SUICIDAL ADULT ASSESSMENT PROTOCOL – SAAP

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Officially, over 31,000 people commit suicide each year in the United States. Due to the under-reporting of suicides, the actual number of suicides may approach 40,000 to 50,000 annually. Among adults over 25 years old, suicide is the eighth leading cause of death while it rises to the third leading cause of death for youths from 15 to 24 years old. Approximately 85 suicides occur each day; 1 every 17 minutes. The annual number of official suicides in the United States is double the number of murders. Each year, the number of suicide attempts exceeds 1,000,000 for just young adults. The lifetime rate of death by suicide is .72 percent with an adult annual incidence rate of approximately 10.7 per 100,000 people (NIMH, 2002). Suicide not only ends a life, but also dramatically affects family members and close friends. Simon (2004) defines the term "suicide survivors" as "family, friends, significant others, and loved ones of the individual who commits suicide" (p. 209). At least six suicide survivors are impacted with feelings of loss, depression, and guilt for each suicide (Simon, 2004). These individuals are also at increased risk for suicide and additional psychological disorders. Clearly, suicide and suicide attempts represent a serious mental health problem in the United States.

Rationale for the SAAP

Because of the importance of the assessment and treatment of suicidal behavior, the American Psychiatric Association commissioned the development of Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors (American Psychiatric Association [APA], 2003). The steering committee on Practice Guidelines developed these guidelines with the assistance of a work group and multiple consultants familiar with research in

the areas of suicide behavior and risk. Starting with review of over 17,000 citations regarding suicide, the Guidelines were based on 846 relevant empirical studies. According to the Practice Guideline Introduction "this document represents a synthesis of current scientific knowledge and rational clinical practice in the assessment and treatment of adult patients with suicidal behavior" (pg 2). Over 70 risk and protective factors were described. However, these factors were not organized in a manner that would be useful as an assessment tool. Based on the authors' previous development of a guided clinical interview for the assessment of adolescent suicidal risk, ASAP, (Fremouw, Strunk, Tyner, & Musick, in press), an adult protocol was created as a useful screening tool for mental health intake evaluations or suicide risk assessments.

The Suicide Adult Assessment Protocol or SAAP, described in this paper, has an empirical foundation based on the earlier review of suicide assessment factors by Fremouw, dePercell, & Ellis (1990) combined with the comprehensive update of research contained in the American Psychiatric Practice Guidelines (APA, 2003) and Simon's 2004 guidelines in Assessing and Managing Suicidal Risk. In addition, the SAAP integrates the recent empirical and theoretical contributions of Joiner (Joiner, Pettit, Walker, Voelz, Cruz, Rudd, & Lester, 2002; Wingate, Joiner, Walker, Rudd & Jones, 2004) which focus on the unique characteristics of multiple suicide attempts and the pivotal roles of suicide planning and preparedness and one's perception of being burdensome to others as special risk factors. Currently, the SAAP is being field tested with outpatients at Valley Mental Health Clinic, a local mental health care facility. Comments and feedback on this new assessment tool are also welcomed from readers of the current chapter.

The SAAP is an integration of the above resources to form a guided clinical interview for the systematic assessment of adults aged 25 through 64 years old. The SAAP is organized into

sections based on a general risk assessment model which includes both static and dynamic factors. The static factors are demographic and historical variables which cannot be changed by intervention. The dynamic factors include clinical, contextual, and protective variables which have potential for modification. The clinical factors are further divided into two categories based on relative permanence, clinical stable variables such as the presence of an Axis II diagnosis and clinical dynamic variables such as current suicidal plans which are more acute and can change daily.

The SAAP is a guided clinical interview for adult suicidal risk similar in format to the HCR 20 (Webster, Douglas, Laves, & Hearn, 1995) and the ASAP (Fremouw et al., in press), which assess risk of violence by psychiatric inpatients and risk of adolescent suicide, respectively. Based on interview, collateral information, and record review, an individual is evaluated on 28 items. Each item is rated as low, medium, or high and five items have an additional level of Extreme Risk. As suggested by Simon (2004) the assessment of suicide risk is based on clinical judgment and not a total score. This permits consideration of unique or idiosyncratic factors that would be missed in a standard test or a single number. After completion of the protocol, the number of items rated as low risk, medium risk, high risk, or extreme risk is tallied. Other unique factors are considered and then the interviewer assigns an individual to one of four overall risk categories, low risk, medium risk, high risk, or extreme risk for suicidal behavior.

The operationalization of the items into low, medium, high and extreme risk levels is partially based on research using Standardized Mortality Ratios, SMR. Harris and Barraclough (1997) conducted a meta-analysis of 249 reports which examined 44 medical and psychiatric disorders and suicides with at least two years of follow-up data. They calculated a standardized

mortality ratio based on the relative risk of suicide for a particular disorder as compared to the expected rate of suicide in the general population. It reported, for example, that individuals with previous suicide attempts had a SMR of 38:1 and that individuals with a diagnosis of major depression had a SMR of 20:1 as compared to the general population where the value of the SMR is 1:1. Additional items not included in the Harris and Barraclough (1997) meta-analysis were coded in low, medium, high, or extreme risk based on other empirical literature which reported risk ratios. For example, a family history of suicide raises the risk of suicide 4.5:1 times for an individual (APA, 2003).

The four categories of risk for each item are as follows:

Categories	Odds
Low Risk	1-2.9 :1
Medium Risk	3-4.9 :1
High Risk	5-14.9 :1
Extreme Risk	15+ :1

The 28 items in the SAAP are those items that are generally present and useful for assessment based on the guidelines by Fremouw, dePercell, and Ellis (1990) and Simon (2004). The items are associated with suicide completions; not suicide attempts. For example, females have a 3:1 higher ratio of suicide attempts than males, but males have a 4:1 higher ratio of suicide completions than females. Therefore, being male is coded as a medium risk item for suicide while being female is low risk for suicide (APA, 2003).

SAAP Manual

The SAAP is organized into six factors: **Demographic, Historical, Clinical (Stable), Clinical (Acute), Contextual, and Protective. Demographic** items are static, or unchangeable, and include gender, age, race, and marital status. **Historical** items are also static and consist of a

history of suicide attempts, recent, planned serious suicide attempts, family suicide attempts/completions, and childhood trauma. **Clinical (Stable)** items are Axis I diagnoses, Axis III diagnoses, and Axis II diagnoses. **Clinical (Acute)** factors include suicide plan/preparation, suicide desire/ideation, behavioral/emotional dyscontrol, hopelessness, burdensomeness, agitation/panic, psychosis (confusion/hallucinations), and intoxication. **Contextual** items are dynamic, or changeable, and include firearm access, recent loss(es), stressors, social isolation, and jail incarceration. **Protective** items are also dynamic and include family responsibility, religious beliefs, coping/problem solving skills, and social support. Additionally, an **Other Factors** section is included to account for any idiosyncratic items, strengths, and vulnerabilities that may contribute to suicide risk of the individual.

The following sections describe the coding guidelines for the 28 items. The SAAP protocol is contained in Appendix A. Unless otherwise noted, see the American Psychiatric Practice Guidelines (APA, 2003) for the empirical basis for the coding of each item.

A. Demographic Factors

1. Gender: Females are coded as Low Risk, and males are coded as Medium Risk.

2. Age: Males younger than 45 years old are coded as Low Risk, and males 45-65 years old are coded as Medium Risk. Females are coded as Low Risk at all ages.

3. Race: Non-whites are coded as Low Risk, and whites are coded as Medium Risk.

4. Marital Status: Married individuals are coded as Low Risk, and all others, single, separated, divorced, or widowed are coded as Medium Risk.

B. Historical Factors

5. Prior Suicide Attempt: A suicide attempt is any deliberate act of self harm which has at least some probability of death. One previous attempt is coded as High Risk; while two or

more previous attempts are coded as Extreme Risk.

6. Recent, Planned Serious Attempt: A planned, non-impulsive suicide attempt within the previous three months which had moderate lethality (i.e., requiring medical intervention) is coded as Extreme Risk.

7. Childhood Trauma: Severe or chronic childhood physical, sexual, or psychological abuse is coded a High Risk; less severe or acute abuse is coded a Medium Risk.

8. Family Suicide Attempts/Completions: The presence of an immediate family member (parents, siblings) who has attempted or completed suicide is coded as Medium Risk.

C. Clinical Factors – STABLE

9. Axis I Diagnoses: Anxiety disorders are coded as Medium Risk, a diagnosis of Schizophrenia or Alcohol Dependence is coded as High Risk. A diagnosis of Major Depressive Disorder, Bipolar Disorder, Drug Dependence (of opioids or sedatives), or Eating Disorders is Extreme Risk. This can be based on medical records or a comprehensive assessment.

10. Axis III Diagnoses: Huntington's chorea, cancer, and multiple sclerosis are coded as Low Risk. Spinal cord and brain injuries are coded as Medium Risk. HIV/AIDS and epilepsy are coded as High Risk. Also associated with suicide are peptic ulcer disease, lupus, and renal failure. With other illnesses, consider presence/absence of concurrent affective disorder, impact on functioning, and subjective burdensomeness.

11. Axis II Diagnoses: The presence of any "Cluster B" personality disorder (Borderline, Narcissistic, Antisocial, or Histrionic) or combination of symptoms among the personality disorders is coded as Medium Risk. This is usually determined by psychiatric records, but can be based on the current assessment.

D. Clinical Factors – ACUTE

The following items should be rated based on clinical judgment of the severity. Specific definitions of low, medium, high, and extreme are not always offered.

12. Suicide Plan/Preparation: This item should be distinguished from suicidal thoughts, or desires, in that "plans" have been shown to predict death while suicide desire does not (Wingate et al., 2004). Symptoms of plans and preparation include courage to make the attempt, a belief in one's ability to follow through with an attempt, availability of means and opportunity to carry out the plan, plan specificity, and clear preparation (Wingate et al., 2004). If all of these criteria are met, a rating of Extreme Risk should be used, followed by high or medium depending on level of preparedness and specificity of plan.

13. Suicide Desire/Ideation: This item concerns the individual's current thoughts and ideas regarding a suicide attempt. Inquire as to whether or not the individual wishes to die, how often these thoughts are occurring (frequency), whether or not one wishes to live, if passive suicide attempts have been made (reckless driving, careless drug use), if one desires to make an attempt, if one expects to make an attempt now or in the near future, and if one is talking about death more than usual (Wingate et al., 2004).

14. Behavioral/Emotional Dyscontrol: This item addresses behaviors considered to be impulsive and emotions that could be described as out of control or irrational, such as extreme jealousy or anger. Links may exist between this item and Axis II personality disorders, such as antisocial or borderline personality disorder. Research has shown that of the characteristics of personality disorders, this particular clinical item is related most closely with suicide risk (Wingate et al., 2004).

15. Hopelessness: This cognitive component of depression is a crucial consideration

when rating suicide risk. Hopelessness is indicative of thoughts that the future will not get better and that there are no other options. Inquiries into plans and thoughts regarding one's immediate and distant future may be a way to address this item rather than asking directly if one is hopeless.

16. Burdensomeness: Feelings of incompetence are most salient when one experiences a sense of burdensomeness on others. This feeling that one is a burden on others is one of the strongest sources for having a desire to commit suicide (Wingate et al., 2004).

17. Agitation/Panic: These feelings are associated with increased physiological arousal (fight or flight system) and may lead to careless decision-making and irrational thinking.

18. Psychosis (confusion/hallucinations): Although psychosis by itself does not increase one's risk for attempting suicide, disorganized thinking and particularly command hallucinations regarding violence toward self can increase one's suicide risk, as options and a sense of competence or control are not present. Also consider psychosis due to post-partum depression.

19. Intoxication: The disinhibiting effect of alcohol is often a factor in suicide. Although combinations of clinical items are key in determining one's overall risk, the most deadly combinations involve substance use.

E. Contextual Factors

20. Firearm Access: Often times method of suicide is selected based on convenience and availability. Therefore, access to firearms greatly increases risk, specifically with unlocked, loaded handguns in the place of residence or vehicle. Code as Extreme Risk if loaded firearms are easily available.

21. Recent Loss: Recent or anticipated losses or disappointments may trigger or exacerbate suicidal behavior. Examples are death of a loved one, breakup or abandonment of a

romantic relationship, separation or divorce, job loss, bankruptcy, or recent disappointment (e.g., denial of job promotion, rejection of a romantic date). The individual's perception of the severity of the loss or disappointment will determine the magnitude of the risk factor. The more recent the loss, the higher the potential impact will be for the individual. Multiple losses increase suicide risk.

22. Stressors: Life stressors may trigger and/or increase suicidal behavior. Examples are financial instability, marital conflict, unemployment, and job-related stressors. As the quantity and perceived severity of impact of stressors increase, suicide risk increases. Multiple aspects of the individual's life must be accounted for to assess for the presence of stressors.

23. Social Isolation: Lack of social activity and integration as well as living alone increases suicide risk. A sudden or recent increase in social isolation may indicate a greater likelihood for suicide.

24. Jail Incarceration: Suicide is a leading cause of death in correctional facilities. Most jail suicides take place within the first 24 hours of incarceration. Most completed suicides in jails are young, white, single, intoxicated individuals with a history of substance abuse. Hanging is the most common method in jails.

F. Protective Factors

The following items are conceptualized in reverse order from the scoring of the above items. For example, the presence of an item from all other categories indicates a higher risk rating. In this category, however, the presence of an item indicates lowered risk.

25. Family Responsibility: An acknowledgement of love for and responsibility to family, and recognition of a family's love are protective factors for suicide risk. Children living in the home may increase the importance of family responsibility particularly for women.

Lacking a sense of responsibility, belongingness, and connection with family members may increase suicide risk.

26. Religious Beliefs: Strong devotion to religion or faith may reduce the probability of suicide if the individual believes that suicide is a sin or unmoral. Devotion and practice may serve as coping mechanisms by alleviating psychological distress and instilling hope. Information regarding the perception of suicide as related to religious beliefs should be elicited from the individual.

27. Coping/Problem Solving Skills: Historically stable, independent individuals with good coping and problem solving skills are at lower risk for suicide. A thorough evaluation includes an individual's previous reactions to stress, personality traits, thinking styles, and substance abuse. It must also be assessed whether the individual generates solutions to distress other than suicide. If the motivation for suicide is escape, anger/revenge, or guilt, than the probability of suicide risk is increased.

28. Social Support: Social support may be provided from family, significant others, friends, coworkers, or members of organizations. The quantity plus quality of support from the sentiment of the individual must be assessed. A sense of belongingness or connection to a valued support system may buffer other risk factors and decrease suicide risk. In addition, a fear of social disapproval resulting from suicide may be a protective factor.

G. Other Factors

Suicide risk consists of an intricate combination of multiple risk factors. Checklists do not always account for idiosyncratic risk factors, strengths, and vulnerabilities. List anything here that should be considered as risk or protective factors for the individual.

Response Guidelines

After the interviewer rates each of the 28 items, the total number of items in each risk category should be totaled. The interviewer then determines the number of the 21 High Risk and the five Extreme Risk items that were endorsed. If these High and Extreme Risk items were endorsed under the Clinical-Acute, Contextual, or Protective factors, then the risk of suicide is much more imminent than endorsed under Demographic or Historical factors. Based on an overall review of the items, including any "other items," the interviewer makes an OVERALL RISK APPRAISAL as Low, Medium, High, or Extreme, and proceeds with the appropriate responses to ensure the safety of the client.

Listed on page two of the SAAP protocol are eleven possible actions to be considered plus an "other" action. As first presented by Fremouw et al. (1990), these actions are listed in a hierarchical order for consideration but may be employed in any order provided the professional has a rationale for action taken. It is necessary to document the actions taken and the rationale for each action. Furthermore, consultation with peers or supervisors is considered essential when dealing with high or extreme-risk individuals. The use of the SAAP, consultation, and documentation will demonstrate that the mental health professional has exercised a high standard of professional judgment and has engaged in a "best practice" assessment and case management for patients.

If the individual is in the Low-Risk Category, then the original referral question should be pursued with less concern about suicidal risk at the time. The evaluator should continue to monitor for change in risk factors such as recent loss, stressors, onset of depression or hopelessness, or social isolation.

If the individual is above the Low-Risk Category, several actions should be taken. First,

strongly consider notifying family, caregivers, and significant others, as this extends care to a setting other than a clinician's office. These individuals often play crucial roles in continued monitoring of risk as well as taking specific precautions, such as the removal of firearms from the home. As outlined in the Actions Taken portion of the protocol, the evaluator should consider (a) referring for outpatient treatment, (b) referring for psychiatric consultation (and 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. Taking these actions would intensify treatment, provide additional resources such as medication, and ensure that the evaluator has consulted with another professional regarding this risk appraisal. Peer consultation demonstrates concern and sensitivity regarding 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, High, or Extreme-Risk Categories are contracting for No Suicidal Behaviors. These contracts are one of the many therapeutic strategies widely used; the contracts have strong clinical acceptance and demonstrate to the patient to concern of the therapist for the patient's welfare. However, the contract alone is not sufficient to ensure that the patient will not impulsively harm him or herself.

Notifying the family, caregivers, and/or significant others is strongly encouraged. However, if the danger of harm is not imminent, it is desirable to ask the patient's permission to notify family, caregivers, and/or significant others prior to breaching confidentiality. If the danger to self 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. Other parties could be informed of the patient's risk and asked to help with social support and assistance in obtaining

treatment.

Reducing access to firearms and other weapons is imperative for clients at medium, high or extreme-risk. How this is accomplished would depend on where the firearms/other weapons are stored. Involving other parties to reduce this access or remove these potential life-ending means would be the most conservative approach. Simply asking a patient to remove the harmful means would not be sufficient to confirm that this major step is taken. In short, reducing access to lethal means requires the involvement of other parties.

Notifying legal authorities and/or Child Protective Services of risk to self or others should be considered if the suicidal risk is arising from current maltreatment through neglect or abuse or if the patient has angry/aggressive thoughts towards others in addition to him or herself. Ethical guidelines require that mental health professional carefully assess potential dangerousness to others and act with a "duty to protect" others who may be at risk. Notifying legal authorities and/or potential targets of risk 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 in the High or Extreme-Risk Categories 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. Placing individuals in a more protected, intensive therapeutic environment would help monitor potential risk and provide treatment to lower that risk.

If an individual is unwilling to voluntarily commit to more intensive treatment and he or she is demonstrating clear danger through suicidal planning, then involuntary hospitalization

should be considered. The decision to seek involuntary hospitalization would require consultation with a supervisor. This action is always considered the last resort and most restrictive alternative for treatment. Although in certain cases, this placement is necessary, it is sometime counter-therapeutic, as the individual does not desire to be hospitalized. In these cases, proper authorities at the hospital should be notified of this resistance.

Conclusion

The SAAP is a 28-item guided clinical interview for adult suicidal risk based on the empirical literature of suicide completion risk factors. Using this protocol will provide a comprehensive evaluation of a person's current suicidal risk and guidelines for appropriate case management. The empirical basis of these items is primarily contained in the American Psychiatric Association's Practice Guidelines (APA, 2003), which integrates 846 research studies.

SAAP - Suicidal Adult Assessment Protocol (Ages 25-64) 2005

Name bd **Age**___ **Gender** M / F **Date**_____ **Rater**_____

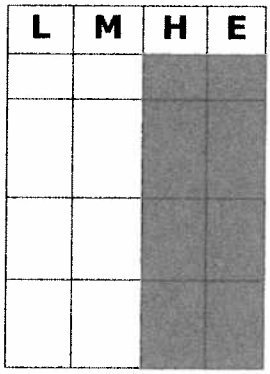
A. Demographic Factors

1. Gender
Female = L, Male = M

2. Age
Males < 45 = L, > 45 = M

3. Race
Nonwhite = L, White = M

4. Marital Status
Married = L, S/D/W = M



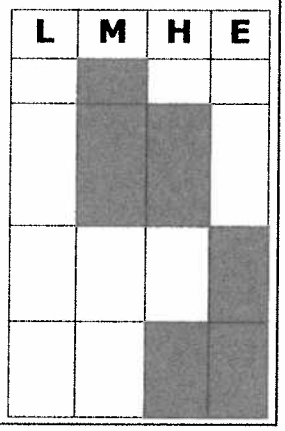
B. Historical Factors

5. Prior Suicide Attempt(s)
None = L, 1 = H, 2+ = E

6. Recent, Planned, Serious Suicide Attempt(s) (3 mo)
No = L, Yes = E

7. Childhood Trauma
None = L, Yes = M, H

8. Family Suicide Attempts/Completions
None = L, Yes = M

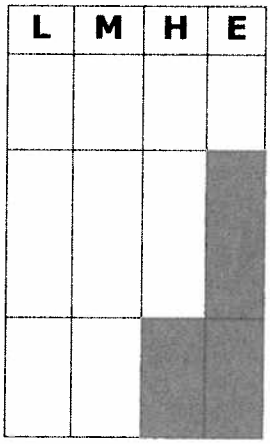


C. Clinical Factors- STABLE

9. Axis I Diagnoses
None = L, Anx = M
Schizo, Ethol = H
MDD, BP, Drug, Eating = E

10. Axis III Diagnoses
Huntington's, Cancer, MS= L
Spinal/Brain Injury = M
HIV/AIDS, Epilepsy = H

11. Axis II Diagnoses (Cluster B)
APD, BPD, NPD, HPD
None = L, Yes = M



D. Clinical Factors – ACUTE

12. Suicide Plan/Preparation
None = L, Yes = M, H, E

13. Suicide Desire/Ideation
None = L, Specific = M, H

14. Beh./Em Dyscontrol
None = L, Yes = M, H

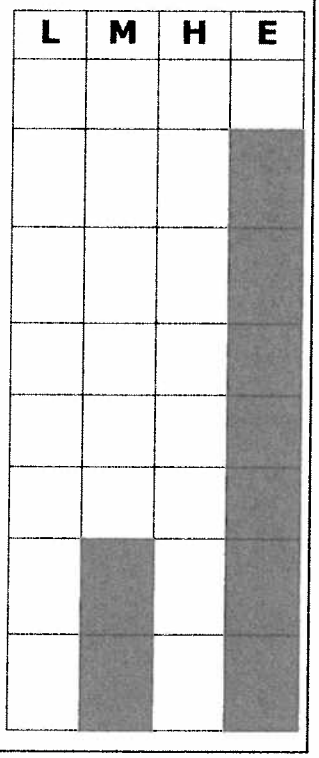
15. Hopelessness
None = L, Yes = M, H

16. Burdensomeness
None = L, Yes = M, H

17. Agitation/Panic
None = L, Yes = M, H

18. Psychosis (confusion/hallucinations)
None = L, Yes = H

19. Intoxication
None = L, Yes = H



E. Contextual Factors

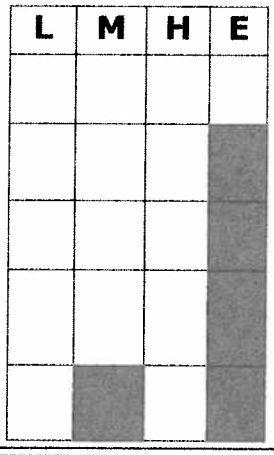
20. Firearm Access
None = L, Yes = M, H, E

21. Recent Loss
None = L, Yes = M, H

22. Stressors
None = L, Yes = M, H

23. Social Isolation
No = L, Yes = M, H

24. Jail Incarceration
No = L, Yes = H



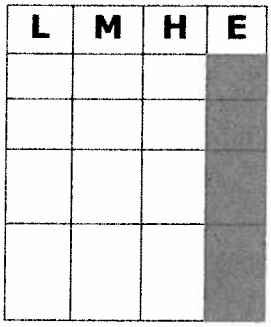
F. Protective Factors

25. Family Responsibility
Yes = L, M, None = H

26. Religious Beliefs
Yes = L, M, None = H

27. Coping/Problem Solving Skills
Yes = L, M, None/Poor = H

28. Social Support
Yes = L, M, None/Poor = H



G. Other Factors

Total Factors: ____ ____ ____ ____

L (28) M (23) H(21) **E (5)**

SAAP - Suicidal Adult Assessment Protocol (Ages 25-64) 2005

OVERALL RISK APPRAISAL (check one):

LOW	MODERATE	HIGH	EXTREME

ACTIONS TAKEN (check all that apply):

1. CONTINUE MONITORING RISK FACTORS _____
2. NOTIFY FAMILY/CAREGIVERS/SIGNIFCANT OTHER _____
3. NOTIFY/CONSULT WITH SUPERVISOR _____
4. RECOMMEND/REFER TO OUTPATIENT TREATMENT _____
5. RECOMMEND/REFER TO PSYCHIATRIC CONSULT/MED EVAL _____
6. CONTRACT FOR NO SUCIDAL BEHAVIORS _____
7. RECOMMEND ELIMINATION OF FIREARMS (ETC.) ACCESS _____
8. NOTIFY LEGAL AUTHORITIES AND/OR CPS OF RISK _____
9. RECOMMEND/REFER TO DAY TREATMENT _____
10. RECOMMEND/REFER TO VOLUNTARY HOSPITALIZATION _____
11. INITIATE INVOLUNTARY HOSPITALIZATION _____
12. OTHER_____ _____

_____ _____ _____

Interviewer Supervisor Date