Columbia-Suicide Severity Rating Scale Training Webinar

• Hosted by Oregon Health Authority Public Health Division’s SBHC Program and Suicide Prevention Program

• Trainer: Adam Lesser, LCSW
  Deputy Director, The Columbia Lighthouse Project
Suicide in Oregon


• In 2016, 771 Oregon residents died by suicide.
• 98 of these suicides occurred among Oregon youth aged 10-24.
• Suicide is the 2nd leading cause of death among Oregonians aged 10-24 years and has been rising since 2011.
• Male youth are 4X more likely to die by suicide than female youth.
Simulation for Health Care Professionals

- 20-30 minute online learning experience.
- Awards .75 CEUs for physicians, nurses, social workers, and school psychologists.
- Promotes integration of behavioral health in the primary care setting.
- Includes *Virtual Patient* role-play conversation.
- Incorporates practice using motivational interviewing techniques.
AT-RISK in PRIMARY CARE

Adolescents

Learning Objectives

After completing the simulations, users will be able to:

- Recognize the importance of mental health as part of the role of primary care.
- Build rapport with patients using motivational interviewing tactics.
- Broach the topic of mental health and correct common misconceptions.
- Demonstrate appropriate ways to ask a patient about suicidal ideation.
- Take appropriate steps for referral and follow up.

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Conversation

• Broach topic of mental health and normalize mental health concerns.

• Engage Justin in discussion of his mental health and factors that may be contributing to his headaches.

• Uncover thoughts of suicide, assess risk.

• Motivate inclusion of parents.
Accessing the Simulations

www.kognito.com/oregon
Identify Yourself:
SBHC staff select Primary Care Professional

Create an Account (Step 1)

First Name
Last Name
Email Address
Re-enter Email Address
Choose Password
Re-enter Password

Training Point-of-View (POV):
Please indicate which choice most closely represents your role in your institution

Choose your Training POV...

By clicking "Next Step" you are agreeing to the Terms of Use

Next Step

Already have an account? Sign In

ED Staff
Primary Care Professional

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Provide Detailed Information

Step 1  Step 2  Done.

Please select your institution from the drop-down menu. If your institution is not listed, please complete the form on your Spread the Word page.

What is your role at your school?
- Teacher
- Administrator
- Support Staff
- Counselor / Psychologist / Social Worker
- Nurse
- Other

Do you work as a mental health provider?
- Yes
- No

Credit Type

Please select your credit type:
- Yes
- No

CONTINUE

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On March 12, they are holding 3 trainings:

- **QPR-T: Suicide Risk Assessment and Management Training**
- **suicide to Hope training** (which is considered the next step for those who have taken ASIST and want to learn more about ongoing suicide care)
- **Connect: Suicide Postvention Training** (understanding how postvention is prevention).

The conference will be March 13-14, and Dr. Sally Spencer-Thomas and Craig Miller will be speaking. Conference tracks include: loss and attempt survivors; suicide safer care/systems of care, community suicide prevention, and youth/education.

For more information including the agenda and to register, visit: [https://www.linesforlife.org/2018-oregon-suicide-prevention-conference/](https://www.linesforlife.org/2018-oregon-suicide-prevention-conference/)
Suicide Prevention Healthcare Leader Forum will take place on March 14 from 1-2:30pm

Featured Speakers:

- Zero Suicide faculty member Becky Stoll from Centerstone. One of the nation’s largest not-for-profit providers of community-based behavioral health care, Centerstone has tracked significant reductions of suicides within their system since they began implementing Zero Suicide.

- Jan Ulrich from the Zero Suicide Initiative will provide an overview of the Zero Suicide Academy including information about who is eligible to attend the Academy, what the application process entails, and what organizations can gain from participating.

Please register for Zero Suicide Healthcare Leader Forum at: https://attendee.gotowebinar.com/register/1031451147562097665
Identification, Triage and Monitoring Using The Columbia Suicide Severity Rating Scale

Increasing Precision, Improving Care Delivery and Redirecting Scarce Resources

Adam Lesser, LCSW
Deputy Director
Before We Begin

- Suicide is very personal
- Many of us are survivors, who miss our clients, friends or relatives
- Some may be attempt survivors
- You shouldn’t hold yourself responsible for something you didn’t do/say in the past based on what you will learn today

Please take care of yourself during and after this training
Suicide is a Global Public Health Crisis, Yet Preventable

Nearly 1 million People Die From Suicide Around the World Each Year
More Deaths Than Natural Disasters, War and Homicide Combined
Suicide Kills More People than Car Crashes

“the under-recognized public health crisis of suicide”

Thomas Insel, Director of NIMH
Suicide Touches Everyone
135 People Are Affected for Every Death
Suicide is the #1 Killer of Teenage Girls Across the Globe
2nd Leading Cause of Death Among 13-17, 20-36 in the US,
60% Rate Increase in 8-12 since 2012
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
Pyramid of Suicidal Behaviors (Adults)


**Substance Abuse and Mental Health Services Administration, Results from the 2015 National Survey on Drug Use and Health, 2015.
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 in Every Sector of Society...
Need to Screen and Care for the Caretakers

Corrections

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

Doctors
Breaking But Not Surprising News: Large Portion of Overdoses Are Suicides

Desperately Self-Medicating in lieu of proper treatment
Alarming Perspective: Life Expectancy Decreasing

Only Developed Nation in the World
Rural Areas: One of Our Greatest Challenges

- Highest rates of suicide
- Populations spread out across great distances
- Less consistent access to medical and mental healthcare
- Closest physicians may be several hours away and overburdened
- High rates of gun ownership (Miller et al., 2013)
Data on 2011-2015 Suicides in States with the Highest and Lowest Rates of Gun Ownership

<table>
<thead>
<tr>
<th></th>
<th>high</th>
<th>low</th>
<th>ratio</th>
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<tbody>
<tr>
<td>person years</td>
<td>189 million</td>
<td>189 million</td>
<td></td>
</tr>
<tr>
<td>percent of households with guns</td>
<td>56%</td>
<td>20%</td>
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</table>

**Male**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>firearm suicides</td>
<td>16487</td>
<td>3921</td>
<td>4.2</td>
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<tr>
<td>nonfirearm suicide</td>
<td>8125</td>
<td>8757</td>
<td>0.9</td>
</tr>
<tr>
<td>total</td>
<td>24612</td>
<td>12678</td>
<td>1.9</td>
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**Female**

<p>| | | | |</p>
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<thead>
<tr>
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<tr>
<td>firearm suicides</td>
<td>3015</td>
<td>335</td>
<td>9.0</td>
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<tr>
<td>nonfirearm suicide</td>
<td>3495</td>
<td>3586</td>
<td>1.0</td>
</tr>
<tr>
<td>total</td>
<td>6510</td>
<td>3921</td>
<td>1.7</td>
</tr>
</tbody>
</table>

States with the highest percentage of gun owners include: Wyoming, Montana, Idaho, Mississippi, Vermont, Alaska, Arkansas, W. Virginia, S. Dakota, Tennessee, Maine, Alabama, Utah, Kentucky and Louisiana. States with the lowest percentage of gun owners include: Hawaii, Massachusetts, Rhode Island, New Jersey and New York.
Oregon Suicide Facts

- 2016 - 11th highest rate in U.S.
- 1 in 4 suicides in Oregon are Veterans
- Over 80% of gun deaths in Oregon are suicides
- Eviction/loss of home was a factor associated with 199 deaths by suicide (7%) between 2009 and 2012
## Oregon Methods of Suicide

### Mechanism of Injury in Suicides by Sex, Oregon 2016

<table>
<thead>
<tr>
<th>Method</th>
<th>Males</th>
<th>%</th>
<th>Females</th>
<th>%</th>
<th>Total</th>
<th>%</th>
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<tbody>
<tr>
<td>Firearm</td>
<td>355</td>
<td>61</td>
<td>59</td>
<td>31</td>
<td>414</td>
<td>54</td>
</tr>
<tr>
<td>Hanging / suffocation</td>
<td>131</td>
<td>23</td>
<td>53</td>
<td>28</td>
<td>184</td>
<td>24</td>
</tr>
<tr>
<td>Poisoning</td>
<td>58</td>
<td>10</td>
<td>60</td>
<td>32</td>
<td>118</td>
<td>15</td>
</tr>
<tr>
<td>Fall</td>
<td>14</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>All Other</td>
<td>4</td>
<td>1</td>
<td>9</td>
<td>5</td>
<td>15</td>
<td>2</td>
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<tr>
<td><strong>Total</strong></td>
<td>582</td>
<td></td>
<td>190</td>
<td></td>
<td>772</td>
<td></td>
</tr>
</tbody>
</table>

Source: WISQARS, CDC
Suicide Rates by County
2003-2012
2015-16 SWS
57,000 students statewide

Table 22: Depression and Suicide Ideation

<table>
<thead>
<tr>
<th></th>
<th>Grade 6 State</th>
<th>Grade 8 State</th>
<th>Grade 11 State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you ever feel so sad</td>
<td>19.0</td>
<td>25.9</td>
<td>31.9</td>
</tr>
<tr>
<td>or hopeless almost every</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>day for two weeks or more</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in a row that you</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>stopped doing some usual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>activities?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you ever seriously</td>
<td>10.5</td>
<td>17.6</td>
<td>18.1</td>
</tr>
<tr>
<td>consider attempting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>suicide?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actually attempted</td>
<td>6.2</td>
<td>9.4</td>
<td>7.8</td>
</tr>
<tr>
<td>suicide?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
Unfortunately, People Who Need Treatment Do Not Get It!

- Most people with mental health issues are not suicidal but 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
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 attempt survivors including those who make highly lethal attempts 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
“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

— 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
“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
– 80% give some kind of hints/warnings to friends or family, even if don’t tell clinician
People Want to Be Asked

• Makes a pact with himself “If one person asks me...
• Goes to Golden Gate Bridge
• Approached by a German tourist
• “I instantly realized that everything in my life that I’d thought was unfixable was totally fixable – except for having just jumped.”
• “Most people considering suicide want someone to save them. What we need is a culture in which no one is afraid to ask.”
“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>
Means Safety Works
Very Little Method Substitution in all cases

• **United Kingdom 1958** – replacing coal gas with natural gas– suicide rate by carbon monoxide poisoning was cut by 1/3

• **New Zealand 1992** – stricter gun licensing and required locked storage reduced gun suicide in youth by 66%

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

• **Switzerland 2003**- Firearm suicides in men 18-43 decreased by 27% as a direct result of reducing size of Army by 50% thusly reducing the number of soldiers storing guns at home

• **Israeli military 2006** - restricted gun access for off-duty soldiers, suicide rate dropped 40% in military
Ashley Williams - Maryland
I had PPD with my second child. Things got bad. Very bad. I'm not sure when I started planning suicide, but at the time, it felt like something normal... Like going grocery shopping.

I needed something reliable because I couldn't botch this and then be a medical burden to my family. I don't have a gun. Finding a manner that was fast and reliable took a long time and it was during that time that I recognized what was happening and got help.

That was years ago. I'm fine now, but I would most likely not be here to write this had there been a gun in my home at that time
Working With the Firearm Community

- An estimated 55 Million Americans own a firearm
- CDC reports 22,018 firearm suicides in 2015 (50% of total suicides)
- 2/3 of all gun deaths are suicides

Uses for C-SSRS
- In gun/sporting shops
- At firing ranges
- In firearm safety training
- At firearm tradeshows
SUICIDE IS PREVENTABLE AND EFFORTS DEPEND FIRST UPON ACCURATE IDENTIFICATION
The Problem and Consequences of Not Having Common Definitions

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

Many different terms for the same behavior

Negative implications on appropriate management of suicide - 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 data sets is compromised*
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 over 100 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:
Importance of a Common Language
“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

Public-Private Partnership: National Action Alliance – Toolkit for Zero Suicide

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

- C-SSRS and Safety Planning to be used in training all staff to screen *all patients* statewide
The Centerstone Care Pathway:

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

• Screen everyone at every service delivery point
• 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
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
- Hostage Negotiators
- Parents
- Youth
- Crisis Response Teams
- Hotlines

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

- Peer to Peer
- Hospitals
- Pediatricians
- VA
- Clergy
- Child Protective Services
- Officers Standing Overnight

In behavioral healthcare:
- Peer counselors
- Paraprofessionals
- Receptionists — “get to hear all the casual conversations staff don’t”
- Nurses
- Nurses’ aides
- Custodial/Janitorial Staff
ACE Cards in Development for use across all military branches
ACE Cards in the community

### In English and Spanish versions

#### ACE CARD

**Ask Your Fellow Firefighter**
- CARE FOR YOUR FELLOW FIREFIGHTER
- ESCORT YOUR FELLOW FIREFIGHTER

**Ask Your Kids**
- CARE FOR YOUR KIDS
- ESCORT YOUR KIDS

**Ask Your Friends**
- CARE FOR YOUR FRIENDS
- ESCORT YOUR FRIENDS

**Ask Amigos y Familia**
- CARE FOR AMIGOS Y FAMILIA
- ESCORT AMIGOS Y FAMILIA

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#### Answer Questions 1 and 2

1. How many times did you want or wished you could go to sleep and not wake up?

   - **If YES to 1, answer questions 3, 4, 5 and 6. If NO to 1, go directly to question 6.**

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 any intention of acting on these thoughts of killing yourself: as opposed to you have the thoughts but you definitely would not act on 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?

---

#### Always Ask Question 6

6. Have you done anything, started to do anything, or prepared to do anything to end your life?

   - **Examples:** Found pills, or drugs a gun, gave away valuable, wrote a will, cut yourself, tried to hang yourself, etc.

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### Answer Questions 3, 4, 5, and 6

#### No

- **If NO to 3, 4, 5 and 6, go to question 7.**

#### Yes

- **If YES to 3, 4, 5 and 6, continue on to question 8.**

---

#### Always Ask Question 6

Any YES must be taken seriously. Seek help from friends, family, co-workers, and inform them as soon as possible.

**If the answer to 6, 5 or 6 is YES, immediately ESCORT the individual to Emergency Personnel for Care.**

**DON’T LEAVE THEM ALONE.**

#### New York State Psychiatric Institute

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#### Suicide Prevention Lifeline

**1-800-273-TALK (8255)**

STAY ENGAGED UNTIL YOU MAKE A WARM HAND OFF TO SOMEONE WHO CAN HELP.

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#### National Suicide Prevention Lifeline

**1-800-273-TALK (8255)**

STAY ENGAGED UNTIL YOU MAKE A WARM HAND OFF TO SOMEONE WHO CAN HELP.

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#### Columba University Department of Psychiatry

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#### Request for Questions That Can Save a Life

**New York State Psychiatric Institute**

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#### Request for Questions That Can Save a Life

**New York State Psychiatric Institute**
Must Go Beyond the Medical Model: Marines Reduce Suicide by 22%

Undersecretary of Defense
Urgent Memo

MEMORANDUM FOR DEPUTY ASSISTANT SECRETARY OF THE ARMY FOR MILITARY PERSONNEL/QUALITY OF LIFE
DEPUTY ASSISTANT SECRETARY OF THE NAVY FOR MILITARY PERSONNEL POLICY
DEPUTY ASSISTANT SECRETARY OF THE AIR FORCE FOR RESERVE AFFAIRS AND AIRMEN READINESS

SUBJECT: Use of the Columbia-Suicide Severity Rating Scale

- Total force roll-out
  - In the hands of whole community
  - ALL support workers: lawyers, financial aid counselors, chaplains
Military Chaplains Peer-to-Peer

https://youtu.be/MfBXroY5doo
Linking of Systems: Organizational Vision/Top-Down Models

Department Health & Mental Health

Provider By Provider | All Services | Between Services | All Systems of Care

- Child Protective Services
- First Responders and Crisis Lines
- Hospitals
- Homeless Services
- Primary Care
- Schools
- Law Enforcement
- Justice/Lawyers

Linking Systems

Inpt → Bridge → Outpt

Precision of communication: enables quicker response to those who need it
Since Asking With An Everyone, Everywhere Approach Utah Achieves Decrease in Suicide

Reversed an alarming increasing trend over the past 10 years

A former Nevada Senator grappled with her state’s suicide rate and looked to progress made in Utah for hope, saying:

“Utah recently reversed an upward trend in suicides and experts are citing the implementation of the C-SSRS.”
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)

A GREAT OPPORTUNITY FOR PREVENTION!

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

• High school screening identified 69% of the students with significant mental health issues compared to clinical professionals who identified only 48%. When both screening and professional referral were used 82% were identified (Scott et al., 2009)

• College Screening Project - data suggest that screening brings high-risk students into treatment
  – Only 1 suicide in 4 years post-screening vs. 3 suicides in 4 years pre-screening program (Haas et al., 2008)

• 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)
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
Joint Commission promotes the C-SSRS

“The research shows that this tool will help organizations focus on folks who are at highest risk.”

- Anne Bauer, MD, field director, Accreditation and Certification Operations, The Joint Commission.

[Hospitals and health care systems] have either developed something themselves or they’re using a piecemeal approach, with different tools in different departments: What may appear to be a person at risk in one area may not appear to be at risk in another. When the ED is asking their set of questions, and then the social worker asks another set, then the psychiatrist asks another, you’re reducing the signal strength. You’re not honing in on the needle in the haystack.
TRAINING ON THE C-SSRS
### Ideation Severity

#### SUICIDAL IDEATION

**Instr. questions 1 to 6. Both are negative, proceed to the "Suicidal Ideation" section.**

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. With the intention to die or act to end your life, have you felt unhappy, sad, or low in spirit?</td>
<td></td>
</tr>
<tr>
<td>2. Non-specific suicidal thoughts: have you had any thoughts of killing yourself?</td>
<td></td>
</tr>
<tr>
<td>3. Active suicidal ideation with any intent: have you had any thoughts of killing yourself?</td>
<td></td>
</tr>
<tr>
<td>4. Active suicidal ideation with some intent: have you had any thoughts of killing yourself?</td>
<td></td>
</tr>
<tr>
<td>5. Active suicidal ideation with specific plan: have you had any thoughts of killing yourself?</td>
<td></td>
</tr>
<tr>
<td>6. Lethality of actual suicide attempts: do you have any thoughts of completing suicide?</td>
<td></td>
</tr>
</tbody>
</table>

#### SUICIDAL BEHAVIOR

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many times did you try to end your life?</td>
<td></td>
</tr>
<tr>
<td>How many times did you actually try to end your life?</td>
<td></td>
</tr>
<tr>
<td>How many times did you actually try to end your life and did it work?</td>
<td></td>
</tr>
</tbody>
</table>

### Ideation Intensity

#### INTENSITY OF IDEATION

<table>
<thead>
<tr>
<th>Level</th>
<th>Description of Ideation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Least Severe Ideation:</td>
<td></td>
</tr>
<tr>
<td>Most Severe Ideation:</td>
<td></td>
</tr>
</tbody>
</table>

#### Frequency

- How many times have you had these thoughts?
  - Less than once a week
  - Once a week
  - 2-3 times a week
  - 4 times a week or more

#### Duration

- How long did the thought(s) last?
  - Less than 1 hour
  - 1 hour or more

#### Controllability

- Can you control the thoughts or can they control you?
  - Can control thoughts
  - Cannot control thoughts

#### Relevant

- When was the last time you had a thought of dying or acting to end your life?
  - More than 1 month ago
  - Between 1 and 6 months ago
  - In the last 6 months
  - In the last 3 months

#### Lethality

- How many times did you actually try to end your life?
- How many times did you actually try to end your life and did it work?

### Lethality of Actual Suicide Attempts

<table>
<thead>
<tr>
<th>Lethality of Actual Suicide Attempts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

### Behaviors

#### SUICIDAL BEHAVIOR

- Have you ever talked to someone about your plan to kill yourself?
- Have you ever written to anyone about your plan to kill yourself?
- Have you ever looked up methods to kill yourself?
- Have you ever tried to get hold of a gun or other weapons to kill yourself?
- Have you ever tried to get hold of medicine or other substances to kill yourself?

#### PREPARATORY ACTS OR BEHAVIOR

- Have you made any preparations for killing yourself?
- Have you done anything to make it easier for you to kill yourself?
- Have you taken any steps towards making a suicide attempt or preparing to kill yourself (e.g., buying a gun, giving a car to a friend, writing a will)?

#### Actual Attempt

- Have you ever been in the process of attempting suicide?
- Have you been in the process of attempting suicide and stopped before you hurt yourself?

#### Ideation Intensity

- How many times have you had a thought of dying or acting to end your life?
- How many times have you had a thought of dying or acting to end your life and did it work?

#### Lethality of Actual Suicide Attempts

- Have you ever been in the process of attempting suicide?
- Have you ever been in the process of attempting suicide and stopped before you hurt yourself?
C-SSRS is Simply....

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 (Full and Screener C-SSRS)
- **Ideation Intensity** – 5 intensity items (Full C-SSRS Only)
- **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 (Full and Screener C-SSRS)
- **Lethality of Actual Suicide Attempts** (Full C-SSRS Only)
C-SSRS is a Semi-structured Interview

• 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
Multiple Sources: 
*Don’t Have to Rely on Individual’s 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)

- Very helpful for children and adolescents who may not give same info as parents or other caregivers
Examples...

– A peer comes to your office and reports that his friend posted on Instagram that he wants to die.

– A loved one brings a family member into the ER. The patient denies suicidal thoughts, but the family member shares with you that 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.

– Client is at intake for outpatient services and denies lifetime suicidal ideation and behavior but medical record sent from inpatient hospital indicates admission for recent attempt.
SUICIDAL IDEATION
This is the Full C-SSRS Ideation Page

Typical Administration Time= Few Minutes
C-SSRS Screener Ideation Questions

<table>
<thead>
<tr>
<th>SUICIDE IDEATION DEFINITIONS AND PROMPTS</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask questions that are bolded and underlined.</td>
<td>YES NO</td>
</tr>
<tr>
<td><strong>Ask Questions 1 and 2</strong></td>
<td></td>
</tr>
<tr>
<td>1) Wish to Be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fail asleep and not wake up.</td>
<td></td>
</tr>
<tr>
<td><em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><em>Have you actually had any thoughts of killing yourself?</em></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): 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.”</td>
<td></td>
</tr>
<tr>
<td><em>Have you been thinking about how you might do this?</em></td>
<td></td>
</tr>
<tr>
<td>4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient 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.”</td>
<td></td>
</tr>
<tr>
<td><em>Have you had these thoughts and had some intention of acting on them?</em></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><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>
</tr>
</tbody>
</table>

Psychosis: Auditory hallucinations count as suicidal ideation
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)**</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)**</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>
</tbody>
</table>
Ideation Severity Demo

http://youtu.be/2kpB3Tq2mqU
Method or Plan?

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. Suicidal ideation with plan (Question 5)
2. Suicidal ideation with method (Question 3)
Intensity of Ideation

Once most severe type of ideation is determined, a few follow-up questions are asked:

- Frequency
- Duration
- Controllability
- Deterrents
- Reasons for ideation (stop the pain or make something else happen)
# Intensity of Ideation

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).

## Most Severe Ideation:

<table>
<thead>
<tr>
<th>Type # (1-5)</th>
<th>Description of Ideation</th>
<th>Most Severe</th>
</tr>
</thead>
</table>

## Frequency

**How many times have you had these thoughts?**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Less than once a week</td>
<td>(2) Once a week</td>
</tr>
</tbody>
</table>

## Duration

**When you have the thoughts, how long do they last?**

<table>
<thead>
<tr>
<th>Duration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Fleeting - few seconds or minutes</td>
<td>(2) Less than 1 hour/some of the time</td>
</tr>
</tbody>
</table>

## Controllable

**Could/can you stop thinking about killing yourself or wanting to die if you want to?**

<table>
<thead>
<tr>
<th>Controllable</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Easily able to control thoughts</td>
<td>(2) Can control thoughts with little difficulty</td>
</tr>
</tbody>
</table>

## Deterrents

**Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?**

<table>
<thead>
<tr>
<th>Deterrents</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Deterrents definitely stopped you from attempting suicide</td>
<td>(2) Deterrents probably stopped you</td>
</tr>
</tbody>
</table>

## Reasons for Ideation

**What sort 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 (in other words you couldn’t go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Completely to get attention, revenge or a reaction from others</td>
<td>(2) Mostly to get attention, revenge or a reaction from others</td>
</tr>
</tbody>
</table>
**INTENSITY OF IDEATION**

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).

**Most Severe Ideation:**

<table>
<thead>
<tr>
<th>Type # (1-5)</th>
<th>Description of Ideation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Frequency**

*How many times have you had these thoughts?*

(1) Less than once a week  (2) Once a week  (3) 2-5 times in week  (4) Daily or almost daily  (5) Many times each day

**Duration**

*When you have the thoughts, how long do they last?*

(1) Fleeting - few seconds or minutes  (2) Less than 1 hour/some of the time  (3) 1-4 hours/a lot of time  (4) 4-8 hours/most of the day  (5) More than 8 hours/persistent or continuous

**Controllability**

*Could/can you stop thinking about killing yourself or wanting to die if you want to?*

(1) Easily able to control thoughts  (2) Can control thoughts with little difficulty  (3) Can control thoughts with some difficulty  (4) Can control thoughts with a lot of difficulty  (5) Unable to control thoughts  (0) Does not attempt to control thoughts

**Deterrents**

*Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*

(1) Deterrents definitely stopped you from attempting suicide  (2) Deterrents probably stopped you  (3) Uncertain that deterrents stopped you  (4) Deterrents most likely did not stop you  (5) Deterrents definitely did not stop you  (0) Does not apply

**Reasons for Ideation**

*What sort 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 (in other words you couldn’t go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*

(1) Completely to get attention, revenge or a reaction from others  (2) Mostly to get attention, revenge or a reaction from others  (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain  (4) Mostly to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)  (5) Completely to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)  (0) Does not apply

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*New York State Psychiatric Institute*
# Intensity of Ideation

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).

- **Most Severe Ideation:**
  - Type # (1-5)
  - Description of Ideation

## Frequency

**How many times have you had these thoughts?**
- (1) Less than once a week
- (2) Once a week
- (3) 2-5 times in week
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## Duration

**When you have the thoughts, how long do they last?**
- (1) Fleeting - few seconds or minutes
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- (4) 4-8 hours/most of the day
- (5) More than 8 hours/persistent or continuous

## Controllability

**Could/can you stop thinking about killing yourself or wanting to die if you want to?**
- (1) Easily able to control thoughts
- (2) Can control thoughts with little difficulty
- (3) Can control thoughts with some difficulty
- (4) Can control thoughts with a lot of difficulty
- (5) Unable to control thoughts
- (0) Does not attempt to control thoughts

## Deterrents

**Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?**
- (1) Deterrents definitely stopped you from attempting suicide
- (2) Deterrents probably stopped you
- (3) Uncertain that deterrents stopped you
- (4) Deterrents most likely did not stop you
- (5) Deterrents definitely did not stop you
- (0) Does not apply

## Reasons for Ideation

**What sort 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 (in other words you couldn’t go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?**
- (1) Completely to get attention, revenge or a reaction from others
- (2) Mostly to get attention, revenge or a reaction from others
- (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain
- (4) Mostly to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)
- (5) Completely to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)
- (0) Does not apply
### Intensity of Ideation

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).

#### Most Severe Ideation:

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<thead>
<tr>
<th>Type # (1-5)</th>
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<tr>
<td></td>
<td></td>
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</table>

#### Frequency

**How many times have you had these thoughts?**

1. Less than once a week
2. Once a week
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#### Duration

**When you have the thoughts, how long do they last?**

1. Fleeting - few seconds or minutes
2. Less than 1 hour/some of the time
3. 1-4 hours/a lot of time
4. 4-8 hours/most of day
5. More than 8 hours/persistent or continuous

#### Controllability

**Could/can you stop thinking about killing yourself or wanting to die if you want to?**

1. Easily able to control thoughts
2. Can control thoughts with little difficulty
3. Can control thoughts with some difficulty
4. Can control thoughts with a lot of difficulty
5. Unable to control thoughts
0. Does not attempt to control thoughts

#### Deterrents

**Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?**

1. Deterrents definitely stopped you from attempting suicide
2. Deterrents probably stopped you
3. Uncertain that deterrents stopped you
4. Deterrents most likely did not stop you
5. Deterrents definitely did not stop you
0. Does not apply

#### Reasons for Ideation

**What sort 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 (in other words you couldn’t go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?**

1. Completely to get attention, revenge or a reaction from others
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4. Mostly to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)
5. Completely to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)
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**INTENSITY OF IDEATION**

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<table>
<thead>
<tr>
<th>Most Severe Ideation:</th>
<th>Type # (1-5)</th>
<th>Description of Ideation</th>
</tr>
</thead>
</table>

### Frequency
**How many times have you had these thoughts?**
1. Less than once a week  
2. Once a week  
3. 2-5 times in week  
4. Daily or almost daily  
5. Many times each day

### Duration
**When you have the thoughts, how long do they last?**
1. Fleeting - few seconds or minutes  
2. Less than 1 hour/some of the time  
3. 1-4 hours/a lot of time  
4. 4-8 hours/most of day  
5. More than 8 hours/persistent or continuous

### Controllability
**Could/can you stop thinking about killing yourself or wanting to die if you want to?**
1. Easily able to control thoughts  
2. Can control thoughts with little difficulty  
3. Can control thoughts with some difficulty  
4. Can control thoughts with a lot of difficulty  
5. Unable to control thoughts  
6. Does not attempt to control thoughts

### Deterrents
**Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?**
1. Deterrents definitely stopped you from attempting suicide  
2. Deterrents probably stopped you  
3. Uncertain that deterrents stopped you  
4. Deterrents most likely did not stop you  
5. Deterrents definitely did not stop you  
6. Does not apply

### Reasons for Ideation
**What sort 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 (in other words you couldn’t go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?**
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5. Completely to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)  
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### INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).

<table>
<thead>
<tr>
<th>Most Severe Ideation:</th>
<th></th>
<th></th>
<th>Most Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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#### Frequency

**How many times have you had these thoughts?**

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### Duration

**When you have the thoughts, how long do they last?**

(1) Fleeting - few seconds or minutes  (2) Less than 1 hour/some of the time  (3) 1-4 hours/a lot of time

#### Controllability

**Could/can you stop thinking about killing yourself or wanting to die if you want to?**

(1) Easily able to control thoughts  (2) Can control thoughts with little difficulty  (3) Can control thoughts with some difficulty  (4) Can control thoughts with a lot of difficulty  (5) Unable to control thoughts  (0) Does not attempt to control thoughts

#### Deterrents

**Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?**

(1) Deterrents definitely stopped you from attempting suicide  (2) Deterrents probably stopped you  (3) Uncertain that deterrents stopped you  (4) Deterrents most likely did not stop you  (5) Deterrents definitely did not stop you  (0) Does not apply

#### Reasons for Ideation

**What sort 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 (in other words you couldn’t go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?**

(1) Completely to get attention, revenge or a reaction from others  (2) Mostly to get attention, revenge or a reaction from others  (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain  (4) Mostly to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)  (5) Completely to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)  (0) Does not apply
Clinical Guidance

For Intensity of Ideation, risk is greater when:

- Thoughts are more frequent
- Thoughts are of longer duration
- Thoughts are less controllable
- Fewer deterrents to acting on thoughts
- Stopping the pain is the reason

• Gives you a 2-25 score that will help inform clinical judgment about risk

• Duration found to be most predictive in adolescents (King, 2009)
<table>
<thead>
<tr>
<th>C-SSRS Suicidal Behavior Section</th>
<th>Lifetime</th>
<th>Past 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual Attempt:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A potentially self-injurious act</td>
<td></td>
<td></td>
</tr>
<tr>
<td>committed with at least some</td>
<td></td>
<td></td>
</tr>
<tr>
<td>wish to die, as a result of an</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(behavior was at least</td>
<td></td>
<td></td>
</tr>
<tr>
<td>thought of as a method to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>kill oneself. Intent does</td>
<td></td>
<td></td>
</tr>
<tr>
<td>not have to be 100%. If there</td>
<td></td>
<td></td>
</tr>
<tr>
<td>is a real threat to die</td>
<td></td>
<td></td>
</tr>
<tr>
<td>associated with the act,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>then it can be considered as</td>
<td></td>
<td></td>
</tr>
<tr>
<td>an actual suicide attempt.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There does not have to be any</td>
<td></td>
<td></td>
</tr>
<tr>
<td>injury or harm, just the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>potential for injury or harm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If person pulls trigger while</td>
<td></td>
<td></td>
</tr>
<tr>
<td>gun is in their hands,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>this is considered an attempt.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inferring intent: Even if</td>
<td></td>
<td></td>
</tr>
<tr>
<td>an individual desires to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>die, it may be inferred</td>
<td></td>
<td></td>
</tr>
<tr>
<td>clinically from the behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or circumstances. For example,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a highly lethal act is</td>
<td></td>
<td></td>
</tr>
<tr>
<td>clearly not an accident so</td>
<td></td>
<td></td>
</tr>
<tr>
<td>such intent to die would be</td>
<td></td>
<td></td>
</tr>
<tr>
<td>inferred (e.g., gunshot to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>head, jumping from window</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of high rise building). Also,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>if someone desires to die,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>but they thought that</td>
<td></td>
<td></td>
</tr>
<tr>
<td>they could be killed,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>intent may be inferred.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you made a suicide attempt?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you done anything to harm yourself?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you done anything dangerous where you could have died?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where did you do?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Did you do it as way to end your life?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Why did you do it? (even a little) when you?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Were you trying to end your life when you?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Or did you think it was possible you could have died from?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has subject engaged in Non-Suicidal Self-Injurious Behavior?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interrupted Attempt:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When the person is interrupted (by an outside circumstance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>from starting the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>potentially self-injurious act (if not, the actual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>attempt would have occurred).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overdose: Person has pills</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>in hand but it stopped from ingesting. Once</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>they ingest all pills, this becomes an attempt rather than an interrupted</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>attempt. Inserting: Person has a gun pointed toward self,</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>gun is taken away by someone else, or is somehow prevented from pulling trigger.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Once they pull the trigger, if gun fails to fire, it is an attempt.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Jumping: Person is pushed to jump, is grabbed and taken down from bridge.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has there been a time when you wanted to do something to end your life but someone or something stopped you before you actually did anything?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, describe:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attempted or Self-Interrupted Attempt:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When person begins to take steps toward making a suicide attempt, but steps interrupted before they actually have engaged in any self-injurious behavior.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examples are similar to interrupted attempts, except that the individual stops themselves, or is somehow prevented from taking the action.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has there been a time when you wanted to do something to try to end your life but you stopped yourself before you actually did anything?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, describe:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preparatory Acts or Behavior:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acts or preparation towards someday making a suicide attempt. This can include anything beyond a verbalization or thought, such as assessing 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).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, describe:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.
Suicide Attempt Definition

A self-injurious **act** undertaken 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
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)
Suicide Attempt

• A suicide attempt begins with the first pill swallowed or scratch with a knife

• Questions:
  – Have you made a suicide attempt?
  – Have you done anything to harm yourself?
  – Have you done anything dangerous where you could have died?
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
Suicidal Behavior – Actual Attempts

**SUICIDAL BEHAVIOR**
(Check all that apply, so long as these are separate events; must ask about all types)

**Actual Attempt:**
A potentially self-injurious act committed with at least some wish to die, *as a result of act*. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is *any* intent/wish to die associated with the act, then it can be considered an actual suicide attempt. *There does not have to be any injury or harm*, 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.

- **Have you made a suicide attempt?**
- **Have you done anything to harm yourself?**
- **Have you done anything dangerous where you could have died?**
  - What did you do?
  - Did you _____ as a way to end your life?
  - Did you want to die (even a little) when you _____?
  - Were you trying to end your life when you _____?
  - *Or did you think it was possible you could have died from _____?***
  - Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)? (Self-Injurious Behavior without suicidal intent)

- **Has subject engaged in Non-Suicidal Self-Injurious Behavior?**

---

**Since Last Visit**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

**Total # of Attempts**

---

---

May help to infer intent

Important: Shows you did the appropriate assessment and decided it should not be called suicidal
Other Suicidal Behaviors....

Interrupted Attempt

• When person starts to take steps to end their life but someone or something stops them

• Examples
  – Bottle of pills or gun in hand but someone grabs it
  – On ledge poised to jump

• Question:
  – Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?
Aborted/Self-Interrupted 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

• Examples:
  – 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

• Question:
  – Has there been a time when you started to do something to end your life but you stopped yourself before you actually did anything?
Preparatory Acts or Behavior

• Definition:
  – Any other behavior (beyond saying something) with suicidal intent

• Examples
  – Collecting or buying pills
  – Purchasing a gun
  – Writing a will or a suicide note

• Question:
  – Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as, collecting pills, getting a gun, giving valuables away, writing a suicide note)?
All Behaviors Are Prevalent
Very Few (.5%-2%) Need Follow-Up

472 Interrupted, Aborted and Preparatory (87%)
vs.
70 Actual Attempts (13%)

Only 14 out of 2962 Vets screened positive (.47%)

Only 5 (.17%) required more acute care
Behavior Demo

http://youtu.be/2Fk0XuQwcMc
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. Actual suicide attempt
2. Interrupted attempt
3. Aborted attempt
Further Case Examples

During pill count, 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

Several weeks after being informed by her husband that he was having an affair, patient went to Haiti to see him to discuss the situation. She became enraged during their discussion and grabbed his gun with the intention of shooting herself. However, her husband struggled with her, took the gun away before she was able to pull the trigger, and hid it from her. States that she was feeling pain and hurt, and that she was so upset that she wanted to die.

1. Actual suicide attempt
2. Aborted attempt
3. Interrupted attempt
Further Case Examples

The voice commanded the patient, age 18, to jump from the roof. Although the patient went to the roof, he did not jump.

1. Aborted attempt
2. Interrupted attempt
3. Actual suicide attempt
Further Case Examples

The patient was feeling despondent about her financial situation. Her rent was due and the landlord had threatened to evict her. She went to the bathroom and took a razor from the cabinet. She cut one of her wrists and began bleeding. She bandaged up her wrist herself. During an interview a week later, she stated she had never cut herself before. She was adamant that she did not need to be hospitalized.

1. Suicide attempt
2. Non-suicidal self-injurious behavior
3. Not enough information
Lethality

(Compilation of Beck Medical Lethality Rating Scale)

What actually happened in terms of medical damage?

For example if there was a cut, did it require a Band-Aid or a bandage? Did it bleed a little bit or profusely?

**Actual Lethality/Medical Damage:**
0. No physical damage or very minor physical damage (e.g. surface scratches).
1. Minor physical damage (e.g. lethargic speech; first-degree burns; mild bleeding; sprains).
2. Moderate physical damage; medical attention needed (e.g. conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel).
3. Moderately severe physical damage; medical hospitalization and likely intensive care required (e.g. comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures).
4. Severe physical damage; medical hospitalization with intensive care required (e.g. comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area).
5. Death
Potential Lethality

Likely lethality of attempt if no medical damage. Examples of why this is important are cases in which there was no actual medical damage but the potential for very serious lethality

- Laying on tracks with an oncoming train but pulling away before run over
- Put gun in mouth and pulled trigger but it failed to fire – Both 2

Potential Lethality: Only Answer if Actual Lethality=0

Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over).

0 = Behavior not likely to result in injury
1 = Behavior likely to result in injury but not likely to cause death
2 = Behavior likely to result in death despite available medical care
Suicidal Behavior Administration

• Select (check) all that apply

• Only select if discrete behaviors
  • For example, if writing a suicide note is part of an actual attempt, do not give a separate rating of Preparatory Behavior (ONLY MARK A SUICIDE ATTEMPT)

• Reminder: Ideation & Behavior Must Be Queried Separately
  • Just because ideation is denied, it does not mean that there will not be any suicidal behavior

• Listen to what the person believed would happen not what you think regarding lethality
C-SSRS SCREENER

### Combined Behaviors Question

**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 of killing yourself?

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

**3.** Have you been thinking about how you might do this?  
E.g. “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.”

**4.** Have you had these thoughts and had some intention of acting on them?  
As opposed to “I have the thoughts but I definitely will not do anything about 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.

If YES, ask: **Was this within the past three months?**
## C-SSRS Timeframes

**Lifetime**

**Ideation:** Most suicidal time most clinically meaningful – even if 20 years ago, much more predictive than current

**Behavior:** Lifetime behavior highly predictive (e.g. history of suicide attempt #1 risk factor for suicide)

---

### Suicidal Ideation

<table>
<thead>
<tr>
<th>Question</th>
<th>Lifetime: Time He/She Felt Most Suicidal</th>
<th>Past 1 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wish to be Dead</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2. Non-Specific Active Suicidal Thoughts</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

---

### Suicidal Behavior (Check all that apply, so long as these are separate events; must ask about all types)

<table>
<thead>
<tr>
<th>Actual Attempt:</th>
<th>Lifetimen</th>
<th>Past 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you made a suicide attempt?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you done anything to harm yourself?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you done anything dangerous where you could have died?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

---

Has subject engaged in Non-Suicidal Self-Injurious Behavior?
Monitoring is Critical

Capture all events and types of thoughts since last assessment:
“Since I last saw you have you done anything.......had thoughts of...”

Recommended EVERY visit

• You don’t want the time you didn’t ask to be the time you needed to ask
TRIAGE WITH THE C-SSRS
Research Supported Thresholds for Imminent Risk Identification

Operationalized criteria for triage and next steps whatever they may be (e.g. referral to mental health, one-to-one, etc.)

Indicated clinical management response

Scientific data to inform clinical judgment

Indicates Need For Most Extreme Next Step
Screener Demo

http://youtu.be/fx3N3uDUQbo
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
WITH A FLEXIBLE TOOLKIT
YOU CAN TAILOR THE C-SSRS
FOR SPECIFIC USES
### Pediatric C-SSRS / Cognitively Impaired

#### SUICIDAL BEHAVIOR

<table>
<thead>
<tr>
<th>Actual Attempt:</th>
</tr>
</thead>
<tbody>
<tr>
<td>An intentional self-destructive act committed with at least some suicidal intent.</td>
</tr>
</tbody>
</table>

**Has subject engaged in Non-Suicidal Self-Injurious Behavior?**

- **Yes**
- **No**

#### Interrupted Attempt:

- When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if another such attempt would have occurred):
  - Overdose: Person has pills in hand but is stopped from ingesting.
  -圆满: 患者有药在手但被阻止摄入。
  - Stabbing: Person has knife but is stopped from attempting.

#### Aborted or Self-Interrupted Attempt:

- When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempt, except that the individual stops himself, instead of being stopped by something else:
  - Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but stopped yourself before you actually did anything? What did you do?
  - If yes, describe.

#### Preparatory Acts or Behavior:

- Acts or preparation to make oneself safe from acting on suicidal thoughts.
  - 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?
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.
### Additional Questions

<table>
<thead>
<tr>
<th>Legal Troubles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently facing any legal troubles?</td>
</tr>
<tr>
<td><em>Within military structure or outside</em></td>
</tr>
<tr>
<td>If yes, how have these circumstances impacted you/your family?</td>
</tr>
<tr>
<td>Additional Information:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Troubles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you experiencing any financial troubles?</td>
</tr>
<tr>
<td>If yes:</td>
</tr>
<tr>
<td>Do these concerns feel overwhelming or unmanageable?</td>
</tr>
<tr>
<td>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?</td>
</tr>
<tr>
<td>Is this financial stress or hardship the worst crisis you have ever experienced?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State of Service (pre-deployment, post-deployment, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-deployment _____</td>
</tr>
<tr>
<td>Post-deployment _____</td>
</tr>
<tr>
<td>Multiple deployments _____</td>
</tr>
<tr>
<td>Are the thoughts/behaviors we talked about related to your _____? (e.g., pending deployment)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital or Relationship Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you having any marital or relationship stress or problems?</td>
</tr>
<tr>
<td><em>Ask about domestic violence</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug or Alcohol Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you use drugs or alcohol?</td>
</tr>
<tr>
<td>Do you have a history of drug or alcohol abuse?</td>
</tr>
<tr>
<td>Additional Information:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you experiencing pain – chronic or intermittent?</td>
</tr>
<tr>
<td>Additional Information:</td>
</tr>
</tbody>
</table>
Tennessee Crisis Assessment Tool

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)
Fagot, Brent, Less, Good, Emans, Brown, Fisher, Zitler, Berke, Giedd, & O'Neal
© 2008 The Research Foundation for Mental Hygiene, Inc.

RISK ASSESSMENT

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Past 3 Months  Suicidal and Self-Injurious Behavior  Lifetime  Clinical Status (Recent)

- Actual suicide attempt
- Attempted suicide
- Aborted or Self-Interrupted attempt
- Other preparations made to kill self
- Self-Injurious behavior without suicidal intent

- Suicidal ideation
  - Checking Most Severe in Past Month
  - Wish to be dead
  - Suicidal thoughts
  - Suicidal thoughts with method (but without specific plan or intent to act)
  - Suicidal intent (without specific plan)
  - Suicidal intent with specific plan
  - Activating Events (Recent)
  - Recent losses or other significant negative events (legal, financial, relationship, etc.)

- Desires:
  - Pending incarceration or homelessness
  - Protective Factors (Recent)
  - Career or pending isolation or feeling alone

- Treatment History
  - Previous psychiatric diagnoses and treatments
  - Hopeless or disaffected with treatment
  - Non-compliant with treatment
  - Not receiving treatment

- Other Risk Factors

- Describe any suicidal, self-injurious or aggressive behavior (include dates)

YES  NO

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?

3. Have you thought about how you might do this?

4. Have you had these thoughts and 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 that might 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.
IMPACT ON CARE DELIVERY, SERVICE UTILIZATION AND STIGMA
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
Picking up People At the Right Time

“[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.”

Feb 2010

Feb 2011

**Economic crises/increases in unemployment worse than national average in Reading and Berks county area

After C-SSRS, # of psychiatric consults always stayed below rates before implementation
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 last year – now 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
Asking These Questions Helps Protect Against Internal and External Liability

“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)

“I believe it sets the standard...we take a proactive position in patient safety”
—Patient Safety Risk Manager
Breaking the Silence

When We “Just Ask” We Break the Silence and Give Permission to Connect and Build a Path to Openness and Resilience Across Generations

“This is not only saving millions of lives, it is literally changing the way we live our lives, breaking down barriers that have been built over thousands of years. But we are just one nation and every nation deserves this lifesaving tool.”
C-SSRS Training Opportunities

• Live Webinars every 6-8 weeks
• Interactive on-line training through National Action Alliance for Suicide Prevention Zero Suicide Website (zerosuicide.sprc.org/toolkit/identify)
• Recorded trainings on YouTube channel
• Download a recorded training from Dropbox
• Receive a DVD by mail with recorded trainings
For questions and other inquiries, email: kelly.posner@nyspi.columbia.edu

Website address for more information: cssrs.columbia.edu
Reminders

Part II: Oregon Safety Planning webinar
April 30th at 7:30AM

Oregon Zero Suicide Academy: Sept. 18-19, 2018

Suicide Prevention Healthcare Leader Forum will take place on March 14 from 1-2:30pm

Please register for Zero Suicide Healthcare Leader Forum at:
https://attendee.gotowebinar.com/register/1031451147562097665

This Training has been recorded and will be available on the State SBHC Program website: www.healthoregon.org/sbhc