

Suicide Risk Assessment

An Inventory of Scientific Findings

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Table of Contents

Introduction	3
Fluid Vulnerability Theory	4
Who Should Use the SRA?	4
Suicide Risk Assessment (SRA)	5
Scale Descriptions	6
Unique Features	10
Truth-correction	11
Confidentiality	11
Additional Benefits and Services	12
Empirical Research	12
Summary	13

Introduction

Suicide Risk Assessment (SRA) development was influenced by M. David Rudd's suicide theory and its peer-reviewed research. The Suicide Risk Assessment (SRA) assesses what are generally considered "core competencies" in suicide risk assessment. Lang (2013) emphasized clinicians should use a suicide screening tool with patients who have co-existing concerns, like depression, anxiety, or substance (alcohol/drug) use. Sometimes, it is argued that by not administering a suicide risk assessment, a clinician is neglectful (Simon, 2002).

- It is not enough to simply ask a patient about the presence of suicidal thoughts, or ask if they are suicidal (Gross, 2005).
- There is little doubt that the majority of mental health professionals are untrained and unprepared to assess and treat suicidal patients (Schmitz, et al., 2012).

Suicidal thinking (ideation) is more widespread than most people think. Worldwide approximately one million people die by suicide annually. In the United States there are, on average, 35,000 suicides a year. According to the Federal Substance Abuse and Mental Health Services Administration (SAMHSA), 1.1 million Americans attempt suicide each year, 2.2 million have a suicide plan, and 8.4 million have serious suicidal thoughts (www.thefinaleap.com). Approximately 65,000 Americans receive emergency room treatment each year following a suicide attempt. The number of people thinking seriously about suicide, making suicide plans and attempting suicide is alarmingly high.

The standard of care in suicidology endorses the administration, documentation and incorporation of risk-appropriate treatment programs. Information derived from suicide risk assessments enables clinicians to better understand their patient's suicide risk, increase their foreseeability, and develop treatment plans that are in the best interest of their patients (or inmates). **Failure to administer and document these suicide risk assessments is usually considered malpractice or negligence.**

Other factors are included in suicide risk assessments that relate to foreseeability and suicide risk. For example: Suicidal history, suicidal thoughts (ideation), suicidal intentions and associated DSM-5 disorders (e.g., depression, anxiety, alcohol, drug, stress, and substance use, etc.). Also reviewed are risk factors (e.g., family history of suicide, availability of pills, guns, etc.) and protective factors (e.g., available social support, religious beliefs, fear of death, etc.). **Although focused, comprehensive and meaningful, a suicide risk assessment alone does not prevent suicides. Once suicide risk has been determined, it is incumbent upon the clinician to adjust the patient's treatment plan and take appropriate actions to prevent suicide.**

The standard of care for suicide risk assessments is to complete a comprehensive suicide risk assessment and then, take action appropriate to the patient's level of suicide risk (Joiner, Walker, Rudd & Jobes, 1999). At a minimum, suicide risk requires closer monitoring and an intensified level of care.

Primary Care

Primary care physicians are the group most likely to see patients at risk of suicide before their suicide. Patients that die by suicide visit their primary care physicians more than twice as often before their death as their mental health clinician (Luoma, Martin, Pearson, 2002). In general, primary care settings are considered good opportunities for detection and early intervention of suicide risk (Katon, Unutzer & Simon, 2004). With regard to suicide liability exposure (Stuber & Quinnett, 2013) "Healthcare professionals are at risk for being sued if they do not assess at-risk patients in their care for suicide and intervene appropriately depending upon the level of risk that the patient presents."

There is little doubt that the majority of mental health professionals are untrained and unprepared to assess and treat suicidal patients (Schmitz, et al., 2012).

Correctional Facilities

Before moving on, it is worthwhile to note that jails, prisons, penitentiaries and other correctional and detention facilities have a legal duty to ensure the safety of their inmates. As part of this responsibility the department or facility and staff has a duty to prevent inmates from committing suicide. To prevent these suicides many programs (departments or facilities) have incorporated a suicide risk assessment at inmate intake (or at regional reception centers). Inmates identified as being at risk of suicide are closely monitored and as warranted medically supervised and/or enrolled in group counseling programs. Similar programs have saved lives while concurrently meeting detention or correctional facilities duty to ensure the safety of their inmates.

Fluid Vulnerability Theory

Suicide Risk Assessment (SRA) development was influenced by M. David Rudd's suicide theory and its peer-reviewed research. David Lang (2003) emphasized clinicians should use a suicide risk screening tool (assessment or test) with patients who have co-existing concerns like depression, anxiety or substance (alcohol/drug) use or abuse. Rudd (2006) applied Fluid Vulnerability Theory (FVT) to suicidality, which provides a conceptual model for understanding suicide risk over time. At the risk of oversimplification, patients who have not attempted suicide, or attempted once, are classified acutely suicidal, as they have limited periods (crises) of heightened suicide risk. In contrast, chronically suicidal patients have attempted suicide two or more (2+) times and their suicide symptoms are treated over long periods of time. When working with chronically suicidal patients it is important to clearly state in the patient's record (progress notes) that the patient is at chronic risk for suicide. When an acutely suicidal patient's symptoms have abated or subsided, that patient is no longer a significant

suicide risk. In contrast, when a chronically suicidal patient's acute suicide symptoms have been resolved, their susceptibility to future suicidal crises has not. They are still at risk and this should be noted in their chart or progress notes.

Who Should Use the Suicide Risk Assessment?

The Suicide Risk Assessment (SRA) is a concise, yet comprehensive evidence-based suicide risk assessment or self-report test. The Suicide Risk Assessment (SRA) differentiates between acute and chronically suicidal patients. It identifies periods of heightened suicide risk, recognizes escalating suicide risk when it occurs, assists in determining suicide foreseeability, helps in establishing appropriate levels of care and documents treatment decisions. The SRA assesses core competencies and documents the assessment procedures involved. If you want to consistently incorporate these core competencies in your suicide risk assessments – you should consider using the Suicide Risk Assessment (SRA).

Some clinicians have the education, training and time necessary to individually complete a comprehensive suicide risk assessment. Even so, many of these clinicians use self-report suicide risk assessments to focus and ensure comprehensiveness in their suicide risk assessments, while enhancing their foreseeability. The SRA is used by both experienced and new suicide assessors. Clinicians who lack suicide risk assessment training should consider using the Suicide Risk Assessment (SRA) to screen and identify suicide risk. They can then clarify any unresolved issues that emerge and modify the treatment recommendations (level of care) accordingly. If a clinician does not assess their emotionally disturbed patient's suicide risk and understand the foundation upon which their foreseeability is based, they are unnecessarily exposing themselves to tort and malpractice allegations.

Regular use of the SRA has several important advantages. It consistently assesses important suicide domains. It provides a sound basis for treatment decisions that assist the clinician's suicide risk foreseeability. It documents the Suicide Risk Assessment methodology and enhances the quality of patient care. The SRA augments but does not replace a clinician's follow-up on Suicide Risk Assessment findings.

Suicide Risk Assessment

The SRA is a clinical resource that is focused specifically on suicide risk assessment. As noted by O'Carroll et al. (1996) suicide behavior is distinguished by three characteristics:

1. Intention to die
2. Suicide attempt-related self-inflicted injury

3. Outcome (injury or death)

The SRA evaluates and documents each of these suicide-related characteristics. In addition the SRA analyzes two of the three “standards of practice” in suicidology: Foreseeability (a thorough risk assessment) and treatment planning (modify treatment plan based upon suicide risk assessment). The third element, namely “follow-up” is endorsed and recommended. **It is strongly recommended that clinicians use all available information in decision making; no decision should be based solely on SRA results.**

The Suicide Risk Assessment (SRA) is a 142 item self-report assessment that comprise 8 domains associated suicide risk. The test takes 25 minutes to complete. It should be noted that the Suicide Risk Screen (SRA) is a suicide screening tool. Sometimes it is argued that by not administering a suicide risk assessment, a clinician is neglectful (Simon, 2002).

The SRA takes 25 minutes to complete and can be administered by paper-pencil (test booklet format) or on the computer screen. Regardless of how the SRA is administered, all SRA tests are scored online and reports are available on-site within 3 minutes of data (answers) entry.

There are 8 SRA scales that assess several domains associated with suicide risk:

- | | |
|---------------------------|----------------------------|
| 1. Truthfulness Scale | 5. Suicide Risk Scale |
| 2. Depression Scale | 6. Alcohol Scale |
| 3. Anxiety Scale | 7. Drug Scale |
| 4. Substance Use Disorder | 8. Stress Management Scale |

Scale Descriptions

It is important that users of the SRA familiarize themselves with the definition of each scale. For that purpose a description of each SRA scale follows.

Truthfulness Scale

Client truthfulness is an important area of inquiry in the Suicide Risk Assessment (SRA). Consequently it has domain status. The SRA Truthfulness Scale determines whether or not the patient being assessed was truthful while completing the SRA. The assessor can then decide if he/she can rely upon the patient’s SRA answers. When the SRA Truthfulness Scale is valid (accurate), assessors and treatment staff can trust the

patient's answers and use this information to enhance a patient's level of care. Accurate (truthful) information provides a sound basis for treatment recommendations.

Depression Scale

Identifies depression and quantifies symptom severity. The higher the Depression Scale score, the more severe the depression. Elevated Depression Scale scores identify early, to middle stages of depression. The higher the score, the more severe the depression. The Depression Scale score can be interpreted independently as a self-report or in terms of its interaction with other SRA scale scores.

With regard to depression the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* a Major Depression Episode diagnosis mandates at least one of the patient's endorsed symptoms is either a "depressed mood" or "the loss of interest or pleasure in nearly all of the patient's activities." In a depression, the patient should experience at least four additional symptoms from the following list of nine symptoms of depression.

1. Depressed mood most of the day, nearly every day.
 2. Diminished interest/pleasure.
 3. Significant weight loss/gain.
 4. Insomnia or hypersomnia.
 5. Psychomotor agitation/retardation.
 6. Fatigue/loss of energy.
 7. Feeling worthless/guilt.
 8. Difficulty thinking/concentrating.
 9. Suicidal ideation (thoughts).
- A "severe depression" is comparable to a clinical depression, which on its own merits warrants treatment. Severe depression has been linked to suicide attempts. Co-occurring anxiety and/or substance (alcohol/drug) use is a malignant sign and further heightens suicide risk.
 - A very chronic form of depression is "persistent depressive disorder" which is diagnosed when the mood disturbance (depression) continues for at least two years in adults. This diagnosis is new in DSM-5. People, with depression, are at heightened risk of suicide. Alcohol, drug abuse and Substance Use Disorders have also been linked to suicide in the research literature.

Anxiety Scale

Identifies anxiety and quantifies symptom severity. The scale provides a quantitative score that varies directly with the self-reported symptoms and concerns. The higher the Anxiety Scale score, the more severe the anxiety.

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) defines anxiety as excessive worry (apprehensive expectations) about a number of events or activities. The intensity, duration and frequency of the anxiety is out of proportion to the actual likelihood of the anticipated event. DSM-5 anxiety symptom categories include six (6) symptoms. The patient needs to select (endorse) three (3) or more of the following six symptoms:

1. Restless or on edge
2. Easily fatigued/tired
3. Difficulty concentrating
4. Irritability
5. Muscle tension
6. Sleep disturbance

Some mental health professionals maintain a synonym for anxiety is “stress.” Stress is a known contributor to DSM-5 disorders like depression, anxiety substance (alcohol/drug) abuse, hopelessness, etc. Co-occurring disorders can heighten suicide risk. In summary, anxiety can be an important risk factor in suicide risk.

Drug Scale

Measures prescription and non-prescription drug use and, as appropriate, the severity of abuse. An elevated (Problem Risk range) Drug Scale Score identifies early stage or emerging drug problems. An SRA Drug Scale score in the Severe Problem range identifies established and severe drug abuse. Elevated (Problem Risk range) co-occurring symptoms clusters (disorders) like alcohol, anxiety, substance (alcohol/drug) abuse, etc., often interact -- heightening suicide risk. Elevated Drug Scale scores do not occur by chance. Nevertheless, elevated Alcohol Scale and Drug Scale scores are indicative of co-occurring poly-substance abuse and the highest score typically reflects the patient's substance of choice. Any Drug Scale score in the severe problem range must be taken seriously. The Drug Scale can be interpreted independently or in combination with other elevated Suicide Risk Assessment (SRA) scales.

Alcohol Scale

Measures alcohol (beer, wine or liquor) use and the severity of abuse. A recently published study found that the Alcohol Scale percentile score is a strong predictor of DUI/DWI offender recidivism (Bishop, 2011). An elevated (Problem Risk range) Alcohol Scale score identifies emerging or early stage alcohol problems. An SRA Alcohol Scale

score in the Severe Problem range identifies established and severe drinking problems. Co-occurring poly-substance abuse must always be interpreted carefully. Alcohol Scale scores in the Severe Problem range must be taken seriously; elevated Alcohol Scale scores do not occur by chance. The Alcohol Scale can be interpreted independently or in combination with other elevated Suicide Risk Assessment (SRA) scales.

Stress Management Scale

Assesses the patient's ability to manage the stress that they are experiencing. It is now known that inability to manage stress exacerbates physical and emotional. More specifically, poorly managed stress (pressure, anxiety) contributes to heightened anxiety, depression and substance (alcohol/drug) use. Thus, an elevated (Problem Risk range) Stress Management Scale score in conjunction with other elevated Suicide Risk Assessment (SRA) scales provides considerable insight into the patient's situation. When a patient doesn't manage stress well, other problems are usually exacerbated. Such problem augmentation or magnification applies to all co-occurring (co-morbidity) SRA problems, as represented by their SRA Stress Management Scale scores. As a general rule, the higher the SRA scale score, the more severe the problem.

Substance Use Disorder Scale

The Suicide Risk Assessment (SRA) Substance Use Disorder is based upon *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* classification criteria. The Substance (alcohol/drug) Use Disorder is characterized by the patient continuing to use a substance (alcohol/drug) despite significant substance-related problems. *DSM-5* substance (alcohol/drug) use criterion consists of eleven symptoms, which are paraphrased as follow.

1. Takes substances in larger amounts or over a longer period than intended.
2. Important social, occupational or recreational activities are given up.
3. Multiple unsuccessful efforts to decrease or discontinue use.
4. Recurrent use in physically hazardous situations.
5. Spends a lot of time obtaining, using and recovering.
6. Continues use despite physical or psychological problems.
7. Almost all daily activities revolve around the substance(s).
8. Tolerance has greatly increased.
9. An intense desire, urge or craving for the substance(s).
10. Has withdrawal symptoms when cuts down or stops using.
11. Failure to fulfill major role obligations at school, work or home.

The severity of a patient's disorder is determined by how many of the eleven (11) Substance Use Disorder symptoms they endorse.

Unique Test Features

Truthfulness Scale

There are many terms that address the notion of truthfulness within the context of assessment, treatment and rehabilitation, including: *Denial*, *problem minimization*, *misrepresentation* and *equivocation*. The prevalence of denial among patients and offenders is extensively discussed in the psychological literature (Marshall, Thornton, Marshall, Fernandez, & Mann, 2001; Brake & Shannon, 1997; Barbaree, 1991; Schlank & Shaw, 1996). The impact the Truthfulness Scale score has on other scale or test scores is contingent upon the severity of denial or untruthfulness. In assessment, socially-desirable responding impacts assessment results when respondents attempt to portray themselves in an overly favorable light (Blanchett, Robinson, Alksnis & Sarin, 1997).

Truthfulness Scale awareness increased with the release of the Minnesota Multiphasic Personality Inventory (MMPI) many years ago. Soon thereafter, socially-desirable responding was demonstrated to impact assessment results (Stoeber, 2001; McBurney, 1994; Alexander, Somerfield & Ensminger, 1993; Paulhus, 1991). Truthfulness Scale conceptualization began in earnest with the idea of self-response accuracy. Test users want to be sure that respondents' self-report answers were truthful. Evaluators and assessors need to know if they can rely upon the test data being accurate. In other words, can the respondent's self-report answers be trusted? Research also shows that truthfulness is a factor in diagnosis, treatment effectiveness and recidivism with all patients.

Client (patient or offender) truthfulness has been associated with more positive treatment outcomes (Barber, et. al., 2001). Denial often accompanied lack of accountability, lack of motivation to change, resistance and general uncooperativeness (Simpson 2004). Problem minimization has also been linked to lack of treatment progress (Murphy & Baxter, 1997); treatment dropout (Daly & Peloski, 2000; Evans, Libo & Hser, 2009); and offender recidivism (Nunes, Hanson, Firestone, Moulden, Greenberg & Bradford, 2007; Kropp, Hart, Webster & Eaves, 1995; Grann & Wedin, 2002). Some researchers have suggested that client denial should be eliminated prior to commencing treatment. Denial reduction methods include use of survivor reports, directed group work, or addressing cognitive distortions that may cause denial (Schneider & Wright, 2004).

As multidimensional as denial is (Barrett, Sykes, & Byrnes, 1986; Brake & Shannon, 1997; Happel & Auffrey, 1995; Laflen & Sturm, 1994; Langevin, 1988; Orlando, 1998;

Salter, 1988; Trepper & Barrett, 1989), truthfulness is equally multifaceted. Yet, client truthfulness (and denial) are integral to accurate assessment, testing and evaluation. Consequently, truthfulness will continue to be studied in the future.

SRA Database

Every time a SRA is scored the test data is automatically stored on the diskette for inclusion in the SRA database. This applies to SRA diskettes used anywhere in the United States and Canada. When the preset number of tests are administered (or used up) on a SRA diskette, the diskette is returned for replacement and the test data contained on these used diskettes is input, in a confidential (no names) manner, into the SRA database for later analysis. This database is statistically analyzed annually, at which time future SRA diskettes are adjusted to reflect demographic changes or trends that might have occurred. This unique and proprietary database also enables the formulation of annual summary reports that are descriptive of the populations tested. Summary reports provide important testing information, for budgeting, planning, management and program description.

Confidentiality (Delete Client Names)

Client privacy and security is of the utmost importance. When using the SRA you can rest assured, knowing that your client's privacy and confidentiality are safe. Any identifying information (name, ID numbers, etc.) is encrypted, before being stored in our database. A secure algorithm, built into the SRA software, unencrypts this information, before displaying it to you over the web. This ensures that only you can access the data and reports for your clients. This encryption method is HIPAA (federal regulation 45 C.F.R. 164.501) compliant.

Additional Benefits and Services

A host of other, complimentary, benefits and features are included with test purchase. For example, these benefits include:

- Support Services
- Test Upgrades
- Annual Summary Reports (Program Summary)
- Human Voice Audio
- Scanner scoring for high volume testing
- Data Input Verification Feature
- Available in English and Spanish (translation into other languages can be available upon request)

Clinicians regardless of training or experience should consider using the Suicide Risk Assessment (SRA) to screen and identify suicide risk. This information can assist clinicians in identifying and recommending appropriate levels of care.

Empirical Research

As more test administration data is collected on the Suicide Risk Assessment (SRA) reliability and validity studies will be conducted to establish empirical support of the SRA. Additionally, studies will examine the relationship between Depression Scale and Anxiety Scale scores in chronic versus acute suicide risk profiles.

Dr. Lindeman,

Previous research on Truthfulness Scale and Stress Management Scale typically goes in this section but since this was such a new test, with a new philosophy I was not sure whether you wanted it include in the SRA inventory.

Please let me know your thoughts.

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Summary

This document is not intended to be an exhaustive compilation of Suicide Risk Assessment (SRA) research; however, it does summarize many research studies supporting the reliability, validity, and accuracy of the SRA. Moreover, ongoing SRA database research ensures an increasingly comprehensive profile of patients' suicide risk.

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