremouw, de Perczel, & Ellis, 1990; Goldman & Beardslee, 1999; Overholser & Spirito, 2003). Furthermore, for adolescents younger than 16 years old, interpersonal loss or conflict involving a parent is especially impacting. Regarding adolescents aged 16 or older, interpersonal loss or conflict of a significant other is a predominant trigger in suicide. In some cases of recent losses, adolescent suicide functions as a motivational factor. That is, suicide might be perceived as a means to eliminate suffering from a recent loss. Conflict may lead to an anticipation of a serious loss, which could in turn, result in suicide. Additionally, adolescents may believe that suicide could provide a reunion with a deceased loved one (Goldman and Beardslee, 1999).

Coding Guidelines / Suggested Questions

1. Have you recently had conflict with a peer, significant other or parent?

2. Have your parents divorced or separated recently?

3. Have you recently lost someone due to a breakup or a move?

4. Did someone you were close to recently die?

The rating of severity must consider the individual's perception of the magnitude of the loss. The more recent the loss, the higher the potential impact will be for the individual. Multiple losses also increase the risk of suicide. Also consider unfulfilled goals and dreams or recent disappointments, as these items may be just as potent as losses or conflict.

CODING: 0= No recent losses
1= Recent loss of minor magnitude

2= Recent loss of moderate magnitude
3= Recent loss of severe magnitude

14. Firearm Access

Adolescents select a method of suicide based on convenience and availability (Overholser & Spirito, 2003). Not surprisingly then, the usage of firearms is the most frequent method for suicide (Gould & Kramer, 2001; McKeown et al., 1998). Therefore, access to firearms greatly increases the risk of suicide. In fact, households that contain firearms are the strongest situational predictive factors of committing suicide, especially for adolescents who have made previous suicide attempts (McKeown et al., 1998). Specifically, an unlocked, loaded handgun in the home poses the greatest risk (Brent, 2001).

Coding Guidelines / Suggested Questions

1. Are there any firearms in your home?

2. Do you have access to any firearms anywhere else (e.g. friend's house)?

3. If yes to 1 and/or 2: Are they locked up? If no: Can you gain access to them?

Score 0 if the individual has no access to firearms. Score 1 if the individual could potentially gain access through relatives, friends, neighbors, etc. Direct access indicates the presence of firearms in the individual's immediate environment. Restricted access, a score of 2, refers to a locked gun cabinet or trigger lock. Unrestricted access, a score of 3, indicates immediate accessibility to unlocked, loaded firearms.

CODING: 0= No firearm access
1= Indirect firearm access
2= Direct, restricted firearm access
3= Direct, unrestricted firearm access

15. Family Dysfunction

Fremouw et al. (1990) state that "foremost among contributing environmental factors [for suicide risk] is the child's family system" (p. 62). Parents of children who attempt or commit suicide have significantly high rates of mood disorders (primarily depression), substance abuse, and psychopathology (Brent, 2001; Gould & Kramer, 2001). Brent (2001) reports the findings of Brent, et al. (1994), which show that not only genetic factors, but also environmental components of parental depression impact adolescent suicide risk. Both the New York and Pittsburgh Psychological Autopsy Studies of completed adolescent suicides report problems in parent-child relationships (Gould et al., 1996; Brent et al., 1993). Divorce or unstable family relationships, inappropriate family boundaries, absent or ineffective discipline, lack of emotional support, physical or sexual abuse, poverty, and family illness are all components of familial distress that impact an adolescent's ability to effectively cope with emotional problems and/or life stressors (Brent, 2001; Gould & Kramer, 2001; Goldman & Beardslee, 1999). For

adolescents, Goldman and Beardslee (1999) suggest that suicidal behaviors could "generally be seen as both embedded in and a response to the family's distress or dysfunction" (p. 425).

Coding Guidelines / Suggested Questions

1. Do you communicate with your family?

2. Does anyone living with you suffer from depression, substance abuse or other psychopathology?

3. How stable do you think your home life is/has been?

4. Is your family supportive?

Support, stability, and psychopathology are three factors to consider in a global assessment of family functioning. A score of 0 indicates minimal to no family problems. A score of 1 suggests occasional family disturbances not involving external involvement. A score of 2 indicates more serious problems such as abuse, illness, separation and instability. A score of 3 indicates severe dysfunction with chronic problems such as abandonment, homelessness and chaos.

CODING: 0=No family dysfunction
1=Mild family dysfunction
2=Moderate family dysfunction
3=Severe family dysfunction

16. Peer Problems

Prinstein (2003) states that "interpersonal factors, and specifically difficulties in peer functioning, have frequently been cited as precipitants to adolescents' suicidal behavior" (p. 191). Although peer problems encompass a wide area of concerns and minimal research has focused on this specific area, several studies have found relationships between suicidal behavior and social isolation, sexual orientation, and peer rejection. In the New York Autopsy Study, Gould et al. (1996) report that adolescents who did not attend school or go to work, indicating social isolation, were at a significantly higher risk for suicide. Because homosexuality often leads to social isolation and/or victimization by peers, rates of depression and substance abuse are high in this group, both of which increase suicide risk for adolescents regardless of sexual orientation (Goldman & Beardslee, 1999; Brent, 2001). Prinstein (2003) reports findings that "low levels of close friendship support and high levels of perceived peer rejection were significantly associated with more severe suicidal ideation" (p. 202).

Coding Guidelines / Suggested Questions

1. Do you have friends?

2. Do you feel like you have support from your friends?

3. Have you been bullied or rejected by peers?

4. Do you attend school? Go to work?

If an adolescent reports problems with a friend or boy/girlfriend but indicates other friends who provide social support, then problems may be considered mild and scored 1. Occasional conflict with no stable or close friends yields a score of 2. If an adolescent reports problems with all peers and feels like he/she has no peer support system, then problems should be considered severe and scored 3.

CODING: 0=No peer problems
1=Mild problems with peers
2=Moderate problems with peers
3=Severe problems with peers

17. School/Legal Problems

Gould et al. (1996) report that "difficulties in school, neither working nor being in school, and not going to college, posed significant suicide risks" in the New York Autopsy Study (p. 1159). From that group of suicide completers, 17% were neither in school nor working at the time of death. The Pittsburgh Autopsy Study found conduct disorder to be a risk factor for suicide, particularly if an affective disorder was not present (Brent et al., 1993). Numerous studies have revealed that suicide risk is greater for incarcerated adolescents than for the general high school population (DiFilippo, Esposito, Overholser, & Spirito, 2003). Morris et al. (1995) examined suicidal behavior in 1801 incarcerated adolescents who completed the Centers for Disease Control Youth Risk Behavior Surveillance System (YRBS). Compared to 7% of high school students who completed the YRBS, 15.5% of incarcerated adolescents had attempted suicide, with 8.2% resulting in serious injury. Only 2% of high school students who made an attempt suffered an injury (cited in DiFilippo et al., 2003).

Coding Guidelines / Suggested Questions

1. Do you attend school regularly?

2. Have you ever been expelled, suspended, or placed in in-school suspension?

5. Have you been in trouble with the police, such as an arrest, probation, or state custody?

If the adolescent is involved in substance abuse, the presence of any school or legal problems such as expulsion or incarceration indicates an increased risk and should be scored 3.

CODING: 0=No school or legal problems
1=Mild school or legal problems
2=Moderate school or legal problems

3=Severe school or legal problems

18. Contagion

When the mass media portrays suicide, a phenomenon known as contagion suicide can occur. Contagion is also referred to as imitation or cluster suicide. This phenomenon is very significant, as 1% to 13% of teenage suicides are estimated to occur in clusters within two weeks of the initial suicide (Gould & Kramer, 2001). Furthermore, when a celebrity commits suicide, this copycat effect is greatly increased due to massive, glamorized media coverage (American Foundation for Suicide Prevention; AFSP, 2003). Imitation suicide also may result when a friend of the adolescent commits suicide (Rhode, Seeley, & Mace, 1997). Therefore, the contagion effect can be created by the media or peer groups.

Coding Guidelines / Suggested Questions

1. Has someone that you have known or admired committed suicide lately?

2. If yes to either 1 or 2: How does this make you feel?

Score 0 if there is no contagion present within the past two weeks. If contagion occurred within the past two weeks, score 3.

CODING: 0=Contagion present (SCORES OF 1 AND 2 ARE NOT USED)
3=No contagion present

PROTECTIVE FACTORS

Protective factors are dynamic and significantly reduce the chance of an individual committing suicide. These factors lessen the risk of suicide by ameliorating existing risk factors. Because the absence of protective factors increases risk of suicide, reverse scoring is used for these items.

19. Reasons for Living

Adolescent suicide risk assessment cannot be complete without an evaluation of reasons for living (Overholser & Spirito, 2003). One assessment tool that is commonly used to evaluate if adolescents believe they have reasons to stay alive (protective factors) is the Brief Reasons for Living Inventory (BRFL-A; Osman et al., 1996). It contains four factors which are relevant to suicidal risk assessment. The first factor is Moral Objections, and an example item is *"I believe only God has a right to end a life."* The second factor is Survival and Coping Beliefs; a sample item is *"I believe I can find other solutions for my problems."* Responsibility to Family is the third factor. Pertinent questions for this factor address the adolescent's love for their family, and also their perception of their family's love for them. The fourth factor is Fear of Suicide: *"I am afraid of death."*

Coding Guidelines / Suggested Questions

1. How does your faith view suicide?

2. What are your expectations about your life problems improving?

3. Do you think things will get better for you?

4. How important is your family to you?

5. Are you afraid of dying?

A poor outlook on the future and no reasons for living is a severe indication of high risk. Score 0 if the individual provides one or more definite reasons for living. Score 1 if the individual provides one reason. If the individual has vague, unconvincing reasons for living score 2. No reasons for living indicate a score of 3.

CODING: 0= Multiple clear reasons for living
1= One clear reason for living
2= Poorly defined reasons for living
3= No reason for living

20. Current Treatment

Donaldson, Spirito, and Overholser (2003) state that therapy "can help to identify low levels of sadness or pessimism that can be confronted and managed before they reach unmanageable levels" (p. 318). In the Pittsburgh Autopsy Study, 85% of the suicide victims were not receiving psychiatric treatment within one month of death; more victims had been in treatment at some point than controls, but the vast majority was not currently in treatment (Brent et al., 1993). Current treatment provides opportunities for therapists to monitor current risk and to provide additional resources if needed (i.e. hospitalization, medication); therefore, current treatment is seen as a current protective factor.

Coding Guidelines / Suggested Questions

1. Are you currently seeing a therapist, counselor, or psychologist?

2. If yes, how long have you been in treatment?

If currently in treatment, a code of 0 should be given. If the adolescent is not in treatment, then a 3 should be coded.

CODING: 0=In current treatment
(SCORES OF 1 AND 2 ARE NOT USED)
3=Not currently in treatment

RESPONSE GUIDELINES

After the evaluator scores the 20 separate items from 0 – 3, a total score (0 – 60) is obtained by adding the sum of the items. If the total score is from 0 – 15, the client falls in the **low-risk** range for suicidal behavior. A score from 16 – 19 places the individual in the **medium-risk** category, and a score 20 and above places the individual in the **high-risk** category. The cutoffs are based on a pilot study of 60 adolescent outpatient evaluations by experienced clinicians, comparing their independent suicide risk ratings of low, medium, and high with total ASAP-20 scores. None of the low risk group received an ASAP-20 score of greater than 15, while only 7% of the high risk group scored below 15.

If the individual is in the low-risk category, then the original referral question should be pursued with less concern about suicidal risk at this time. The evaluator should continue to monitor for change in risk factors such as a recent loss, onset of depression or hopelessness, or contagion. However, the low-risk category overall suggests that suicidal behavior is not likely at this time.

If the adolescent is in the medium or high-risk categories, then several additional actions should be taken. As outlined under Actions Taken, the evaluator should consider (a) referring for outpatient treatment, b) referring for psychiatric consultation for possible medications, and (c) consulting with a colleague or supervisor regarding the risk assessment. At minimum these three steps are strongly encouraged for individuals in the medium-risk category. These steps would intensify treatment, provide additional resources such as medications, and ensure that the evaluator has consulted with another professional regarding this appraisal. Peer consultation demonstrates concern and sensitivity regarding the individual's risk and needs. Documenting the consultation is important to demonstrate appropriate professional action.

Additional actions that can be taken for clients at the medium or high-risk levels are contracting for No Suicidal Behaviors. These No Suicide contracts are one of the many therapeutic strategies widely used; the contracts have strong clinical acceptance and demonstrate to the client the concern of the therapist for the client's welfare. However, the contract alone is not sufficient to ensure that the client may not impulsively harm him or herself. Notifying the family and/or significant others of medium to high risk is strongly encouraged. However, if the danger is not imminent, it is desirable to ask the client's permission to notify family and significant others prior to breaching confidentiality. If the danger is clear and imminent, guidelines for confidentiality do not apply because the mental health professional must act to protect the life of the person at risk. The family/significant other could be informed of the risk

and asked to help with social support, reduction of firearms/poison access, and assistance in obtaining treatment.

Reducing access to firearms and/or poisons is imperative for clients at medium to high risk. How this is accomplished would depend on where the firearms/poisons are stored. Involving family or significant others to reduce this access or remove these potential life ending means would be the most conservative approach. Simply asking an adolescent to remove firearms or poisons would not be sufficient to confirm that this major step is taken. In short, reducing access to firearms/poisons requires the involvement of family or significant others.

Notifying legal authorities and/or CPS of risk to self or others should be considered if suicidal risk is arising from current maltreatment through neglect or abuse or if the client has angry/aggressive thoughts towards others in addition to him or herself. Clinical guidelines require that mental health professionals carefully assess potential dangerousness to others and act with a "duty to protect" others who may be at risk. Notifying potential targets of risk and/or legal authorities are possible appropriate actions when danger extends to others (Fremouw et al., 1990). Finally, the mental health professional should consult with supervisors prior to notifying other agencies.

If an individual is considered high risk for suicidal behaviors, then increased therapeutic care is warranted. Referring the individual to day treatment, voluntary, or crisis hospitalization is strongly recommended. Individuals at high risk for suicidal behaviors are vulnerable to act on their suicidal ideation with little warning. Adolescents, in particular, are highly impulsive in terms of self-injurious behaviors. Any placement of an adolescent should involve the adolescent's family members. Placing adolescents in this more protected, intensive therapeutic environment would help monitor potential risk and provide treatment to lower that risk.

If the adolescent is unwilling to voluntarily commit to more intensive treatment and he or she is showing clear danger through ideation or behaviors toward self or others, then involuntary hospitalization should be considered. This decision to seek involuntary hospitalization would require consultation with a supervisor as well as family members and significant others for the adolescent. This action would only be taken if the adolescent was unwilling or unable to participate in voluntary intensive treatment. Involuntary hospitalization is always considered the last resort and the most restrictive alternative for treatment. Although in certain cases, this placement is necessary, it is sometimes counter-therapeutic as the individual does not want to be hospitalized.

The Actions Taken box on the ASAP-20 form lists 11 possible actions to be considered plus an "other" action. These actions are presented in hierarchal order for consideration but can be employed in any order provided that the professional has a rationale for the action taken. The major guideline is to **document** the actions taken and the rationale for each action. Furthermore, consultation with peers or supervisors is considered essential when dealing with high-risk individuals. The use of the ASAP-20, consultation, and documentation will demonstrate that the interviewer has exercised a high standard of professional judgment and has engaged in a "best practice" assessment and case management for adolescents.

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ADOLESCENT SUICIDE ASSESSMENT PROTOCOL (ASAP-20) - 2004

Client _____ Date _____

Agency _____ Age _____ Gender_____

HISTORICAL ITEMS: **Code: 0=None 1=Mild 2=Moderate 3=Severe**	**Code (0-3)**
1. History of suicide attempts 0=None 3=Definite	
2. History of physical/sexual abuse	
3. History of antisocial behaviors	
4. History of family suicide attempts/completions 0=None 3=Definite	

GENERAL CLINICAL ITEMS: **Code: 0=No 1=Mild 2=Moderate 3=Severe**	**Code (0-3)**
5. Depression	
6. Hopeless	
7. Anger	
8. Impulsivity	
9. Substance abuse	

SPECIFIC SUICIDAL ITEMS	**Code (0-3)**
10. Currently, how often do you <u>think</u> about committing suicide? **0: Almost never** **1: Occasional passing thoughts (monthly)** **2: Regularly (weekly)** **3: Almost daily**	
11. Currently, do you have any <u>plans and methods</u> to commit suicide? **0: None** **1: A general idea, but no specific plans** **2: A specific plan** **3: A specific plan with a method available and time schedule**	
12. Do you <u>intend</u> to commit suicide? **0: No intention** **1: Unlikely** **2: Likely, someday** **3: Likely, in the near future**	

Total Page 1 _____

CONTEXT ITEMS: Code: 0=No 1=Mild 2=Moderate 3=Severe	Code (0-3)
13. Recent losses	
14. Firearm access	
15. Family dysfunction	
16. Peer problems	
17. School / legal problems	
18. Contagion 0=None 3=Definite	

PROTECTIVE ITEMS:					Code (0-3)
19. Reasons for living	0=Many	1=One	2=Vague	3=None	
20. Current treatment	0=Yes			3=No	

TOTAL 1-20 (pages 1 and 2) _____

_____

OTHER CONSIDERATIONS:

RISK APPRAISAL TOTAL SCORE	Low ☐ (0-15)	Medium ☐ (16-19)	High ☐ (20+)

ACTIONS TAKEN: (Check all that apply)

1. **Continue monitoring risk factors** _____
2. **Notify family** _____
3. **Notify/consult with supervisor** _____
4. **Recommend/refer to outpatient treatment** _____
5. **Recommend/refer to psychiatric consult/med evaluation** _____
6. **Contract for NO SUICIDAL behaviors** _____
7. **Recommend elimination of access to firearms/poisons** _____
8. **Notify legal authorities &/or CPS of risk to self/or others** _____
9. **Recommend/refer to day treatment** _____
10. **Recommend/refer to crisis unit/voluntary hospitalization** _____
11. **Initiate involuntary hospitalization** _____
12. **Other: _____** _____

_____ _____

Interviewer **Supervisor**