SUICIDAL OLDER ADULT PROTOCOL – SOAP

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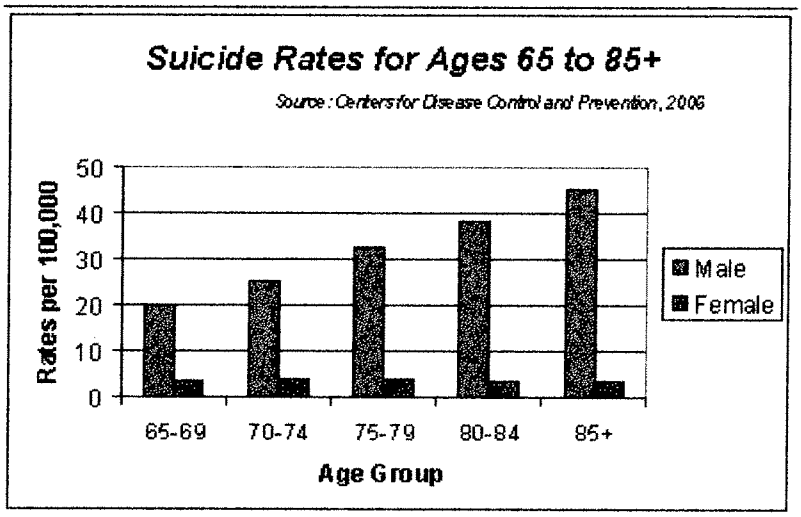
Older adults, 65 years and older, comprise 12.4% of the United States population yet account for16% of completed suicides. The rate of older adult suicide is 14.3 per 100,000 people as compared to the overall rate for adults; 11.1 per 100,000 people. Approximately 14 older adult suicides occur each day; approximately one every hour and a half. Males complete 84.6% of older adult suicides; at a rate 7.7 times greater than females. White males over the age of 85 are at the highest risk for completed suicide of any demographic category; 48.4 per 100,000 individuals. Conversely, for women, the rate of suicide typically peaks during middle adult hood (ages 45-49) and declines after age 60 (CDC, 2006).



While older adults attempt suicide less frequently than younger individuals; they complete suicide at a higher rate. Among individuals over the age of 65, there is approximately one completed suicide for every four attempts. In comparison, among all age groups combined, there is one completed suicide for every 25 attempts and among individuals ages 15-24, every 100-200 suicide attempts yield only one completed suicide (CDC, 2006).

Conwell (2004) suggests that suicide attempts among older adults are more fatal as compared with younger individuals due to three factors: the increased physical frailty of older adults, the increased probability that they live alone, and the increased likelihood that they use more lethal means. In fact, 72% of older adult suicides were completed using a firearm. Ninety-two percent of men completed suicide using a firearm; whereas 8% of women used this lethal means. Depression is the most important cause of older adult suicide while alcohol or substance abuse plays a lesser function as compared with younger individuals (CDC, 2006).

Rationale for the SOAP

Although the assessment and treatment of older adult suicidal behavior is extremely important, there is no current measure or procedure that is widely accepted. Luoma, Pearson, and Martin (2002) report that three-quarters of older suicide victims had been seen by their primary care providers within one month and almost one half were treated within 7 days of their suicides yet the physicians did not detect the risk of imminent suicide. Therefore, the development of a protocol to assist in the screening for suicidal risk is clearly needed. The Suicide Older Adult Protocol (SOAP) for ages 65+, described in this paper, is the third guided clinical interview for assessment of suicide risk. The first was the Adolescent Suicide Assessment Protocol (ASAP; Fremouw, Strunk, Tyner, & Musck, 2006) for ages 13-24, followed by the Suicide Adult Assessment Protocol (SAAP; Fremouw, Tyner, Strunk, & Musick, In Press) for assessment of individuals ages 25-65. All the measures are based on empirical research specific to the population. They began with a review of suicide risk assessment factors by Fremouw, dePercell, & Ellis (1990) and updated with comprehensive reviews such as Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors (American Psychiatric Association [APA], 2003). Because the SOAP is specific to older adults age 65 and older, the

SAAP was revised based on the literature reviews by Conwell and Duberstein (e.g., Conwell, 2004; Conwell & Duberstein, 2001; and Duberstein & Heisel, 2006) to focus on the unique and specific factors involved in suicide among older adults. In addition, the SOAP reflects the conceptual contributions of Bryan and Rudd (2006) who view suicide risk assessment as the combination of a baseline category of risk with identification of acute, short term exacerbating factors.

The SOAP integrates the above resources to form a guided clinical interview for the systematic assessment of adults aged 65 and above. It 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 physical illness and clinical-acute variables such as current suicidal plans which are more dynamic and can quickly change.

The SOAP is a guided clinical interview for adult suicide risk similar in format to the HCR 20 (Webster, Douglas, Laves, & Hearn, 1995) and the ASAP (Fremouw et al., 2006), which asses 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 18 items. Each item is rated as low, medium, or high and 4 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 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 three overall risk categories: low risk, medium risk, or high risk for suicide.

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 studies which examined 44 medical and psychiatric disorders and suicide completions (not just attempts) 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 SMR of 38:1 and that individuals with diagnosis of major depression had 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 Barraclough (1997) meta-analysis were coded in low, medium, high or extreme risk based on other empirical literature which reported risk ratios. The four categories of risk are defined by increasing SMR odds ratios of suicide.

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

SOAP Manual

The SOAP 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, and recent, planned serious suicide attempts (made in the last 3 months). **Clinical-Stable** items are Axis I diagnoses, physical illness and functional impairment of activities of daily living (ADL). **Contextual** items are dynamic, or changeable, and include recent loss/stressors, access to lethal means, and social isolation. **Clinical-Acute** items include psychic distress, hopelessness, burdensomeness, and plans or preparations for suicide. These are rated by the client. **Protective** items are also dynamic and include moral objections, family related concerns, and current mental health treatment. Additionally, an **Other Considerations** 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 18 items. The SOAP protocol is contained in Appendix A. Unless otherwise noted, the American Psychiatric Practice Guidelines (APA, 2003) and Conwell (2004) form the empirical basis for the coding of each item.

A. Demographic Factors

1. Gender/Race/Age: Females of any age or race are coded as Low Risk. Non-white males of any age are also coded as Low Risk. White males 65-80 years old are coded as Medium Risk and White males above the age of 80 are coded as High Risk.

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

B. Historical Factors

3. Prior Suicide Attempts: 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. Spaces are provided to record the history of suicide attempts in terms of dates, means, and whether medical treatment (abbreviated Tx) was provided.

4. Recent, Planned Serious Attempt(s): 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.

C. Clinical Factors – Stable

5. Axis I Diagnosis: Diagnoses of dementia, anxiety disorders, and schizophrenia are coded as Low Risk. A diagnosis of substance abuse is coded as Medium Risk. A diagnosis of major depressive disorder or bipolar disorder is coded as Extreme Risk. Axis I diagnoses can be obtained from medical records or a comprehensive assessment.

6. Physical Illness: For females, the presence of illness does not elevate suicide risk and is therefore coded as Low Risk. For males, the presence of illness elevates suicide risk as mediated by depression (Conwell, 2004), and is coded as Medium Risk.

7. Functional Impairment of ADL: Activities of Daily Living (ADL) include, but are not limited to, tasks such as bathing, dressing, eating, cleaning, cooking, and traveling. Impairment of ADL elevates suicide risk as mediated by depression. Moderate impairment of ADL is coded as Medium Risk and High Impairment of ADL is coded as High Risk.

D. Contextual Factors

8. Recent Losses/Stressors: The death of a loved one within the last 4 years is coded as Medium Risk. Family discord (e.g., marital conflict), financial stressors (e.g., job loss, financial instability, and bankruptcy) and caregiving responsibilities (e.g., responsibility for a child or dependant adult) are coded as either Medium Risk or High Risk ***depending on the number of risk factors present***. If only one of the three risk factors is present (i.e., family discord, **or** financial stressors, **or** caregiving responsibilities) code as Medium Risk. If ***more than one*** of the three risk factors is present (in any combination), code as High Risk.

9. Access to Lethal Means: Method of suicide is often selected on the basis of convenience and availability.

9a. If unlocked, loaded firearms are easily available (in residence or vehicle) code as Medium Risk. If a firearm has been recently purchased (within the last year), code as High Risk.

9b. If pills with potentially lethal dosages or poisons are easily available code as Medium Risk. If pills with potentially lethal dosages or poisons are being stockpiled (accumulated and stored for future use) code as High Risk.

10. Social Isolation: Living alone in the absence of trusted friends or confidants is coded as Medium Risk. [Note: living alone yet possessing trusted friends or confidants does not elevate risk for suicide.]

E. Clinical Factors – Acute

The following items should be rated by the client on the four-point scale provided in the protocol.

11. Psychic Distress: The client should rate her or his current level of psychological misery or distress.

12. Hopelessness: The client should rate her or his current belief that the future is hopeless; that life will not get better.

13. Burdensomeness: The client should rate her or his perception that she or he is a burden on other people.

14. Suicide Plan and Method: Client should rate the presence and, if applicable, the specificity of her or his plan to commit suicide and the methods available to do so.

F. 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 increase risk of suicide, reverse scoring is used for these items.

15. Moral Objections: The presence of moral or religious beliefs that suicide is a sin or immoral should be coded Low Risk.

16. Family Related Concerns: Responsibility for family (including, but not limited to children) and recognition of belongingness to and connection with family members should be coded Low Risk.

17. Mental Health Treatment for Mood Disorder: The absence of mood disorder (major depressive disorder, or bipolar disorder) or current treatment of mood disorder should be coded as Low Risk. The presence of a mood disorder that is not currently being treated should be coded as Medium Risk.

18. Other Reasons for Living: Client should be asked to enumerate any additional reasons for living that may serve as protective factors for not attempting suicide. Lack of ***any*** reasons for living should be coded as Medium Risk.

Other Considerations

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 18 items, the total number of items in each risk category should be totaled. The interviewer then determines the number of the nine High Risk and the four Extreme Risk items that were endorsed. If these High and Extreme Risk items were from the static demographic or historical factors, then the baseline level for risk is elevated to a "chronic high risk" (Bryan and Rudd, 2006). Next, the items endorsed under the Contextual, Clinical-Acute, and Protective factors, are reviewed to determine if acute risk is elevated due to recent stressors, feelings of hopelessness etc, or absence of protective factors. Based on an overall review of the items; baseline of risk plus current dynamic factors (and including any "other considerations,") the interviewer makes an OVERALL RISK APPRAISAL as Low, Medium, or High, and proceeds with the appropriate responses to ensure the safety of the client.

Listed on page two of the SOAP 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 the 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 SOAP, 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 lower 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 and reevaluate if acute changes have occurred.

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 increased frequency of 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, or High Risk categories are contracting for No Harmful 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 lethal means, such as stockpiled medications or poisons, is imperative for clients at medium or high risk. How this is accomplished would depend on where the firearms or medications/poisons 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 assure 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 Risk category 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. Although involuntary commitment may be necessary, it is sometimes counter-therapeutic because the individual does not desire to be hospitalized. Therefore, this action is always considered the last resort and the most restrictive alternative for treatment.

Conclusion

The SOAP is an 18-item guided clinical interview for older adult suicidal risk based on the empirical literature of suicide completion risk factors. This protocol will provide a comprehensive evaluation of a person's current suicidal risk and guidelines for appropriate case management.

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S.O.A.P. - Suicidal Older Adult Protocol (Ages 65-85)

Name_____ Age___ Gender M / F Date_____ Rater_____

A. Demographic Factors

1. Gender/Race/Age
Female/Non-white/65 + = L
Female/White/65+ = L
Male/Non-white/65+ =L
Male/White/65-80 = M
Male/White/80 + = H

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

L	M	H	E

B. Historical Factors

3. Prior Suicide Attempts
None = L 1 = H 2+ = E
Date_____
Means_____
Tx_____

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

L	M	H	E

C. Clinical Factors - Stable

5. Axis I Diagnosis
None = L
Dementia, Anx, Schiz = L
Sub. Abuse = M
Mood Disorders (MDD, BP) = E

6. Phys. Illness*
None = L
Female (COPD, Cancer, Neuro) = L
Males (COPD, Cancer, Neuro) = M

7. Functional Impairment of ADL*
None = L, Moderate = M
High = H

L	M	H	E

Total Factors: ____ ____ ____ ____
L (18) M (17) H (9) E (4)

* As mediated by Depression

D. Contextual Factors

8. Recent Loss/Stressors
None = L
Bereavement (<4yrs) = M
Family Discord,
Financial, Caregiving = M or H

9. Lethal Means Access
9a. Firearms
None = L Yes = M
Recent Purchase = H
9b. Pills/Poisons
No = L Yes = M
Stockpiled = H

10. Social Isolation
No = L
Live Alone Without
Confidants = M

L	M	H	E

E. Clinical Factors - Acute – To be rated by client

11. Do you experience psychic pain, misery or distress?
(L) No **(L)** A little **(M)** Some **(H)** A lot

12. Do you feel hopeless regarding your life (life will not get better)?
(L) No **(L)** A little **(M)** Some **(H)** A lot

13. Do you feel that you are a burden to others?
(L) No **(L)** A little **(M)** Some **(H)** A lot

14. Do you have a plan and or method to commit suicide?
(L) No **(L)** General idea, no specific plans
(M) Specific plan **(E)** Specific plan with method available and scheduled

F. Protective Factors

15. Moral Objections
Yes = L No = M

16. Family Related Concerns
Yes = L No = M

17. Mental Health Treatment For Mood Disorder
NA or Yes = L No = M

18. Other reasons for living: _____

L	M	H	E

OTHER CONSIDERATIONS:

RISK APPRAISAL: (Check one)	Low ☐	Medium ☐	**High** ☐

ACTIONS TAKEN (Check all that apply):

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

_____ _____

Interviewer Supervisor