On the Road to Zero Suicide: Identification & Triage Using the Columbia-Suicide Severity Rating Scale

Decreasing Suicide, Improving Care Delivery and Redirecting Scarce Resources In Healthcare

Adam Lesser, LCSW
Deputy Director

The Columbia Lighthouse Project
IDENTIFY RISK. PREVENT SUICIDE.
Suicide is a Major Public Health Crisis

- More deaths than war, homicide and natural disasters combined
- Leading cause of death across the world and across ages
- **Every 40 sec. worldwide and every 13 minutes in the US** a person dies by suicide
- #1 cause of injury mortality in U.S.; more people die by suicide than motor vehicle crashes

“The under-recognized public health crisis of suicide”
- Thomas Insel, Director of NIMH

*Suicide is a preventable cause of death*
Pyramid of Suicidal Behaviors (Adults)

39,894 Suicides*
405,300 Emergency Room Visits for Attempts*
1,300,000 Suicide Attempts**
2,700,000 Made a Suicide Plan**
9,300,000 Seriously Considered Suicide**

**Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health, 2013.
An Increasing Crisis in Youth and Young Adults

- 2010-2014 suicide is the 2nd leading cause of death in youth 10-24 passing homicide for the first time since 1999

- Suicide by African American girls 10-18, increased almost 150% between 2006-2014

- 8-12 year olds—has increased almost 150% from lowest point in 2008

CDC WISQARS
Suicide Ideation and Attempts Are Unbelievably Common...

IN YOUR AVERAGE HIGH SCHOOLERS

• **8% attempted in the past year!**
• **17% seriously considered it**

Within any typical classroom, it is likely that three students (one boy and two girls) have attempted suicide in the past year.
Relationship to School Violence  
(Safe Schools Initiative, 2002)

• 78% of attackers exhibited a history of suicide attempts or suicidal thoughts prior to their attack
• 27% reported suicide as a motive in their attack - a “suicide in disguise”
• 60% had a documented history of extreme depression or desperation

and yet, only 34% of attackers had received a mental health evaluation and just 17% had been diagnosed
Any Kind of Medical Illness from Asthma to Cancer

25.5% have ideation
8.9% make an attempt

Cancer patients - ideation 17.7%

*independent of depression*

If you have one of the following disorders (high blood pressure, heart attack/stroke, cancer, epilepsy, arthritis, chronic headache, chronic pain, respiratory conditions) you are:

- **30-160%** more likely to have *suicidal thoughts*
- **40-90%** more likely to have an *attempt*
A CRISIS Everywhere

**Corrections**
- Leading cause of death in jails for past 15 years
- 1/3 of all jail deaths
- Rate of suicide is close to **three times** that of general pop
- Many within first 24 hours
- Incarcerated youth: 37% report a suicide attempt
- Recently released prisoners have rates similar to psychiatric hospital discharges

**First Responders**
- A leading cause of death of law enforcement officers alongside car crashes
- In 2012, almost as many died by suicide as were killed in the line of duty
- The rate of police suicide is comparable to the US Army Rates
- In 2014, 104 firefighters in the United States died by suicide, only 87 were killed in the line of duty
Rural Areas: One of Our Greatest Challenges

- Highest rates of suicide
- Large populations, spread out across great distances
- Less consistent access to primary care
- Closest physicians may be several hours away and overburdened
- High rates of gun ownership (Miller et al., 2013)
More guns, more suicides

Reported suicides between 2001 and 2005

Highest: 195 mil - WY, SD, AK, WV, MT, AK, MS, ID, ND, AL, KY, WI, LA, TN, UT

Lowest: 200 mil - HI, MA, RI, NJ, CT, NY

Source: "Guns and Suicide in the United States"
Unfortunately, People Who Need Treatment Do Not Get It!

- 90% of individuals who die by suicide have untreated mental illness (60% depression)

- **Under-treatment of mental illness is pervasive**
  - 50-75% of those in need receive no treatment or inadequate treatment (Alonso et al., 2007; Wang et al., 2005)
  - 70% of children and teens with depression go untreated
  - >80% of adolescents and college students who die by suicide never received any consistent treatment prior to their death
Depression: Most Debilitating Disease in the World

• Depression will be the world’s most burdensome disease by the year 2030 (WHO, 2008)

• Depression is already the most burdensome disease in middle and high income countries (WHO, 2008)

**Depression is the #1 cause of work related absence** and costs US workplaces an estimated $23 billion annually in lost productivity from just those days missed
Need to Ask: Screen and Monitor Like We Do for Blood Pressure

- 45% of all people and 58% of older adults who die by suicide see their primary care doctor in the month before they die (Luoma et al., 2002)
- Many adolescent attempters in the ER do not present for psychiatric reasons (King et al., 2009)
- 25% of all people who die by suicide are seen in ER in past 12 months for non-psychiatric reasons (Gairin et al., 2003)

If we ask we can find them!!
Screening Programs are Successful

• High-school screening programs associated with 2x in detection of at-risk individuals (Scott et al., 2009)

• Meta-analysis concluded that screening results in lower suicide rates in adults (Mann et al., JAMA 2005)

• Elderly primary care screenings - 118% increase in rates of detection and diagnosis of depression (Callahan et al., 1996)
Myths About Suicide
“If someone is really suicidal, they are probably going to kill themselves at some point no matter what you do”

This is FALSE!

- Multiple studies have found that >90% of the most serious attempters do not go on to die by suicide
- Most people are suicidal only for a short amount of time
- So, helping someone through a suicidal crisis can be life-saving
“Asking a depressed person about suicide may put the idea in their heads”

This is FALSE!

- Does *not* suggest suicide, or make it more likely
- Open discussion is more likely to be experienced as relief than intrusion
- Risk is in *not* asking when appropriate
“There’s no point in asking about suicidal thoughts...if someone is going to do it they won’t tell you”

This is FALSE!

- Many will tell clinician when asked, though might not have volunteered it – often a relief
- *Ambivalence* is characteristic in 95%
- Contradictory statements/behavior common
- Many give some hints/warnings to friends or family, even if don’t tell clinician
“Someone making suicidal threats won’t really do it, they are just looking for attention”

This is FALSE!

- Those who talk about suicide or express thoughts about wanting to die, are at risk for suicide and need your attention
- 80% of people who die by suicide give some indication or warning
- Take all threats of suicide seriously. Even if you think they are just “crying for help”—a cry for help, is a cry for help—so help
“If you stop someone from killing themselves one way, they’ll probably find another”

This is FALSE!

- “Means safety” – reducing a suicidal person’s access to highly lethal means - has strong evidence as effective suicide prevention strategy

<table>
<thead>
<tr>
<th>Method</th>
<th>Lethality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firearm</td>
<td>85%</td>
</tr>
<tr>
<td>Suffocation</td>
<td>69%</td>
</tr>
<tr>
<td>Fall</td>
<td>31%</td>
</tr>
<tr>
<td>Poisoning/overdose</td>
<td>2%</td>
</tr>
<tr>
<td>Cuts</td>
<td>1%</td>
</tr>
</tbody>
</table>

- In 2013, guns were used in 51% of completed suicides
- The vast majority of youth who die by firearm suicide use a family member’s gun – 10 every week
Means Safety Works!

- **United Kingdom 1958** – replacing coal gas with natural gas—suicide rate by carbon monoxide poisoning was cut by 1/3 with only small a small increase in other methods

- **England 1998** – introduced individual blister packaging for Tylenol = 44% reduction in Tylenol overdose over next 11 years

- **Switzerland 2003** - Suicides in young men decreased by 10% as a direct result of Army reform that reduced the number of soldiers storing guns at home

- **Israeli military 2006** - restricted gun access for off-duty soldiers, suicide rate dropped 40% in military
Rate of firearm suicides after Australia's gun buyback program

Firearm suicides per 100,000 residents

- 1970
- 1980
- 1990
- 2000
- 2006

1996
Buyback program begins

SOURCE: IZA
Suicide Is Preventable and Efforts Depend First Upon Accurate Identification
The Problem…

Field of medicine challenged by lack of conceptual clarity about suicidal behavior and absence of well-defined terminology (research and clinical)

Variability of terms referring to same behaviors (threat, gesture) “Slap in the face”

16 different terms for the same behavior

...Consequences

Negative implications on appropriate management of suicide and research - if suicidal behavior and ideation cannot be properly identified, it cannot be properly understood, managed or treated in any population or diagnosis

Furthermore, comparison across epidemiological or drug safety data sets is compromised, decreasing confidence in data

“Research on suicide is plagued by many methodological problems… Definitions lack uniformity,…reporting of suicide is inaccurate…”

Reducing Suicide Institute of Medicine 2002
How to Fix the Problem...
Columbia - Suicide Severity Rating Scale


- Developed in NIMH effort to uniquely address need for summary measure – 1st scale to assess full range of ideation and behavior, severity, density, track change
- many leading experts - collaboration with Beck’s group
- 10s of millions administrations
- Available in 116 languages
- Very brief administration time
- Deemed “most” evidenced supported

- Excellent acceptance in practice by patients and providers
- Age: suitable across the lifespan for use with adults, adolescents, and young children.
- Special Populations: indicated for cognitively impaired (e.g. Alzheimer's, Autism)
Adopted by CDC

“The C-SSRS is changing the paradigm in suicide risk assessment in the US and worldwide” – Alex Crosby

Also from CDC:
“Unacceptable Terms”
- Completed suicide
- Failed attempt
- Parasuicide
- Successful suicide
- Suicidality
- Nonfatal suicide
- Suicide gesture
- Manipulative act
- Suicide threat

http://cssrs.columbia.edu/
The C-SSRS Impact: Helping Save Lives
What A Medical Center Can Do: Organizational Vision/Top-Down Models

NYU Langone Medical Center

Oncologists  Emergency  Residents  Physician Asst.  Geriatrics  Cardiology

Pediatricians  Neurology  Surgeons  PTs/OTs  Psychiatry

Orthopaedics  Nurses  Forensic Med.  Administration

Obstetrics  Urologists  Internal Medicine

Policy: Nurse Screens, Worry of High Risk Among Patient, “Nurses Hotline”
Centerstone Reduces Suicide Rate by 40% in TN and IN

“as a multi-state behavioral health organization, we chose the C-SSRS as the tool used to screen and assess all individuals who enter our system. We have found it is the hinge pin of our Clinical Pathway for Suicide Prevention.”

Largest Provider of Community Behavioral Healthcare in the United States
The Care Pathway at Centerstone:

“with so many patients its like mining for gold and the Columbia is the sifter”

• Follow-up/Weekly appts, Means restriction on the other end

• If pt is DO NOT SHOW, attempt and document phone-call **within 2 hours**

• If unable to contact referred to Follow-Up specialist who attempts to contact for 3 days for brief telephone risk assessment and encouragement to re-engage, name populates in purple in EHR, enter *Suicide Pathway and Crisis line* which *never shuts down* until they are tracked down
Becky Stoll
VP of Crisis & Disaster Management at Centerstone explains Zero Suicide using the C-SSRS

http://zerosuicide.sprc.org/video/screening-protocol-centerstone
The Zero Suicide Model
National Action Alliance for Suicide Prevention

• NY- Eval of recent suicides all same picture: *No good risk assessment, no safety plan, no warm hand-off*

• Organizational vision of zero suicides

• C-SSRS and Safety Planning to be used in training all staff to screen *all patients* statewide
Linking of Systems: Organizational Vision/Top-Down Models

**Department Health & Mental Health**

- **Provider By Provider**
- **All Services**
- **Between Services**
- **All Systems of Care**

**Linking Systems**

Inpt → Bridge → Outpt

*Precision of communication: enables quicker response to those who need it*

- Hospitals
- First Responders and Crisis Lines
- Schools
- Law Enforcement
- Primary Care
- Justice

*The Columbia Lighthouse Project*

*Identify Risk, Prevent Suicide.*
A COMPREHENSIVE SUICIDE PREVENTION INITIATIVE FOR GEORGIA’S MENTAL HEALTH PROVIDERS

“AIM” Assessment, Intervention and Monitoring

Georgia DBHDD Implementation Plan

1. Introduced Statewide
2. Overview by Region and regional support
3. Policy development at state level
4. Provider by Provider implementation
5. Providers implement in all services, between services, and in systems of care
State-Wide Dissemination

Georgia Department of
BEHAVIORAL HEALTH and DEVELOPMENTAL DISABILITIES

• Georgia Crisis and Access Line (GCAL) through Behavioral Health Link (BHL)
• Mobile Crisis Response Teams
• Community Hospitals providing designated beds
• Crisis Stabilization Units (CSU) provide walk-in psychiatric and counseling services in a center that is clinically staffed 24 hours per day, 7 days per week, to receive individuals in crisis.
• Crisis Apartments (in development) that provide an alternative to crisis stabilization units and hospitalization
• Assertive Community Treatment teams (ACT) that operate with fidelity to the Dartmouth ACT model.
• Intensive Case Management teams, comprising 10 full-time case managers per team, which coordinate treatment and support services and assist individuals with accessing community resources.
• Peer support Services

Medicaid
• Projects for assistance in Transition from Homelessness (PATH)

***Anticipated large majority of hospitalizations can be avoided

• Forensic services
• Case Management service providers that coordinate treatment and support services and help maintain services and supports already in place.
• Supported housing services
• Supported employment services
• Core services provided through core providers
  • Physician Assessment & Care
  • Diagnostic Assessment
  • Behavioral Health Assessment
  • Group Counseling/Training
  • Family Counseling/Training
  • Community Support
  • Service Plan Development
  • Crisis Intervention
  • Individual Counseling
  • Psychological Testing
  • Nursing Assessment & Care
  • Medication Administration

• Prevention Services such as Suicide Prevention
Utah “All in” Effort – so far

• **Association for Utah Community Health** - Federally Qualified Health Centers
  • Front line personnel and support staff
  • Street medicine/homeless outreach providers

• **University of Utah Department of Emergency Medicine** - crisis and social work teams using C-SSRS and S&B Safety Plans.

• **Utah Division of Child and Family Services** - all new child welfare caseworkers trained in screening, referral and safety planning

• **Utah Commission on Criminal and Juvenile Justice**
  • Statewide domestic violence sentencing and treatment guidelines.
  • Law enforcement, judges, prosecutors and state-contracted DV treatment providers

• **Utah Domestic Violence Coalition**
  • Promoting the C-SSRS at annual DV conference
  • Staff at state-contracted domestic violence shelters

• **Utah Department of Commerce/Utah Trafficking in Persons Committee**

• **Utah Association of Domestic Violence Treatment Providers** - contracted treatment providers providing court ordered treatment to individuals adjudicated on charges of cohabitant abuse.

• **Unified Fire Authority** - EMT/Paramedic and Fire Fighters.

• **Utah Safety Net** - 2014 Safety Net Conference workshop.
C-SSRS helps Utah achieve DECREASE in SUICIDE

Reversed an alarming increasing trend

In their legislative suicide prevention report they state "we are committed to becoming a Zero Suicide System of Care"

“Screening and assessment using the C-SSRS had been an important piece to this comprehensive multi system approach. We are on year 2 of a Statewide... project that highlights the use of the CSSRS and subsequent interventions... Another step in our "all-in" adoption of shared tools and language"

- Utah Division of Substance Abuse and Mental Health
The C-SSRS Impact: Redirecting Scarce Resources
Improved Identification with Decreased False Positives

PHQ-9 Suicide Item: Thoughts that you would be *better off dead* or of *hurting yourself* in some way

Outpatient Psychiatry Pilot – Self Report Computer Version (523 Encounters)

- 6.2% positive screen on C-SSRS
- 23.8% endorsed item #9 of PHQ-9

*Most, but not all, of the positive Columbia screen patients endorsed #9 of PHQ9 e.g. Cases were missed*
C-SSRS vs. Open Ended Leads to Improved Detection

• Detected 29.7% of patients with suicidal ideation and 18.7% of patients w/ history of suicide attempt undetected by clinician interview (Bongiovi-Garcia et al., 2009)

• Telephone assessment w/ C-SSRS detected (59%) of suicide attempts compared to chart reviews (18%) (ED-SAFE study, Arias et al, 2014)
"[The C-SSRS] allowed us to identify those at risk and **better direct limited resources in terms of psychiatric consultation services and patient monitoring** and it has also given us the **unexpected benefit** of identification of mental illness in the general hospital population which **allows us to better serve our patients and our community.**"
Rhode Island Senate Commission Hearing Report on ER Overuse

**Recommendation:**

• "Support the **state wide coordination and implementation** of an evidence based suicide/mental health assessment tool and training for Rhode Island healthcare providers and first responders for determination of placement in emergency department or alternative settings."

• "...this recommendation would be critical in assisting those in the field with an additional tool for **everyday use**."

  - Testimony by a Pawtucket police officer: "...the officer highlighted the important and timely decisions that law enforcement must make...the limited training that law enforcement often receives outside of the police academy was discussed and the importance of providing our first responders with the appropriate tools to assess an individual was identified as a necessary tool."
The Problem in Schools: Who Do We Refer?

New York City

• Four hospitals: 61-97% of referrals did not require hospitalization.

• NYC DOE:
  • “The great majority of children & teens referred by schools for psych ER evaluation are not hospitalized & do not require the level of containment, cost & care entailed in ER evaluation.”
  • “Evaluation in hospital-based psych ER’s is costly, traumatic to children & families, and may be less effective in routing children & families into ongoing care.”

One Student sat 9 hours in a principal’s office waiting for EMT
Screening in Schools – The Solution

- 38 middle schools/nurse delivery: an estimated 100+ students were identified that would have otherwise been missed, while dramatically reducing unnecessary referrals.

640 middle schools this year – then on to the High Schools

“City schools expand suicide training” (C-SSRS):
“This enhanced service has made more appropriate referrals for students to see support staff in the school and referrals to community agencies as needed…”
– Crain’s, NY 7/20/12

25% of teachers report being approached by an at-risk child
What is the C-SSRS
Assessment of Suicidal Ideation and Suicidal Behavior

- **Ideation Severity** - 1-5 rating, of increasing severity (from a wish to die to an active thought of killing oneself with plan and intent)

- **Ideation Intensity** – 5 intensity items that total 2-25

- **Behaviors** - All relevant behaviors assessed and all items include definitions for each term and standardized questions for each category are included to guide the interviewer for facilitating improved identification

- **Lethality of Actual Suicide Attempts**
<table>
<thead>
<tr>
<th>Intensity of Ideation</th>
<th>Description</th>
<th>Type</th>
<th>Most Severe</th>
<th>Most Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIFE TIME - Most Severe Ideation (i.e., 1-5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recency - Most Severe Ideation (i.e., 1-5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td>How many times have you had these thoughts?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td>When you have the thoughts how long do they last?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>Could you stop thinking about killing yourself or wanting to die if you wanted to?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deterrents</td>
<td>Are there things (e.g., family, religion, pain of death) that stopped you from wanting to die or acting on thoughts of committing suicide?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason for Ideation</td>
<td>What sorts of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### SUICIDAL BEHAVIOR

(Defer all that apply, so long as these are separate events; must ask about all types)

<table>
<thead>
<tr>
<th>Actual Attempt:</th>
<th>Lifetime</th>
<th>Past 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No  □</td>
<td>Yes □</td>
</tr>
<tr>
<td></td>
<td>No  □</td>
<td>Yes □</td>
</tr>
<tr>
<td></td>
<td>No  □</td>
<td>Yes □</td>
</tr>
<tr>
<td></td>
<td>No  □</td>
<td>Yes □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has subject engaged in Non-Suicidal Self-Injurious Behavior?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes No Yes No</td>
</tr>
<tr>
<td>Yes No Yes No</td>
</tr>
<tr>
<td>Yes No Yes No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interrupted Attempt:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes No Yes No</td>
</tr>
<tr>
<td>Yes No Yes No</td>
</tr>
<tr>
<td>Yes No Yes No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aborted or Self-Interrupted Attempt:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes No Yes No</td>
</tr>
<tr>
<td>Yes No Yes No</td>
</tr>
<tr>
<td>Yes No Yes No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preparatory Acts or Behavior:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes No Yes No</td>
</tr>
<tr>
<td>Yes No Yes No</td>
</tr>
<tr>
<td>Yes No Yes No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suicidal Behavior:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal behavior was present during the assessment period</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actual Lethality:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Damage:</td>
</tr>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>Enter Code</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Lethality:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only if Actual Lethality:</td>
</tr>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>Enter Code</td>
</tr>
</tbody>
</table>
C-SSRS Screener
* only 3-6 questions

**Combined Behaviors Question**

<table>
<thead>
<tr>
<th>COLUMBIA-SUICIDE SEVERITY RATING SCALE</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUICIDE IDEATION DEFINITIONS AND PROMPTS</strong></td>
<td>YES</td>
</tr>
<tr>
<td>Ask questions that are bolded and underlined.</td>
<td></td>
</tr>
<tr>
<td>Ask Questions 1 and 2</td>
<td></td>
</tr>
<tr>
<td>1) Wish to be Dead:</td>
<td></td>
</tr>
<tr>
<td>Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.</td>
<td></td>
</tr>
<tr>
<td>Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td></td>
</tr>
<tr>
<td>2) Suicidal Thoughts:</td>
<td></td>
</tr>
<tr>
<td>General non-specific thoughts of wanting to end one's life/commit suicide, &quot;I'm killing myself&quot; without general thoughts of ways to kill oneself/associated me plan.</td>
<td></td>
</tr>
<tr>
<td>Have you actually had any thoughts of killing yourself?</td>
<td></td>
</tr>
<tr>
<td>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</td>
<td></td>
</tr>
<tr>
<td>3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):</td>
<td></td>
</tr>
<tr>
<td>Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. &quot;I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it.&quot;</td>
<td></td>
</tr>
<tr>
<td>Have you been thinking about how you might kill yourself?</td>
<td></td>
</tr>
<tr>
<td>4) Suicidal Intent (without Specific Plan):</td>
<td></td>
</tr>
<tr>
<td>Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to &quot;I have the thoughts but I definitely will not do anything about them.&quot;</td>
<td></td>
</tr>
<tr>
<td>Have you had these thoughts and had some intention of acting on them?</td>
<td></td>
</tr>
<tr>
<td>5) Suicide Intent with Specific Plan:</td>
<td></td>
</tr>
<tr>
<td>Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.</td>
<td></td>
</tr>
<tr>
<td>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td></td>
</tr>
<tr>
<td>6) Suicide Behavior Question:</td>
<td></td>
</tr>
<tr>
<td>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</td>
<td></td>
</tr>
<tr>
<td>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.</td>
<td></td>
</tr>
<tr>
<td>If YES, ask: How long ago did you do any of these?</td>
<td></td>
</tr>
<tr>
<td>• Over a year ago? • Between three months and a year ago? • Within the last three months?</td>
<td></td>
</tr>
</tbody>
</table>
Data Confirmation…
4 and 5 Predicts Attempts in National Attempter Study
(Posner et al., *AJP* December 2011)

- C-SSRS Lifetime Ideation, types 4 and 5, predicted suicide attempts in adolescent suicide attempters, followed over a year

- **Beck SSI NOT predictive**

- C-SSRS Lifetime Ideation, types 4 and 5, predicted actual, interrupted or aborted attempts on CSHF
Prediction in Non-Suicidal Adults and Adolescents

• Confirmed by eC-SSRS data: 35,007 (3776 subjects) across depression, epilepsy, insomnia, fibromyalgia (Mundt et. al., JCP 2013)
  • Patients with baseline prior ideation of 4 or 5 or prior behavior are 4-5x more likely to report suicidal behavior at follow up
  • *Patients with both are 9x more likely to report suicidal behavior*

• Prediction in adolescent emergency department follow-up study (King et al)
  • Duration predictive
  • Attempt and lifetime attempt not predictive, *reinforcing ideation assessment*
  • NSSI not predictive
Each Type of Ideation Severity Confers Increasingly Greater Risk

<table>
<thead>
<tr>
<th>History of Lifetime Suicidal Ideation at Study Start</th>
<th>All Patients N=8837 OR (95% CI)</th>
<th>Psychiatric Patients N=6760 OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Ideation Reported</td>
<td>0.8% incidence rate  N=4975</td>
<td>1.1% incidence rate  N = 3184</td>
</tr>
<tr>
<td>Wish to Be Dead</td>
<td>6.21 (4.18 – 9.23)***  N=1491</td>
<td>4.99 (3.29 – 7.56)***  N = 1351</td>
</tr>
<tr>
<td>Non-Specific Active Suicidal Thoughts</td>
<td>6.69 (4.16 – 10.76)***  N=635</td>
<td>5.53 (3.38 – 9.04)***  N = 568</td>
</tr>
<tr>
<td>Active Suicidal Ideation with Any Methods (Not Plan), without Intent to Act</td>
<td>11.16 (7.43 – 16.76)***  N=775</td>
<td>8.36(5.44 – 12.84)***  N = 725</td>
</tr>
<tr>
<td>Active Suicidal Ideation with Some Intent to Act, without Specific Plan</td>
<td>19.27 (12.97 – 28.63)***  N=581</td>
<td>15.24 (10.07 – 23.09)***  N = 545</td>
</tr>
</tbody>
</table>
### Common Odds Ratios for prospectively reporting a suicidal behavior as a function of the ideational intensity scores

<table>
<thead>
<tr>
<th>Ideational Intensity</th>
<th>Patients not prospectively reporting suicidal behavior</th>
<th>Patients prospectively reporting suicidal behavior</th>
<th>Odds ratio of prospective suicidal behavior report (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>N = 4918 (99.2%)</td>
<td>N = 39 (0.8%)</td>
<td>--</td>
</tr>
<tr>
<td>MINIMAL (2-5)</td>
<td>778 (95.5 %)</td>
<td>37 (4.5%)</td>
<td>6.00 (3.80 – 9.46)***</td>
</tr>
<tr>
<td>MODERATE (6-10)</td>
<td>1686 (92.1 %)</td>
<td>145 (7.9 %)</td>
<td><em>10.85 (7.58 – 15.51)</em>**</td>
</tr>
<tr>
<td>MODERATELY SEVERE (11-15)</td>
<td>921 (90.5 %)</td>
<td>97 (9.5 %)</td>
<td>13.28 (9.10 – 19.38)***</td>
</tr>
<tr>
<td>SEVERE (16-20)</td>
<td>175 (86.6 %)</td>
<td>27 (13.4 %)</td>
<td>19.46 (11.64 – 32.51)***</td>
</tr>
<tr>
<td>VERY SEVERE (21-25)</td>
<td>11 (78.6 %)</td>
<td>3 (21.4 %)</td>
<td>34.39 (9.23 – 128.09)***</td>
</tr>
</tbody>
</table>

*** $p < .001$; ** $p < .01$; * $p < .05$; no asterisks $p > .05$
Research Supported Behaviors

• **Preparatory Behavior**
  • Those with recent preparatory behavior (e.g., collecting pills, razors, or loaded weapon) \(8-10\)x more likely to die by suicide (Brown & Beck, unpublished)

• **Interrupted Suicide Attempts**
  • \(3\)x more likely to die by suicide (Steer, Beck & Lester, 1988)

• **Aborted Suicide Attempts**
  • Subjects who made aborted attempts \(2\)x as likely to have made a suicide attempt (Barber et al., 1998)
**Data Supports Importance of Full Range:**

All Lifetime Suicidal Behaviors Predict Suicidal Behavior

<table>
<thead>
<tr>
<th>Behavior reported at baseline</th>
<th>Patients not prospectively reporting suicidal behavior</th>
<th>Patients prospectively reporting suicidal behavior</th>
<th>Odds ratio of prospective suicidal behavior report (95% CI; ***p-values &lt; .001)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual Attempt</td>
<td>522 (85.6 %)</td>
<td>88 (14.4 %)</td>
<td>4.56 (3.40 – 6.11)***</td>
</tr>
<tr>
<td>Interrupted Attempt</td>
<td>349 (82.7 %)</td>
<td>73 (17.3 %)</td>
<td>5.28 (3.88 – 7.18)***</td>
</tr>
<tr>
<td>Aborted Attempt</td>
<td>461 (84.7 %)</td>
<td>83 (15.3 %)</td>
<td>4.75 (3.53 – 6.40)***</td>
</tr>
<tr>
<td>Preparatory Behavior</td>
<td>177 (81.2 %)</td>
<td>41 (18.8 %)</td>
<td>4.92 (3.38 – 7.16)***</td>
</tr>
</tbody>
</table>

A person reporting any one of the lifetime behaviors at baseline is ~5X more likely to prospectively report a behavior during subsequent follow-up.
## Number of Different Lifetime Suicidal Behaviors Predict Suicidal Behavior

<table>
<thead>
<tr>
<th></th>
<th>Patients not prospectively reporting suicidal behavior</th>
<th>Patients prospectively reporting suicidal behavior</th>
<th>Odds ratio of prospective suicidal behavior report (95% CI; ***p-values &lt; .001)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Behaviors</td>
<td>N = 3577</td>
<td>N = 201</td>
<td>4.56 (3.40 – 6.11)***</td>
</tr>
<tr>
<td>Reported at BL</td>
<td>2791 (97.3%)</td>
<td>76 (2.7%)</td>
<td></td>
</tr>
<tr>
<td>One Behavior</td>
<td>345 (91.5 %)</td>
<td>32 (8.5%)</td>
<td>3.41 (2.22 – 5.23)***</td>
</tr>
<tr>
<td>Two Behaviors</td>
<td>214 (84.3 %)</td>
<td>40 (15.7%)</td>
<td>6.86 (4.57 – 10.32)***</td>
</tr>
<tr>
<td>Three Behaviors</td>
<td>172 (81.5 %)</td>
<td>39 (18.5 %)</td>
<td>8.33 (5.50 – 12.62)***</td>
</tr>
<tr>
<td>Four Behaviors</td>
<td>55 (79.7 %)</td>
<td>14 (20.3 %)</td>
<td>9.35 (4.98 – 17.54)***</td>
</tr>
</tbody>
</table>

Any type of lifetime behavior increases likelihood of future behavior by ~ 3.4 times and increases proportionally with increased number of different behaviors reported.
All Serious Suicidal Behaviors are Assessed Worrisome Answers are Rare

*Only 1.9% had any worrisome answer
*Only .9% with ~50,000 administrations

The Overwhelming Majority (87%) of Behaviors are Not Actual Attempts (13%)
First-Ever Universal Screening uses the C-SSRS at Parkland Memorial Hospital and Finds only 1.8% of 100,000 Patients

- Screening all patient encounters: “We believe that it’s important to screen everyone because some of this risk may go undetected in a patient who presents for treatment of non-psychiatric symptoms.” (Dr. Kimberly Roaten, Department of Psychiatry)

- Specialized algorithm in electronic health record that triggers appropriate clinical intervention based on patient answers to C-SSRS questions

- Dedicated Resources including 12 psychiatric social workers and a behavioral health team

  “When suicidal behaviors are detected early, lives can be saved…. even within the first few days of implementing the screening program, we were able to intervene with patients at high risk.”

  Dr. Celeste Johnson, Director of Nursing
Multiple Sources: 
**Don’t Have to Rely on Individual’s Report**

- Most of the time, a person will give you relevant information, but when indicated....
- Allows for utilization of *multiple sources* of information
  - Any source of information that gets you the most clinically meaningful response (subject, family members/caregivers, records)
- Very helpful for children and adolescents who may not give the same information as parents or other caregivers
Inferring Intent

- Intent can sometimes be inferred clinically from the behavior or circumstances
  - e.g., if someone denies intent to die, but they thought that what they did could be lethal, intent can be inferred
  - “Clinically impressive” circumstances; highly lethal act where no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story, setting self on fire, or taking 200 pills)
Everyone, Everywhere Can Ask

• 812 nurses trained - 99% reliability independent of mental health training and education
• Strong inter-rater reliability among non-clinicians in juvenile justice
  - (Kerr, et. al. 2014)

  • First Responders
  • Juvenile Justice
  • Corrections
  • Parents
  • Youth
  • Crisis Response Teams
  • Hotlines

In schools:
• Teachers
• Safety Officers
• Coaches
• Road patrol
• Bus drivers

In behavioral healthcare settings:
• Peer to Peer
• Hospitals
• Pediatricians
• VA
• Clergy
• Child Protective Services
• Officers Standing Overnight

“ This is prevention for the masses now, not just the educated, the wealthy or those in the medical field. It is available and accessible for all of humanity.”
Asking These Questions Protects Against Risk

“If a practitioner asked the questions... It would provide some legal protection”

—Bruce Hillowe, mental health attorney specializing in malpractice litigation (Crain’s NY, 11/8/11)

Implemented by national risk managers of The Doctor’s Company, a medical malpractice insurance company to be used by physician members

“I believe it sets the standard...we take a proactive position in patient safety” – Patient Safety Risk Manager
Triage with the C-SSRS
The Key to Triage... Operationalized Criteria for Next Steps

• Allows for setting parameters for triggering next steps whatever they may be (e.g. referral to mental health, one-to-one, etc.)
  
  • 4 or 5 on recent ideation or any recent behavior to indicate need for immediate action
  
  • Decreases unnecessary referrals, interventions, etc.

• Provides the best available information to inform your clinical judgment

*In the past, people didn’t know what to manage, so they would hear any wish to die and intervene...*
## Thresholds for Next Steps...

<table>
<thead>
<tr>
<th>Ask Questions 1 and 2</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1)</strong> <em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2)</strong> <em>Have you actually had any thoughts about killing yourself?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If <strong>YES</strong> to 2, answer questions 3, 4, 5, and 6. If <strong>NO</strong> to 2, go directly to question 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3)</strong> <em>Have you thought about how you might do this?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4)</strong> <em>Have you had these thoughts and had some intention of acting them?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5)</strong> <em>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **6)** *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*  
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. |
New York State
Electronic Medical Record

- 4/5 past month OR behavior past 3 months = highest level “SUICIDE WARNING”
- 4/5 OR behavior ever = “SUICIDE HISTORY” – suicidal risk elevated
This is the C-SSRS Screener with Triage Points (Inpatient Med/Surg)
**Harvard Partners in Care Safety Assessment**

**INSTRUCTIONS:** This flow chart illustrates an approach to assessing the safety of an individual with suicidal thoughts. It is based on the screening version of the Columbia Suicide Severity Rating Scale (C-SSRS). Sources of information can include not only the patient but also other individuals. This scale can guide decision-making, though the clinician’s judgment should always take precedence (for example, if there is reason to think that a patient might be reluctant to report the full severity of suicidal thinking). The clinician should always keep in mind that suicide prediction is not an exact science; if worried, best to err on the side of seeking consultation.

### Risk Factors
- Can’t enjoy anything
- Anxiety and/or panic
- Insomnia
- Hopelessness or despair
- Homicidal ideation
- Psychotic disorder or command hallucinations
- Personality Disorder (e.g., borderline, narcissistic)
- Mood disorder
- PTSD or Hx of abuse or trauma
- ETOH or substance use/abuse or withdrawal
- Impulsivity, aggression or anti-social Bx
- Ongoing medical illness (e.g., CNS, TBI, chronic pain)
- FHx of suicide, Recent or anticipated loss (relationship, financial, health, place to live) or event with despair, humiliation, or shame
- Lack of social support and/or increasing isolation
- Perceived burden on others
- Legal issues, incarceration
- Local suicide cluster or exposure to one via media
- Access to lethal means, e.g., firearms, stockpile
- Non-compliant or not in treatment

### Protective Factors
- Ability to cope with stress or frustration
- Sense of responsibility to others
- Social support
- Has a reason to live
- Religious beliefs
- Positive therapeutic relationship
- Engaged in work or school
- Fear of death
- Cultural, spiritual or moral attitudes against suicide

### Risk Factors vs. Protective Factors

**Urgent psychiatric assessment:** Face-to-face by mental health professional before patient leaves clinic OR send to ER if not possible

### WISH TO DIE
- Over the past MONTH, have you wished you were dead or wished you could go to sleep and not wake up?

**IDEATION**
- Over the past MONTH, have you had any thoughts of killing yourself?

**RECENT METHOD**
- Have you been thinking about how you might kill yourself?

**RECENT INTENT**
- Have you had any intention of acting on these thoughts?

**ACTUAL, INTERRUPTED OR ABORTED (SELF-INTERRUPTED) ATTEMPTS or PREPARATORY BEHAVIORS**
- Have you ever done anything, started to do anything, or prepared to do anything to end your life? ex: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

**TIMING: When?**
- Within last week
- Within last three months
- Within last year
- More than one year ago

**Decision whether to continue outpatient management**
- Continue with outpatient management though consider consulting D-CARE
- Return to Initial Algorithm: assess severity of depression

**Additional materials on assessing safety available on PCOI**

**NOTE:** If patient has mental health treaters, it can be very helpful to involve them to discuss the level of care needed and set up a follow-up plan.
Screener Demo

http://youtu.be/fx3N3uDUQbo
With a Flexible Toolkit You Can Tailor the C-SSRS for Specific Uses
<table>
<thead>
<tr>
<th>SUICIDAL BEHAVIOR</th>
<th>Lifetime</th>
<th>Past 3 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actual Attempt:</strong> A potentially self-injurious act committed with at least some wish to die, as a result of an act. Behavior was in past thought of as method to kill oneself. Intent does not have to be 100%. If there is any intent desire to die associated with the act, then it can be considered an actual suicide attempt. <strong>There does not have to be any injury or harm,</strong> just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Did you ever do anything to try to kill yourself or make yourself not alive anymore? What did you do?</strong> Did you ever hurt yourself on purpose? Why did you do that? Did you ___ as a way to end your life? Did you want to die (even a little) when you ___? Were you trying to make yourself not alive anymore when you ___? Or did you think it was possible you could have died from ___? Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, get something else to happen)? (Self-Injurious Behavior without suicidal intent). If yes, describe.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Has subject engaged in Non-Suicidal Self-Injurious Behavior?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Has subject engaged in Self-Injurious Behavior, intent unknown?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interrupted Attempt:</strong> When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, actual attempt would have occurred). Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. <strong>Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?</strong> If yes, describe.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Aborted or Self-Interrupted Attempt:</strong> When person begins to take steps toward making a suicide attempt, but steps themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops himself before being stopped by something else. <strong>Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?</strong> If yes, describe.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preparatory Acts or Behavior:</strong> Acts or preparation towards immediately making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). <strong>Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)-like giving things away, writing a goodbye note, getting things you need to kill yourself?</strong> If yes, describe.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Tennessee Crisis Assessment Tool

Ask Questions 1 and 2

1) *Have you wished you were dead or wished you could go to sleep and not wake up?*

2) *Have you actually had any thoughts about killing yourself?*

If **YES** to 2, answer questions 3, 4, 5, and 6. If **NO** to 2, go directly to question 6

3) *Have you thought about how you might do this?*

4) *Have you had these thoughts and had some intention of acting them?*

5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*

6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*

Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.
Easily Integrated into Existing Checklists

California corrections department spent approx. $24 million in 2010 on a suicide-watch program, which they believe could be cut in half by these methods.
<table>
<thead>
<tr>
<th>Legal Troubles</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Are you currently facing any legal troubles?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Within military structure or outside</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, how have these circumstances impacted you/your family?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Information:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Troubles</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Are you experiencing any financial troubles?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Do these concerns feel overwhelming or unmanageable?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Sometimes a person can feel that others close to them (e.g., family) would be better off financially if the person were no longer alive. Have you experienced this?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Is this financial stress or hardship the worst crisis you have ever experienced?</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State of Service (pre-deployment, post-deployment, etc)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-deployment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-deployment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple deployments</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Are the thoughts/behaviors we talked about related to your ___?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(e.g., pending deployment)</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital or Relationship Stress</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Are you having any marital or relationship stress or problems?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Ask about domestic violence.</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug or Alcohol Use</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Do you use drugs or alcohol?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Do you have a history of drug or alcohol abuse?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Information:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pain</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Are you experiencing pain – chronic or intermittent?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Information:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Primary Care**

**Columbia-Suicide Severity Rating Scale (CSRSS) Primary Care Screen with Trage Points**

<table>
<thead>
<tr>
<th>Suicide Ideation Definitions and Prompts</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask questions that are in bold and underlined.</td>
<td>YES</td>
</tr>
<tr>
<td>Ask Questions 1 and 2</td>
<td></td>
</tr>
<tr>
<td><strong>1) Wish to be Dead:</strong> Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.</td>
<td></td>
</tr>
<tr>
<td>Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td></td>
</tr>
<tr>
<td><strong>2) Suicidal Thoughts:</strong> General non-specific thoughts of wanting to end one’s life/commit suicide. “I’ve thought about killing myself” without general thoughts of ways to kill oneself/associated methods, intent, or plan.</td>
<td></td>
</tr>
<tr>
<td>Have you had any actual thoughts of killing yourself?</td>
<td></td>
</tr>
<tr>
<td><strong>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):</strong> Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it…I would never go through with it.”</td>
<td></td>
</tr>
<tr>
<td>Have you been thinking about how you might do this?</td>
<td></td>
</tr>
<tr>
<td><strong>4) Suicidal Intent (without Specific Plan):</strong> Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to “I have the thoughts but I definitely will not do anything about them.”</td>
<td></td>
</tr>
<tr>
<td>Have you had these thoughts and had some intention of acting on them?</td>
<td></td>
</tr>
<tr>
<td><strong>5) Suicide Intent with Specific Plans:</strong> Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.</td>
<td></td>
</tr>
<tr>
<td>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td></td>
</tr>
<tr>
<td><strong>6) Suicide Behavior Question:</strong> Have you ever done anything, started to do anything, or prepared to do anything to end your life?</td>
<td></td>
</tr>
<tr>
<td>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.</td>
<td></td>
</tr>
<tr>
<td><strong>Response Protocol to C-SSRS Screening (Linked to last item marked “YES”):</strong></td>
<td></td>
</tr>
<tr>
<td>Item 1: Behavioral Health Referral</td>
<td></td>
</tr>
<tr>
<td>Item 2: Behavioral Health Consultation</td>
<td></td>
</tr>
<tr>
<td>Item 4: Behavioral Health Consultation and Patient Safety Precautions</td>
<td></td>
</tr>
<tr>
<td>Item 5: Behavioral Health Consultation and Patient Safety Precautions</td>
<td></td>
</tr>
<tr>
<td>Item 6: Behavioral Health Consultation, Psychiatric Nurse/Social Worker, and consider Patient Safety Precautions</td>
<td></td>
</tr>
<tr>
<td>Item 9: Development of Behavioral Health Consultation and Patient Safety Precautions</td>
<td></td>
</tr>
</tbody>
</table>

**Disposition:**
- Behavioral Health Referral
- Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- Behavioral Health Consultation and Patient Safety Precautions

---

**The Columbia LightHouse Project**

**Identify Risk. Prevent Suicide.**
# Safe-T/C-SSRS Triage Tool for NYOMH for Psychiatric Care/Behavioral Health

## SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up

### New York State Office of Mental Health

#### Step 1: Identify Risk Factors

<table>
<thead>
<tr>
<th>C-SSRS Suicidal Ideation Severity</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) wish to be dead</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) current suicidal thoughts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) recent suicidal behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) wish to harm self</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) known plan to harm self</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) wish to die in the near future</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) wish to die in the distant future</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Examples:** Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out life insurance, etc.

#### Step 2: Assess the Physical Environment

- Assess the physical environment, focusing on immediate access to methods.
- The most common methods of suicide in hospitals are hanging, suffocation, and jumping.

#### Step 3: Determine Level of Risk and Develop Interventions

**Risk Stratification**

- **Low Risk**
  - No immediate risk factors
  - Provide information about warning signs
  - Provide National Suicide Prevention Lifeline card and local emergency contacts
  - Wellness Recovery Action Plan (WRAP)
  - Re-assess at treatment plan review

- **Moderate Risk**
  - One risk factor identified
  - Provide information about warning signs
  - Provide National Suicide Prevention Lifeline card and local emergency contacts
  - Wellness Recovery Action Plan (WRAP)
  - Re-assess at treatment plan review

- **High Risk**
  - Two or more risk factors identified
  - Referral to mental health professional to evaluate risk factors and determine appropriate treatment setting

**Possible Interventions**

- Assessment of patient's medical stability
- Observation status
- Psychotropic treatment
- Pharmacological treatment
- Family/significant others engagement
- Psychotherapy (CBT, DBT)
- Psychosocial (coping skills, stress management, support network, etc.)
- Safety Plan
- Telephone follow-up upon discharge

**Place on Facility High Risk List**

- Refer to psychologist or psychiatrist to evaluate for hospitalization
- Place on facility high risk list

### Additional Resources

- **C-SSRS Suicidal Ideation:**
  - C-SSRS Suicide ideation (0-2 or 3-5)
  - C-SSRS Suicide behavior (0-2 or 3-5)
  - C-SSRS Suicidal behavior (within 6 months)

- **Risk Assessment:**
  - Suicide risk assessment should be conducted in outpatient setting.
  - More individual in whom the idea of suicide is temporary but does not plan to carry it out.

- **Hospitalization:**
  - Evaluate patient for hospitalization.
  - Consider hospitalization for patients with severe psychiatric illness or severe suicide risk.

- **Family History:**
  - History of suicide
  - History of substance abuse

- **Psychiatric History:**
  - Major depression
  - Bipolar disorder
  - PTSD
  - ADHD
  - Cluster B Personality disorders or traits

- **Current and Past Psychiatric:**
  - Alcohol or substance abuse disorders
  - Mood disorders
  - Anxiety disorders

- **Presenting Symptoms:**
  - Depression
  - Anxiety
  - Agitation
  - Insomnia
  - Command hallucinations

- **Recent Onset:**
  - Recent onset of severe depression
  - Recent onset of severe anxiety

- **Change in Treatment:**
  - Change in pharmacological treatment
  - Change in provider or treatment (i.e., medications, psychotherapy, milieu)
  - Hospitalization or outpatient treatment
  - Non-compliance or non-receiving treatment

- **Access to lethal methods:**
  - Access specifically about presence or absence of a firearm in the home or workplace or ease of accessing other lethal means
Innovative Delivery: Implementation by All Gatekeepers

Examples of utilization:
- Laminated cards
- Metal key chains
- Apps on phone
- Portable printers in EMT

By healthcare professionals:
- Electronic records
- Piece of paper in a chart
- Phone kiosks

Electronic delivery, automatic risk notification
eC-SSRS A Critical Piece of an Optimal Prevention Plan

**FDA Best Practices Meeting for Meta-analyses**
“optimal solution for minimizing bias”

- Coordinated data – like pilot, surgeon and anesthesiologist checklists
- Computers and clinicians are complementary
- Widely deployed and proven to be low burden to patients and providers
- Scalability

- Post Discharge
  - Most at-risk time
  - Can call from home
- NJ – Youth in Schools
  - Summertime vulnerability
  - Reduced burden on school personnel
- National Guard Sites
Have the Courage to Help a Buddy

Have you or someone you know:

✓ Wished you were dead or wished you could go to sleep and not wake up?
✓ Actually had any thoughts of killing yourself?
✓ Been thinking about how you might do this?
✓ Had these thoughts and had some intention of acting on them?
✓ Started to work out or worked out the detail of how to kill yourself? Do you, they, intend to carry out this plan?
✓ Ever done anything, started to do anything, or prepared to do anything to end your life, such as: collecting pills, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump, actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc? 

If yes to any of these contact your Director of Psychological Health (DPH), Unit Suicide Intervention officer (SIO) or Chaplain!

One Suicide is one too many.

For assistance:
✓ Talk to your Battle Buddy and chain of command
✓ Call the Military Crisis Line at 1-800-273-TALK (8255) and press "1" for Military Crisis Line

DPH, Michelle Hammond-Susten: 770-646-2391
Chaplain: ___________________________
SIO: _______________________________

Don’t wait, call them now.
Working with all aspects of hospitals, systems, states and programs to develop and consult on implementation policies and plans

- Helping Develop Alert and Monitoring Systems
- Integrating into Electronic Medical Records
- Ensuring Fidelity
- Providing a Menu of Options
- Facilitating Implementation with Innovative Resources
For questions and other inquiries, email: posnerk@nyspi.columbia.edu

Website address for more information: http://www.cssrs.columbia.edu/