On the Road to Prevention:

Identification & Triage Using the Columbia-Suicide Severity Rating Scale (C-SSRS)

Increasing Precision, Improving Care Delivery and Redirecting Scarce Resources

Administration Training

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Zelazny, J.; Fisher, P.; Burke, A.; Oquendo, M.; Mann, J.

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Suicide: A Major Public Health Crisis in the U.S.

- Every 15 minutes someone dies by suicide in the U.S.
- 2nd leading cause of death: *children*
  - Bully victims 2-9x more likely to consider suicide
- 3rd leading cause of death: *adolescents*
- *10% of High School students attempt suicide each year*
- 4th leading cause of death: *adults*
- Rate DOUBLED for African American males 1980-1996
- #1 cause of injury mortality in U.S.; more people die by suicide than motor vehicle crashes
- Majority of suicide decedents see their doctor prior to their death
  - 45% in the month prior to their death; 80% in the year prior: excellent opportunity for prevention
- 1st or 2nd leading cause of death in *law enforcement officers*
  - In 2012, nearly as many policepersons died by suicide as were killed in the line of duty
  - Rate comparable to that in US Army
- Most common cause of death in *incarcerated persons*
  - Suicide rates 3x general population
  - ~60% of inmate suicides have no psychiatric illness & no clear warning signs

Suicide is a preventable public health problem – prevention efforts depend upon appropriate identification and screening.

Columbia-Suicide Severity Rating Scale (C-SSRS)

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Zelazny, J.; Fisher, P.; Burke, A.; Oquendo, M.; Mann, J.

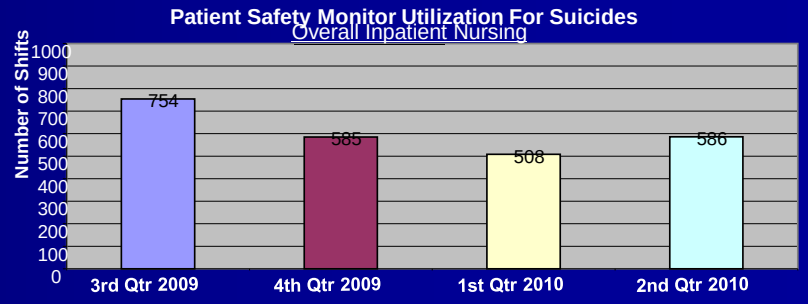
- OPERATIONALIZED THRESHOLDS FOR NEXT STEPS RESULTING IN SIGNIFICANT REDUCTION OF UNNECESSARY INTERVENTIONS AND BURDEN
- Extensively used internationally across research, clinical and institutional settings
- Several million administrations
- Available in 103 languages
- Used across the lifespan:
  - Special Populations: indicated for cognitively impaired (e.gAlzheimer's, Autism)
- Systematic use of C-SSRS shown to decrease burden compared to other methods or doing nothing
- **Adopted by CDC – link to C-SSRS in CDC document**
- **Average administration time less than 1 minute**

REDUCED BURDEN & COST IN HOSPITAL SETTING

REDIRECTING SCARCE RESOURCES WHILE IDENTIFYING THOSE AT GREATEST RISK

TJC BEST PRACTICES LIST

Reading Hospital: IMPROVED IDENTIFICATION WHILE REDUCING UNNECESSARY ONE-TO-ONES



- Extremely sensitive and specific
- 1,000 sites across the country (nurses, coordinators, physicians) – overwhelming majority said **"easy to incorporate", "has improved safety", "is beneficial"**
- Excellent Patient Satisfaction (Cleveland Clinic)

Who can do it?
No Mental Health Training Required

- No mental health training required
- 812 nurses trained - 99% reliability independent of mental health training and education
- In behavioral healthcare settings:
  - Peer counselors
  - Paraprofessionals
  - Professionals
  - Nurses
  - Nurses' aides, etc.
- Other settings: All types of gate keepers
  - Teachers
  - First responders
  - Coaches
  - Road patrol
  - Bus drivers

Critical to have next steps in place for people who screen as high risk (e.g. teacher referral to counselor)

C-SSRS Requests/Uses

- The Joint Commission Best Practices Library
- World Health Organization-Europe: *100 Best Practices for Adolescent Suicide Prevention*
- AMA Best Practices Adolescent Suicide
- U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marines, and National Guard
- Health Canada
- Hospitals and Community Clinic Settings
  - Inpatient and ERs; general medical and psychiatric, Crisis services, Special Needs Clinics, VA's
- A county-wide Suicide cluster in New York
- Japanese National Institute of Mental Health and Neurology
- Israeli Defense Force and Israeli National Suicide Prevention Program
- Korean Association for Suicide Prevention
- Planned statewide dissemination in Victoria, Australia – Health and Law Enforcement agencies
- Managed Care Organizations
  - Systems all throughout Tennessee/Integrated with Mobile Crisis Teams
- International Mission Organizations
- Drug and Alcohol Addiction Centers
- National Institute on Alcohol Abuse and Alcoholism: NIAAA
- Commissioned by VA to do online training for clinical trials
- Center of Excellence for Research on Returning War Veterans
- Fire Departments
- Police Departments
- Judges/legal/police – to help reduce unnecessary hospitalization
- Primary care
- Worker's Compensation Administration
- Surveillance Efforts; CDC Definitions are Columbia Definitions
- Prisons / juvenile justice
- Suicide Section of **SCID**
- Clinical Practice, nationally and internationally
- Crisis negotiation teams
- Schools (Middle Schools, High Schools, and College Campuses)
- Homeless populations
- Claims/HMOs
- Clergy (ex: Hindu priests and priestesses)
- EAPs

Counties…States…Countries

Linking Systems

Inpt → Bridge → Outpt

Enables quicker response to those who need it due to precision of communication

Hospital Screening: Cleveland Clinic

Systematically assessing using the C-SSRS decreases burden

Improved Identification with Decreased False Positives

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

- 6.2% positive screen on C-SSRS

vs.

- 23.8% endorsed item #9 of PHQ9

Most, but not all, of the positive Columbia screen patients endorsed #9 of PHQ9 indicating that cases had been missed

C-SSRS Findings: Obesity Patients

Comparison of Retrospective and Prospective Data

	Retrospective Double-blind	Prospective C-SSRS Extension
Trial Phase [2]		
Number of Patients [3]	8600	~ 5600
Suicidal Ideation	452	12*
Suicidal Behavior	6	4

[1] Stemmed from positive responses on PHQ-9
[2] Double-blind phase ranged from 12 to 104 weeks; Extension phase was 52 weeks
[3] Maximum number of patients entering the extension phase of the trials

* Markedly lower rates of suicidal behavior with systematic monitoring

"[Using the C-SSRS] may actually be able to **make a dent in the rates of suicide** that have existed in our population and have remained constant over time…that would be an enormous achievement in terms of public health care and preventing loss of life."

- Jeffrey Lieberman, M.D., President Elect of American Psychiatric Association (APA)

C-SSRS Screen is Simply….

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

Two Screen Questions for Ideation

- *Have you wished you were dead or wished you could go to sleep and not wake up?*
- *Have you actually had any thoughts of killing yourself?*

If answer is "No" to both, no more questions on ideation

- Relevant behaviors assessed in one additional question
- All items include definitions for each term and standardized questions for each category are included to guide the interviewer for facilitating improved identification

eC-SSRS..Depressed Subjects…*ALL* of These Behaviors Are Prevalent

(only 13% of behaviors are attempts)

% OF REPORTED SUICIDAL BEHAVIOR

n = 28,699 administrations

ALL PREDICTIVE; multiple behaviors = greater risk

No Behavior: 28,303 (98.6%)

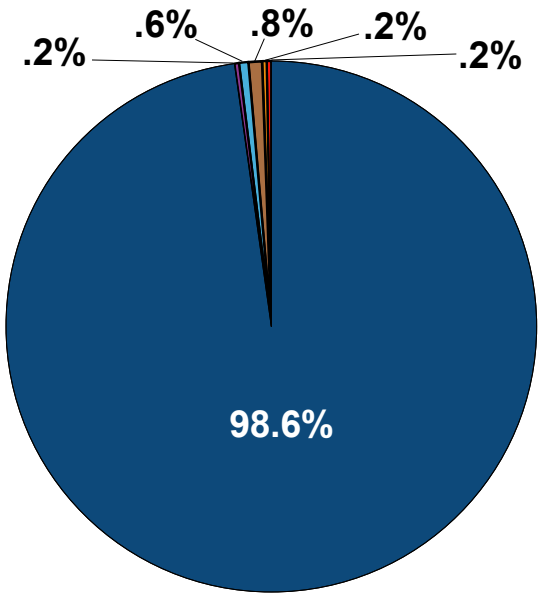
Actual Attempt: 70 (.2%)

Interrupted Attempt: 178 (.6%)

Aborted/Self-Interrupted Attempt: 223 (.8%)

Preparatory Behavior: 71 (.2%)

Nonsuicidal Self-Injury: 45 (.2%)



***Only 1.7% had any worrisome answer**
***Only .9% with ~50,000 administrations**

472 Interrupted, Aborted/Self-Interrupted, Preparatory vs. 70 Actual Attempts

Mundt et al., 2011

Multiple Sources
Don't Have to Rely on Individual Report

- Most of time person will give you relevant info, 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)

Example…

- A loved one brings a family member into the ER. The patient denies suicidal thoughts, but the family member shares with you that the he has been talking about suicide for the past two weeks and wrote a note yesterday and that is why he is here in the ER

Suicidal Ideation

1. Wish to die

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

2. Active Thoughts of Killing Oneself

- *Have you actually had any thoughts of killing yourself?*

**** If "NO" to both these questions Suicidal Ideation Section is finished.****
**** If "YES" to 'Active thoughts' ask the following three questions.****

3. Associated Thoughts of Methods

- *Have you been thinking about how you might do this?*

4. Some Intent

- *Have you had these thoughts and had some intention of acting on them?*

5. Plan and Intent

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

Auditory hallucinations qualify as ideation

This is the C-SSRS Screener

*Minimum of 3 Questions

*Max of 6 Questions

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	Past month	
Ask questions that are in bolded and underlined. The rest of the information at each question is for staff information only.	Yes	NO
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) Suicidal Thoughts: 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." *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a 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…and I would never go through with it.*" *Have you been thinking about how you might kill yourself?*		
4) Suicidal Intent (without Specific Plan): 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.*" *Have you had these thoughts and had some intention of acting on them?*		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. *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) Suicide Behavior Question *"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. **If YES, ask:** *How long ago did you do any of these?* ☐Over a year ago? ☐Between three months and a year ago? ☐Within the last three months?		

If 2 yes, ask 3-6

If 2 is no, go to 6

Suicide Attempt Definition

A self-injurious act committed with at least some intent to die, *as a result of the act*

- There does not have to be any injury or harm, just the ***potential*** for injury or harm (e.g., gun failing to fire)
- Any "non-zero" intent to die – does not have to be 100%
- Intent and behavior must be linked
- A suicide attempt begins with the first pill swallowed or scratch with a knife

Definition (cont.)

Importance of Inference

- 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)

As Opposed To *Non-suicidal Self-injurious Behavior*

- Engaging in behavior PURELY (100%) for reasons other than to end one's life:
  - Either to affect:
    - Internal state (feel better, relieve pain etc.) - "self-mutilation"

    - and/or -

    - External circumstances (get sympathy, attention, make angry, etc.)

Suicide Attempt? Yes or No

The patient wanted to escape from her mother's home. She researched lethal doses of ibuprofen. She took 6 ibuprofen pills and said she felt certain from her research that this amount was not enough to kill her. She stated she did not want to die, only to escape from her mother's home. She was taken to the emergency room where her stomach was pumped and she was admitted to a psychiatric ward.

1. Yes
2. No
3. Not enough information

Suicide Attempt? Yes or No

Young woman, following a fight with her boyfriend, felt like she wanted to die, impulsively took a kitchen knife and made a superficial scratch to her wrist; before she actually punctured the skin or bled, however, she changed her mind and stopped.

1. Yes
2. No
3. Not enough information

Suicide Attempt? Yes or No

Patient was feeling ignored. She went into the family kitchen where mother and sister were talking. She took a knife out of the drawer and made a cut on her arm. She denied that she wanted to die at all ("not even a little") but just wanted them to pay attention to her.

1. Yes
2. No
3. Not enough information

Suicide Attempt? Yes or No

The patient cut her wrists after an argument with her boyfriend.

1. Yes
2. No
3. Not enough information

Suicide Attempt? Yes or No

Had a big fight with her ex-husband about her stepson. Took 15-20 imipramine tablets and went to bed. Slept all night and until 4-5 pm the next day. States she couldn't stand up or walk. Called EMS – taken to the ER – drank charcoal and admitted to hospital. Unable to verbalize clear intent, but states she was well aware of the dangers of TCA overdose and the potential for death.

1. Yes
2. No
3. Not enough information

Other Suicidal Behaviors….

Interrupted Attempt

- When person starts to take steps to end their life but someone or something stops them
  - Bottle of pills or gun in hand but someone grabs it
  - On ledge poised to jump

Aborted Attempt

- When person begins to take steps towards making a suicide attempt, ***but stops themselves*** before they actually have engaged in any self-destructive behavior
  - Man plans to drive his car off the road at high speed at a chosen destination. On the way to the destination, he changes his mind and returns home
  - Man walks up to the roof to jump, but changes his mind and turns around
  - She has gun in her hand, but then puts it down

Other Suicidal Behaviors….

Preparatory Acts or Behavior

- Any other behavior (beyond saying something) with suicidal intent
  - Collecting or buying pills
  - Purchasing a gun
  - Writing a will or a suicide note

Combined Behaviors Question

→

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Ask Questions 1 and 2		
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2) Suicidal Thoughts: 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.*" ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a 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….and I would never go through with it.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): 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.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***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) Suicide Behavior Question ***"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. **If YES, ask:** ***How long ago did you do any of these?*** ☐Over a year ago? ☐Between three months and a year ago? ☐Within the last three months?		

Further Case Examples

The patient stated that she experienced heartbreak over the "loss of a guy" a week before the interview. She stated that she took 4 clonazepam, called a girlfriend, and talked/cried it out while on the phone. She was dismissive of the seriousness of the attempt, but indicated that she wanted to die at the time she took the overdose.

1. Suicide attempt
2. Interrupted attempt
3. Aborted attempt

Further Case Examples

During pill count, the study staff discovered that 6 tablets were missing. Upon questioning, the patient admitted that she was saving them up so she could take them all together at a later time in order to kill herself.

1. Interrupted attempt
2. Aborted attempt
3. Preparatory behavior

Further Case Examples

The patient reported that he first started thinking about killing himself when he was 12. He thought about how easy it would be to pretend to fall in front of a bus before it was able to stop so that it would look like an accident. Although he thought about it often, he said he did not have the courage to do it.

1. Preparatory behavior
2. Suicidal ideation with plan
3. Suicidal ideation with method

Advantages….Operationalized Criteria for Next Steps or Referral for Management

- For example, specify parameters for triggering referrals to mental health professionals
  - e.g., 4 or 5 on ideation item to indicate need for immediate referral
  - Decreases unnecessary referrals, interventions, exclusions, etc.

In the past, people didn't know what to manage, so they would hear **<u>any</u> answer and intervene…*

Clinical Monitoring Guidance: Threshold for Next Steps

SUICIDAL IDEATION	
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes," ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	Lifetime: Time He/She Felt Most Suicidal
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	Yes ☐ No ☐
2. Non-Specific Active Suicidal Thoughts General, non-specific thoughts of wanting to end one's life/commit suicide (e.g. *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐ No ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject 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 (e.g. thought of method to kill self but not a specific plan). Includes person who would say, *"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".* ***Have you been thinking about how you might do this?*** If yes, describe:	Yes ☐ No ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them".* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	Yes ☐ No ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	Yes ☐ No ☐

Indicates Need for Next Step

Example of Hospital Policy

Thresholds facilitate triage of those at highest risk and direct care delivery
eg.4/5→ Psych consult
3→ Consult to Care team

Streamlining Triage, Care Delivery, and Service Utilization in Hospitals

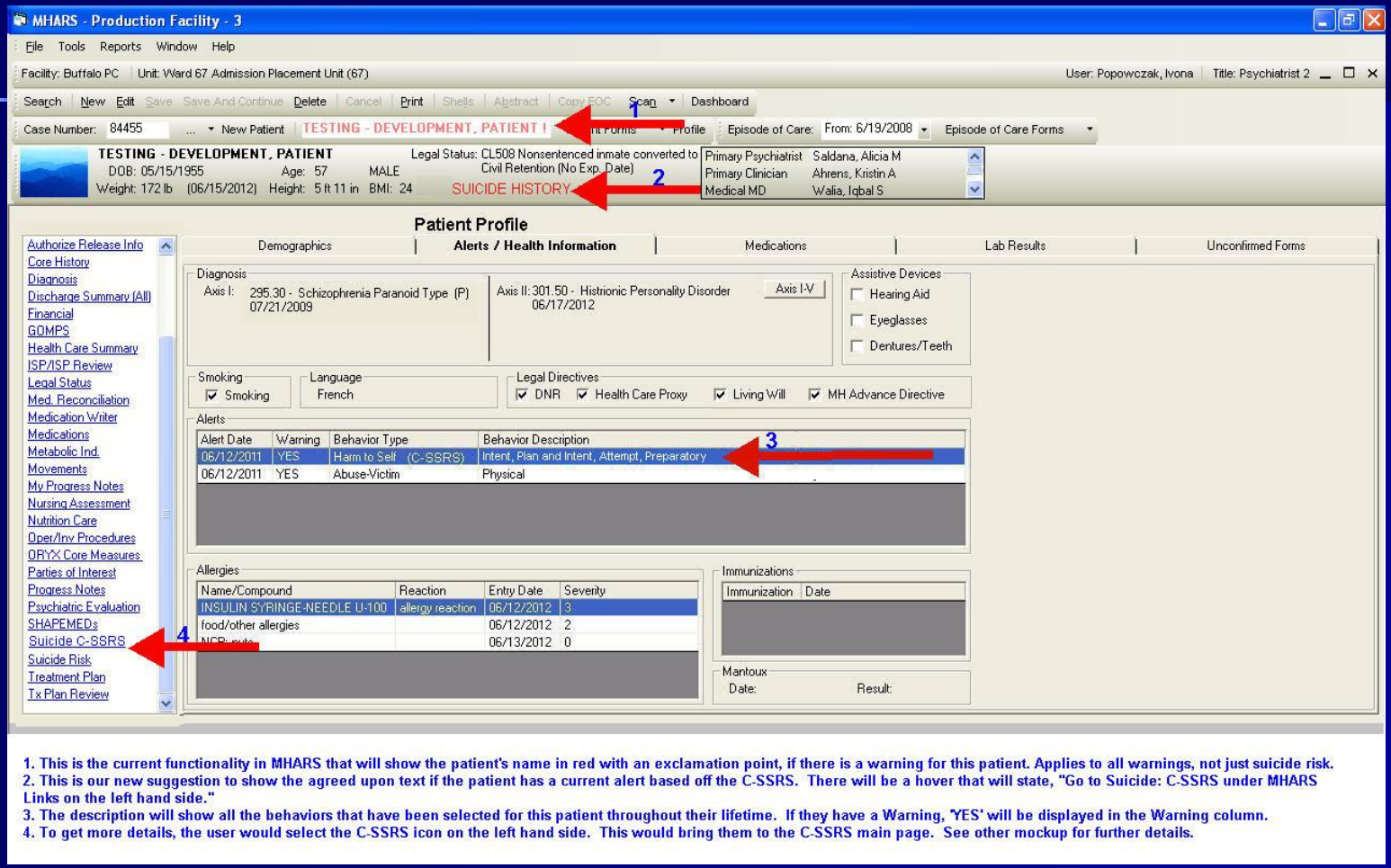
PROCEDURE:

Question	Trigger
Level 4/5 Yes to question 4 or 5	• Nursing Order to call MD for Psych Consult • Nursing Interventions (print on Kardex): • Pt Safety Monitor – 1:1 Observation • Pt Safety Monitor – Within arm's reach at all times • Complete Self Harm Safety Assessment every shift • Affix Suicide Risk Magnet to door • Revise Diet order to Safe tray • Alerts to ATC, Nutrition Services, Environmental Services and Security • Progress note for chart
Level 3 Yes to question 3 (and no to question 4 and 5)	• Consult to Care Team • Nursing Interventions (prints on kardex): • Pt Safety Monitor – 1:1 Observation • Pt Safety Monitor – Within arm's reach at all times • Complete Self Harm Safety Assessment every shift • Affix Suicide Risk Magnet to door • Revise Diet order to Safe Tray • Alerts to ATC, Nutrition Services, Environmental Services, Spruce Facilitator and Security • Progress note for chart

(Reading Hospital Policy)

New York State Electronic Medical Records

Profile with Suicide History



1. This is the current functionality in MHARS that will show the patient's name in red with an exclamation point, if there is a warning for this patient. Applies to all warnings, not just suicide risk.
2. This is our new suggestion to show the agreed upon text if the patient has a current alert based off the C-SSRS. There will be a hover that will state, "Go to Suicide: C-SSRS under MHARS Links on the left hand side."
3. The description will show all the behaviors that have been selected for this patient throughout their lifetime. If they have a Warning, 'YES' will be displayed in the Warning column.
4. To get more details, the user would select the C-SSRS icon on the left hand side. This would bring them to the C-SSRS main page. See other mockup for further details.

- 4/5 past month OR behavior past 3 months = highest level suicide alert
- 4/5 OR behavior ever = "warning" – suicidal risk elevated

Centerstone C-SSRS Policy

****Largest Provider of Behavioral Healthcare in the United States**

Consistent with Centerstone policy all service recipients shall be screened for suicide risk during crisis encounters, intake, and all subsequent service contacts during their course of treatment.

Points of contact:

Service Recipient Contacts Centerstone in Crisis:

- If a service recipient contacts Centerstone endorsing suicidal ideation, the following will occur:
  - If by phone, initial contact will be recorded on a "Crisis Care Call Not"
  - If contact is by phone during business hours and a non-degreed provider handles the call, the service recipient will be instructed to present at the nearest Centerstone location. The provider will contact the nearest Centerstone location to apprise them of the situation
  - Anytime a service recipient presents at a Centerstone location in a crisis situation (whether directed there or self presenting), they will be assessed by a Masters level clinician using the "Columbia-Suicide Severity Rating Scale – Screen Version"
  - If contact is by phone during non-business hours and a non-degreed staff handles the call, the On-Call Crisis Clinician (Indiana) will be contacted if risk is indicated. The phone triage staff will transfer the call to the On-Call Crisis Clinician who will speak with the service recipient to complete a "Telephonic Crisis Assessment"
  - In Tennessee, the Crisis Call Center will handle crisis situations either telephonically or when indicated will dispatch the Crisis Services Team to complete a "Crisis Assessment"

Intake:

- During an intake appointment, the provider will assess for suicide risk utilizing the Columbia-Suicide Severity Rating Scale-Lifetime/Recent version. If a service recipient is deemed as having high suicide risk, the following will occur:
  - Intake provider will develop a crisis management plan to ensure the safety of the service recipient while in outpatient care **or**
  - Intake provider arranged for a higher level of care to include inpatient placement if deemed necessary

Routine Appointment (Clinic or Field Based):

- During a routine appointment, the provider will assess for suicide risk utilizing the Columbia-Suicide Severity Rating Scale-Since Last Visit version. If a service recipient is deemed as having high suicide risk, the following will occur:
  - Provider will develop a crisis management plan to ensure the safety of the service recipient while in outpatient care **or**
  - Provider arrange for a higher level of care to include inpatient placement if deemed necessary

Alert and Monitoring System

The Electronic Health Record (EHR) is designed to offer assistance to providers assessing service recipients for high suicide risk. Based on information collected in the applicable Columbia SSRS tool, a service recipient can be identified as being at high risk for suicide. Those who will be considered at high risk for suicide will have a positive endorsement of **either** of the following (research found these to be highly predictive of completed suicides):

a. A positive endorsement, relative to the past 30 days, in the **"Suicidal Thoughts" section of item # 4** (Have you had these thoughts and had some intention of acting on them?) **or item # 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?).

b. A positive endorsement, relative to the past 90 days, in the **"Suicide Behavior" section of item # 6** (Have you ever done anything, started to do anything, or prepared to do anything to end your life?).

For questions and other inquiries,
email Dr. Kelly Posner at:
posnerk@nyspi.columbia.edu

Website address for more information
on the C-SSRS:
http://www.cssrs.columbia.edu/

Suicidal Ideation Questions

1. Wish to die

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

2. Active Thoughts of Killing Oneself

- *Have you actually had any thoughts of killing yourself?*

**** If "NO" to both these questions Suicidal Ideation Section is finished.****
**** If "YES" to 'Active thoughts' ask the following three questions.****

3. Associated Thoughts of Methods

- *Have you been thinking about how you might do this?*

4. Some Intent

- *Have you had these thoughts and had some intention of acting on them?*

5. Plan and Intent

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

Auditory hallucinations qualify as ideation

What are we seeing?

Events in 35,224 eC-SSRS administrations

(MDD, PTSD, insomnia, epilepsy and fibromyalgia)

Most Serious Ideation **Since Last Call**:	
NONE	**24634 (86.1%)**
Q1 Wish to die	**20929 (10.2%)**
Q2 Active Ideation	487 (1.7%)
Q3 Method?	321 (1.1%)
Q4 Intent?	202 (0.7%)
Q5 Plan and Intent?	23 (0.1%)

~1.7% required any practitioner follow-up; **NONE** in non-psychiatric conditions

0.9% with ~50,000 patients

Events in Pain and Fibromyalgia Patients

	Pain Trial	**Fibromyalgia Trial**
Wish to be dead	0.72%	0.64%
Suicidal Thoughts	0.34%	0.21%
Ideation w/out Intent	0.12%	0.16%
Ideation w/out plan	0.06%	0.11%
Ideation plan intent	0.03%	0.05%
Actual	0%	0%
Nonsuicidal	0%	0%
Interrupted	0%	0%
Aborted	0%	0%
Prep acts	0%	0%
Behavior	0.03%	0.05%
Suicide	0%	0%
Total	1.3%	1.22%
Total at baseline:		22.98%

Who can do it?
No Mental Health Training Required

- No mental health training required
- 812 nurses trained - 99% reliability independent of mental health training and education
- In behavioral healthcare settings:
  - Peer counselors
  - Paraprofessionals
  - Professionals
  - Nurses
  - Nurses' aides, etc.
- Other settings: All types of gate keepers
  - Teachers
  - First responders
  - Coaches
  - Road patrol
  - Bus drivers

Critical to have next steps in place for people who screen as high risk (e.g. teacher referral to counselor)

Format & Administration

- Semi-structured interview - flexible format
- Questions are *helpful tools* – not required to ask any or all questions; just enough to get appropriate answer
- Gather enough clinical information to determine whether to call something suicidal – *MOST IMPORTANT*
- If established that patient has not engaged in any suicidal behavior and/or ideation, then no further questions are required

Informants & Information Sources

- *Any source* of information that informs clinical judgment and gets the most clinically meaningful response
- Typically individual can provide best info about suicidal intent and thoughts
- If clinically indicated: records, parent, spouse, caretaker etc. can inform judgment (e.g. patient won't talk about event)

C-SSRS Format and Administration
...*How many questions should I ask?*

- Semi-structured interview/flexible format
- Questions are provided as helpful tools – it is not required to ask any or all questions – just enough to get the appropriate answer
- Most important: gather enough clinical information to determine whether to call something *suicidal or not*
- If it is established that a patient has not engaged in any suicidal behavior and/or ideation, then no further questions are required

Example….

Rater: "Have you made a suicide attempt?"

Individual: "Yes, I took *50 pills because I definitely wanted to die."*

- You have enough information to classify as an actual attempt, no need to ask additional questions

Interpreting C-SSRS Scores

Integrating Suicidal Ideation and Suicidal Behavior

Example from Fort Carson

	Recent Suicidal Ideation	Past Suicidal Ideation	Recent Suicidal Behavior	Past Suicidal Behavior
Very Low Risk	0	0	0	0
Low Risk	1-2	1-3	0	0
Moderate Risk	3	4-5	0	Y
High Risk	4-5	4-5	0	Y
Very High Risk	4-5	4-5	Y	Y

Decreases False Positives and False Negatives, Reducing Unnecessary Interventions & Redirecting Scarce Resources

PHQ-9 *(commonly used depression screening tool)*

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

…Calls instances suicidal that shouldn't be and misses every type of ideation and behavior that need to be identified

Data confirm that when item followed by C-SSRS, cases that should not have been called suicidal are eliminated

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C-SSRS reduces false positives and avoids false negatives

- **Policy**:
  - Discussed during the Rhode Island ***Senate Commission Hearing*** to ***address ER overuse and ER diversion***. Senators aim to have frontline responders use scale - specifically EMS and community police
- **Corrections:**
  - California corrections department spent approx. **$20 million in 2010** on a suicide-watch program, which they believe **could be cut in half by these methods**

State-Wide Dissemination of C-SSRS

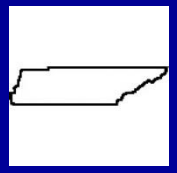
Some examples…

Rhode Island: Senate Commission recommends use of by EMS & police as innovative top-down solution to prevent ER overuse and diversion.

New York: State Suicide Prevention Initiative - screen all patients in state-operated inpatient & outpatient psychiatric service systems, county systems, non-profit behavioral healthcare providers, & youth serving organizations.

Georgia: Dept of Behavioral Health – introducing statewide in comprehensive suicide prevention initiative; use by mental health providers - development & implementation in and between all services and systems of care; top-down systems approach

New Jersey: - disseminating all organizations & schools that provide services to youth; training to use in schools, social service agencies, juvenile justice facilities, religious organizations, military facilities, primary care, & higher education.



Tennessee: – part of State Crisis Assessment tool; policies to use in all divisions and contract vendors used by DOMH, Indian Health Services, mobile crisis units, hospitals, schools, managed care, etc.

"[Using the C-SSRS] may actually be able to **make a dent in the rates of suicide** that have existed in our population and have remained constant over time…that would be an enormous achievement in terms of public health care and preventing loss of life." - Jeffrey Lieberman, M.D., President Elect of American Psychiatric Association (APA)

"New Suicide Prevention Initiatives in Rhode Island"

Released: March 20, 2012

"The use of this scale can be **transformative for Rhode Island** because it will improve care and **allow us to focus resources where they most help people**," -Dale K. Klatzker, President/ CEO of The Providence Center.

"The scale is an **easy way to save lives**…Our staff have been trained by Dr. Posner, the creator of the C-SSRS, and have found it **easy to use and effective**. **By tying it to our electronic health records,** it becomes that much more **streamlined into every day care."**

"Having a **proven method to assess suicide risk** is a huge step forward in our efforts to save lives…have **established the validity** of the C-SSRS. This is a critical step in putting this tool in the hands of health care providers and others in a position to take steps for safety" -Michael Hogan, New York State Office of Mental Health Commissioner

"…the feeling is that the C-SSRS has separated the wheat from the chaff; it focuses attention where it needs to be. This easy to use instrument allows our clinicians to move ahead with confidence and we are similarly confident that we are providing them with the best technology available." – OMH, NY

Data Support:

Importance of Full Range

Lifetime Different Suicidal Behaviors Predict Suicidal Behavior

A person reporting any *one* of the lifetime behaviors at baseline is ~ 4.5 to 5 times more likely to prospectively report a behavior during subsequent follow-up

Baseline Reports	Patients not prospectively reporting suicidal behavior N =3577	Patients prospectively reporting suicidal behavior N =201	Odds ratio of prospective suicidal behavior report (95% CI; ****p-values < .001*)
Actual Attempt	522 (85.6 %)	88 (14.4 %)	4.56 (3.40 – 6.11)***
BL Interupted Attempt	349 (82.7 %)	73 (17.3 %)	5.28 (3.88 – 7.18)***
BL Aborted Attempt	461 (84.7 %)	83 (15.3 %)	4.75 (3.53 – 6.40)***
BL Preparatory Behavior	177 (81.2 %)	41 (18.8 %)	4.92 (3.38 – 7.16)***

Total Number of Behaviors Matters! Number of Different Lifetime Suicidal Behaviors Predict Suicidal Behavior

Any type of Lifetime behavior increases likelihood of behavior during trial by ~ 3.4 times; increases proportionally with increased number of different behaviors reported

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

Potential Liability Protection

"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

- Policies now place more burden on universities to implement interventions to protect students from self-harm (Franke, 2004; Lake et al., 2002)
- Schools implementing programs to enable students to receive appropriate treatment & remain in school; Americans with Disabilities Act protects students' rights to remain in school

Impact on Care Delivery and Service Utilization

Decreased Unnecessary Intervention & Getting Care to Those Who Need It

SUICIDE SCREENING *in a General Hospital Setting: Initial Results*

Presented by: Debra Haas Stavarski, RN, MS; Director, Nursing Research • The Reading Hospital and Medical Center, West Reading, Pennsylvania

PURPOSE

A major barrier to effective suicide screening in the acute care hospital setting has been lack of a brief, valid, reliable, and universally acceptable tool that addresses ideation and behavior, and provides clear operational definitions of both. An abbreviated version of the Columbia-Suicide Severity Rating Scale (C-SSRS) screen was developed as part of a hospital suicide screening protocol. This study evaluated the psychometric properties of the abbreviated C-SSRS screen, protocol performance, and impact on selected outcome indicators.

THEORETICAL FRAMEWORK

The Johnson Behavioral Systems Model was used as the framework for the study. Johnson's model addresses the integration of patient behavior for prevention of illness and injury, as well as influences on behavior of both patient and caregiver.

RESEARCH TEAM

- **Debra Stavarski, RN, MS;** Director of Nursing Research, The Reading Hospital and Medical Center
- **Udema Millsaps, MEd;** Research and Continuing Education Coordinator, Department of Psychiatry, The Reading Hospital and Medical Center
- **Andres J. Pumariega, MD;** Chair of Psychiatry, Cooper University Hospital, Camden, N.J.
- **Kelly Posner, PhD;** Associate Professor of Psychiatry and Director, Center for Suicide Risk Assessment, Columbia University Medical Center, New York, N.Y.
- **Barbara Romig, RN, MSN;** Director of Education/Professional Development, The Reading Hospital and Medical Center
- **Robert Rice, BSN, RN-BC;** Clinical Practice Educator, Inpatient Psychiatry, The Reading Hospital and Medical Center
- **Heather Close, BS;** Former Research Assistant, The Reading Hospital and Medical Center
- **Mary Jo Castellucci, BS;** Systems Analyst, The Reading Hospital and Medical Center

METHODS

Descriptive Study Design
- Instrument ratings
- Inter-rater reliability

Naturalistic Setting
- >500-bed community hospital
- Eastern Pennsylvania

Convenience Sample: Adult Inpatients
- Admitted January – June 2010

INSTRUMENT: ABBREVIATED C-SSRS

- C-SSRS: gold standard for suicide assessment
- Brief, valid, reliable tool desired for routine screening
- Abbreviated C-SSRS (2009)
- Triage algorithm for The Reading Hospital and Medical Center response to C-SSRS levels developed by Posner, Pumariega, Millsaps (2009)

CAREGIVER EDUCATION

- DVD Training on C-SSRS Tool
- Introduction to abbreviated C-SSRS Tool
- Caregiver reflection on attitudes toward suicide assessment
- Vignette training

CLINICAL SUICIDE SCREENING PROTOCOL

- Screening C-SSRS incorporated into admission assessment for all medical-surgical patients
- Automated risk stratification
- Prevention protocol triggered for identified risk
- Safety interventions implemented specific for risk levels 1 - 5

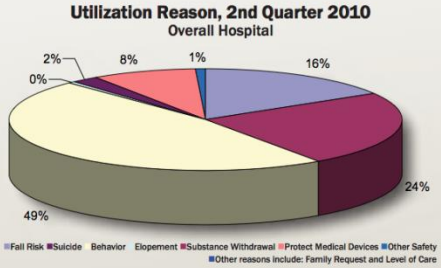
NURSE INTER-RATER RELIABILITY

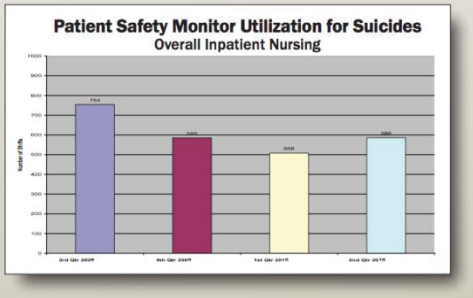
Intra-rater Reliability Broken Down by Experience
Two-Way Random Intra-Rater Reliability

		Consistency		Absolute Agreement		
	No Raters	Single Measure	Average Measure	Single Measure	Average Measure	Crombach's Alpha
Experience Unknown	32	0.643	0.983	0.633	0.982	0.983
Experience 0 to 10 years	466	0.658	0.999	0.657	0.999	0.999
Experience 11 years and above	315	0.618	0.998	0.617	0.998	0.998
Experience 0 to 16 years	562	0.675	0.999	0.673	0.999	0.999
Experience 17 years and above	219	0.643	0.997	0.643	0.997	0.999

The Reading Hospital and Medical Center
www.readinghospital.org

PATIENT SAFETY MONITOR UTILIZATION





IMPLICATIONS FOR PRACTICE

The abbreviated C-SSRS has been successfully incorporated into a clinical suicide screening protocol that is a component of assessment for all patients admitted to the acute care hospital setting, regardless of psychiatric history. This practice, implemented in early 2010, complies with Joint Commission recommendations published in a November 2010 Sentinel Event Alert.

Reduction in Unnecessary Interventions/ Redirecting Scarce Resources

NYC Problem

- 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."

"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**

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

Policy:

- Discussed during the Rhode Island ***Senate Commission Hearing*** to ***address ER overuse and ER diversion***. Senators aim to have frontline responders use scale - specifically EMS and community police

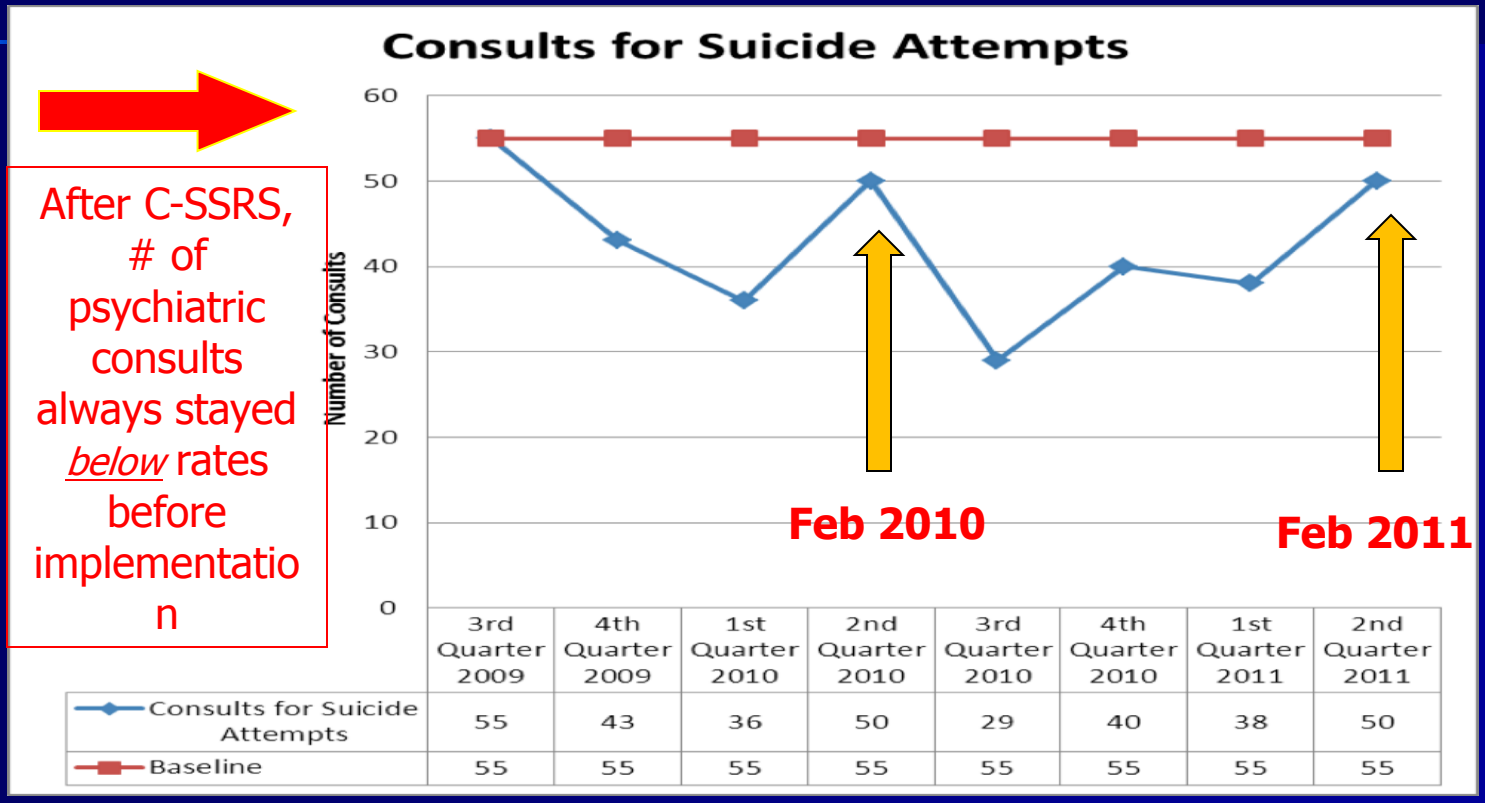
Corrections:

- California corrections department spent approx. **$20 million in 2010** on a suicide-watch program, which they believe **could be cut in half by these methods**

Psychiatric Consultations for Suicide Attempts

July, 2009 to June, 2011 (Reading Hospital)

After C-SSRS, # of psychiatric consults always stayed *below* rates before implementation

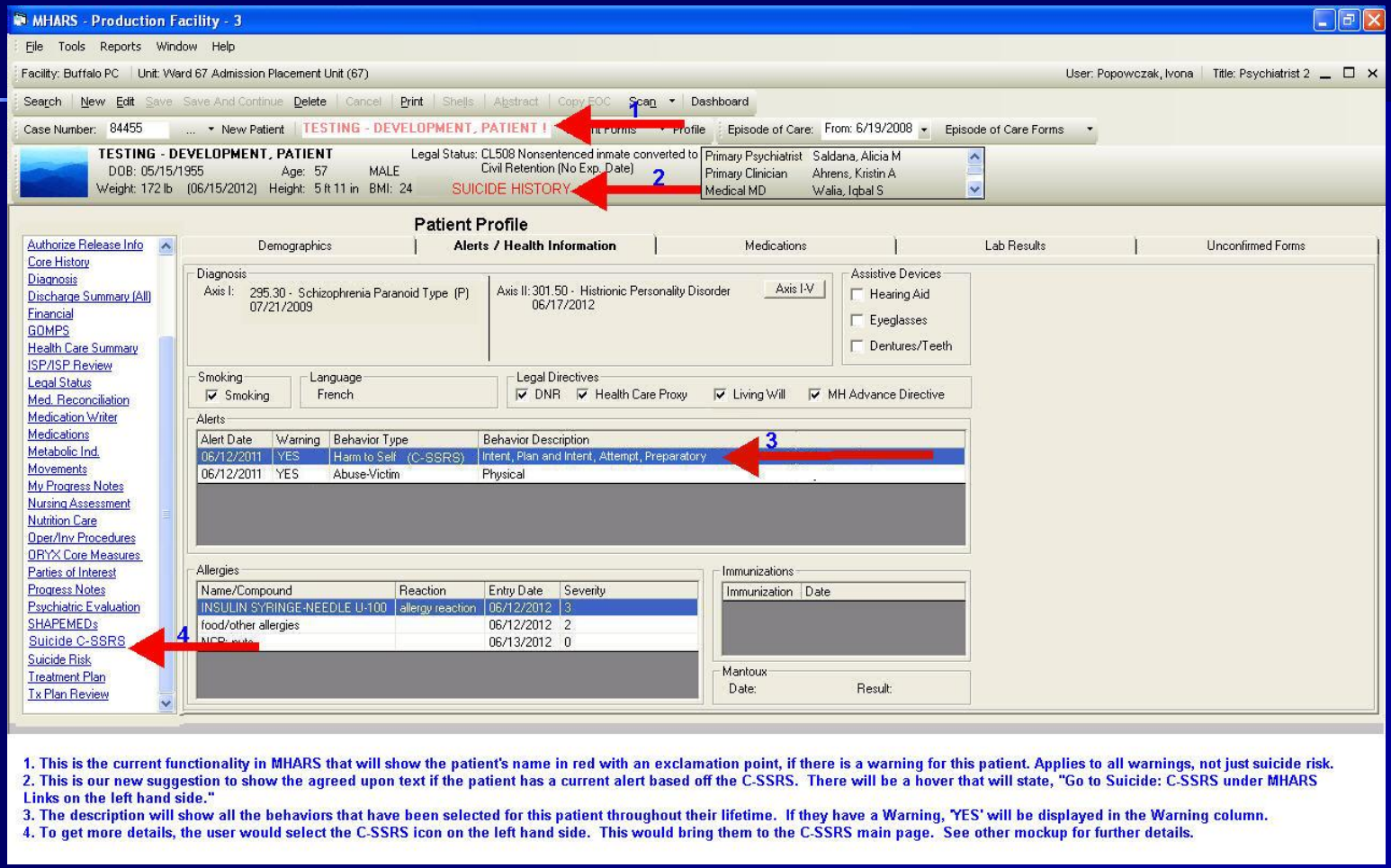


	3rd Quarter 2009	4th Quarter 2009	1st Quarter 2010	2nd Quarter 2010	3rd Quarter 2010	4th Quarter 2010	1st Quarter 2011	2nd Quarter 2011
Consults for Suicide Attempts	55	43	36	50	29	40	38	50
Baseline	55	55	55	55	55	55	55	55

- **Hospital system**: steadily decreased one-to-ones (27,000 screened)- "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."

New York State Electronic Medical Records

Profile with Suicide History



1. This is the current functionality in MHARS that will show the patient's name in red with an exclamation point, if there is a warning for this patient. Applies to all warnings, not just suicide risk.
2. This is our new suggestion to show the agreed upon text if the patient has a current alert based off the C-SSRS. There will be a hover that will state, "Go to Suicide: C-SSRS under MHARS Links on the left hand side."
3. The description will show all the behaviors that have been selected for this patient throughout their lifetime. If they have a Warning, 'YES' will be displayed in the Warning column.
4. To get more details, the user would select the C-SSRS icon on the left hand side. This would bring them to the C-SSRS main page. See other mockup for further details.

- 4/5 past month OR behavior past 3 months = highest level suicide alert
- 4/5 OR behavior ever = "warning" – suicidal risk elevated

Columbia-Suicide Severity Rating Scale (C-SSRS)

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Zelazny, J.; Fisher, P.; Burke, A.; Oquendo, M.; Mann, J.

USES/RECOMMENDATIONS INCLUDE:

- General medical and psychiatric emergency departments / Hospital systems
- Multiple states – top down requirements
- Primary care
- Schools / college campuses
- US Army/National Guard/VAs/Navy and Air Force settings
- Frontline responders (police, fire department, EMTs)
- Substance abuse treatment centers
- Prisons/jails/juvenile justice systems/ judges to reduce unnecessary hospitalizations
- FDA, WHO, TJC Best Practices Library
- CDC, AMA Best Practices Adolescent Suicide, Health Canada, Israeli Defense Force, Japanese National Institute of Mental Health

"If a practitioner asked the questions... It would provide some legal protection" –Bruce Hillowe, mental health attorney specializing in malpractice litigation

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Columbia-Suicide Severity Rating Scale (C-SSRS)

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Zelazny, J.; Fisher, P.; Burke, A.; Oquendo, M.; Mann, J.

- OPERATIONALIZED THRESHOLDS FOR NEXT STEPS RESULTING IN SIGNIFICANT REDUCTION OF UNNECESSARY INTERVENTIONS AND BURDEN
- Extensively used internationally across research, clinical and institutional settings
- Several million administrations
- Available in 103 languages
- Used across the lifespan:
  - Special Populations: indicated for cognitively impaired (e.gAlzheimer's, Autism)
- *Data confirm that 4 or 5 on ideation predict suicide attempts* in national attempter study *(Posner et al,. AJP Dec 2011)*; further confirmed by eC-SSRS: 35,007 administrations, those at baseline with 4 or 5 in prior ideation and/or behavior are 4x – 8x more likely to report subsequent suicidal behavior

Optimal Timeframes to Assess

- Recent
  - For Ideation: During the past month
  - For Behavior: During the past 3 months
- Lifetime
  - For Ideation: Most suicidal time most clinically meaningful – even if 20 years ago, *much more predictive than current*
  - For Behavior: Lifetime behavior highly predictive (e.g. history of suicide attempt #1 risk factor for suicide)