On the Road to Prevention: Innovation in Risk Assessment

Improving Care Delivery and Redirecting Scarce Resources

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Suicide is a Major Public Health Crisis

- Suicide is one of the world's greatest public health epidemics
- Leading cause of death across the world and across ages
- **Every 15 minutes** a person dies by suicide
- #1 cause of injury mortality in U.S.; more people die by suicide than motor vehicle crashes

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

Suicide is a preventable public health problem

Youth Suicide

- Every 1 hour and 48 minutes, a person under the age of 25 dies by suicide ... *this number used to be 2 hours and 11 minutes*

Crisis in Youth

- 2010 became the **2nd leading cause of death** in youth 10-24 passing homicide for the first time in last decade
- Rate of suicide by suffocation for African American girls ages 10-18, increased 238% between 2006-2010
- Suicide rates for those between the ages of 10-14 ***increased 50%*** between 1981 and 2005.

- < 20% of college students who die by suicide receive campus-based services

-CDC WISQARS 2013

Youth Suicidal Ideation and Behavior

IN HIGH SCHOOLERS

- **Attempt: 8-10%**
  - Attempt requiring medical attention: 2-3%

IN DEPRESSED TEENS

- Ideation: 60%
- Attempt: 30%

Within any typical classroom, it is likely that three students (one boy and two girls) have attempted suicide in the past year.

02/12/2005; CDC WISQARS 2004-2011 (3/3/2013), Gould et al., 1998, Grunbaum et al., 2004 Shaffer, 2005

Characteristics of Attackers
(Safe Schools Initiative, 2002)

- 78% of attackers exhibited a history of suicide attempts or suicidal thoughts at some point prior to their attack
- 27% reported suicide as a motive in their attack
- Only 1/3 of attackers had received a mental health evaluation ***and YET*** 60% had a documented history of extreme depression or desperation

A shooter can be a suicide in disguise

Suicide Rates on the Rise in the U.S. Military…

- Almost 20% of all U.S. suicides are active duty or veterans
- Suicide has surpassed combat deaths in active duty military
- Suicide of army reservists and national guardsmen Doubled in 2010
- Active duty troops: 1 suicide every day
- Veterans: 21 suicides per day; 1000 attempts/month

SUICIDE IN . . .

Police Force

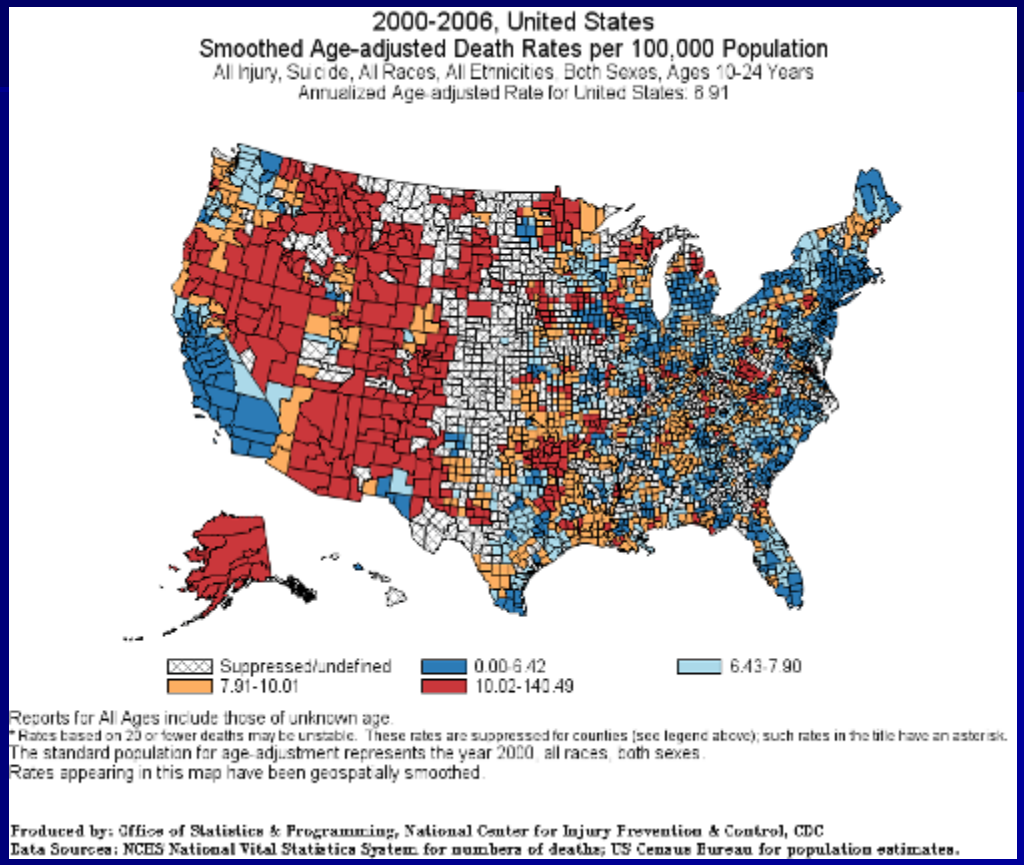
- 1st or 2nd leading cause of death of policemen alongside car accidents
- In 2012, almost as many died by suicide as were killed in the line of duty
- The rate of police suicide is comparable to the rate of suicides in the US Army

Corrections

- Most common cause of death in correctional facilities
- In US prisons and jails, the rate of suicide is close to **three times** that of general pop.
- Nearly 60% of inmates who die by suicide have no psychiatric illness & no clear warning signs
- Incarcerated youth: 31% report a suicide attempt.

Suicides in Rural Areas

- Highest rates of suicide
- Large populations, spread out across great distances
- Less consistent access to primary care
- Closest physicians may be several hours away and overburdened (Ricketts, 2000)



Public Health Burden…..

- 2 million adolescents attempt suicide annually, resulting in 700,000 ER visits
- Attempters constitute high proportion of all emergency referrals to child, adolescent, and adult psychiatric services and subsequently command disproportionate level of resources

Economic Burden of Suicide

- Worldwide, suicide accounts for:
  - $26.7 billion in combined medical and work-loss damages yearly
  - Majority of violence-related injury deaths (64%)
  - US (2005): $5 billion/year

- Within corporate family consisting of 100,000 employees (average of 4 blood relatives per employee):
  - **Every 7 days,** one employee or family member will die by suicide
  - Every day, 3 attempts resulting in significant medical injury and disability, which directly impacts health care costs, particularly for self-insured companies.

12

Scope of the Problem: Depression

- World Health Organization predicts that depression will be second most burdensome disease by the year 2020 (Murray & Lopez, 1997)

Unfortunately…

- 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)
  - < 20% of college students who die by suicide received campus-based services

Suicide prevention efforts depend upon appropriate identification & screening

The Problem…

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

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

…Consequences

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

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

The Need for Consistent Definitions & Data Elements

- " Research on suicide is plagued by many methodological problems... Definitions lack uniformity,...reporting of suicide is inaccurate..."
  Reducing Suicide Institute of Medicine 2002

Alex Crosby, CDC

Furthermore, Expect to See It Across All Medical Disorders and beyond…

- Suicidality prevalent across all medical disorders
  - 25.5% have ideation
  - 8.9% make an attempt

Druss and Pincus, 2000

- Cancer patients population based ideation 17.7% *independent of depression*

Schneider & Shenassa, 2008

So need to get it right…..

How to Fix the Problem…
Columbia - Suicide Severity Rating Scale

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

- Developed by leading experts (collaboration with Beck's group) for National Adolescent Attempter's Study in response to need for a measure to assess *both* behavior and ideation
- Evidence-based and supported
- Feasible, low-burden – short administration time (average is a few minutes)

includes only the most essential, evidence-based items needed in a thorough assessment

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 Forces 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/Mobile Crisis Teams
- Tribal Nations
- 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

C-SSRS Used in Education

Elementary → High School Education

- School Districts
- School Clergy
- Autism, Intellectually Disabled, BOCES
- School-based Wellness Centers
- Suicide Clusters

Nurses
Counselors
Social Workers
One-to-One Aides
Physicians
Coaches
Teachers

Higher Education

- College Campuses and Counseling Centers
- Graduate Schools
- Medical Schools
- International Universities – *e.g.*
  - *University of Victoria, South Africa, National University of Ireland*
- Nursing Schools

RAs
Gatekeepers
Incoming Student Screening
Physicians
Counselors

Research

- As Intervention and to Assess Outcome
  - *e.g. Turnaround for Children, SAMSA, Garret Lee Smith Grant*

National Implementation Efforts in the Military/VA:

- **The National Guard** Psychological Health Program
- **Air Force** - Guide for the Management of Suicidal Behaviors
- **Navy –** All Primary Care
- **Marine Corps – "total force Rollout"** use by all support workers (family advocacy workers, substance abuse specialists, victim advocates, attorneys, and chaplains)
- **VA –** 30-40 VA hospitals
- **Army –** Behavioral Health Data Platform

Predicting Suicide Attempts: Major National Goal of Action Alliance

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

"...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

State-Wide Dissemination

PROVIDENCE Journal

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.”**

State-Wide Dissemination

georgia.gov

Georgia Department of
BEHAVIORAL HEALTH and DEVELOPMENTAL DISABILITIES
DBHDD

Policy

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

*****Anticipated large majority of hospitalizations can be avoided**

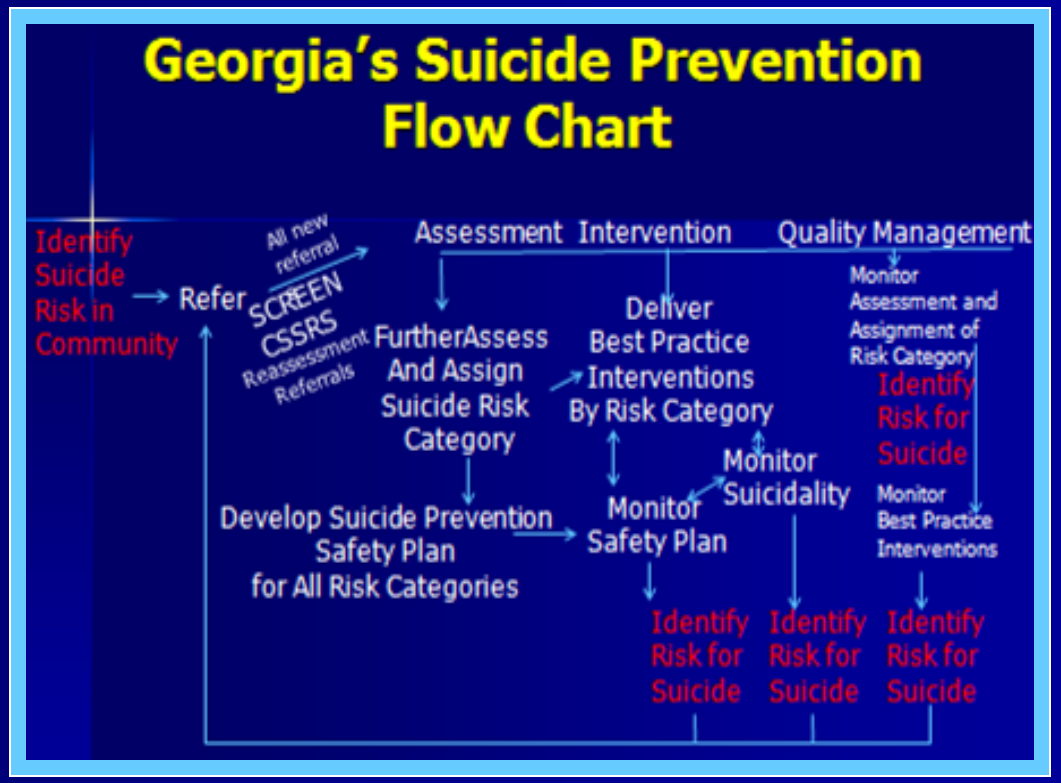
- Forensic services
- Case Management service providers that coordinate treatment and support services and help maintain services and supports already in place.
- Supported housing services
- Supported employment services
- Core services provided through core providers
  - Physician Assessment & Care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

A COMPREHENSIVE SUICIDE PREVENTION INITIATIVE FOR GEORGIA'S MENTAL HEALTH PROVIDERS

"AIM" Assessment, Intervention and Monitoring

Georgia DBHDD Implementation Plan

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



New York State Suicide Prevention Initiative

Revolutionizing Policy and Care

- Eval of recent suicides all same picture: *No good risk assessment, no safety plan, no warm hand-off*
- Comprehensive systems approach to suicide prevention
- Organizational vision of zero suicides
- All Adult and Youth Behavioral Health Care organizations statewide
- *All patients* screened using C-SSRS
- C-SSRS and Safety Planning online learning modules to be used in training all staff

Top-Down Efforts

New Jersey Youth

Traumatic Loss Coalitions for Youth Program

- K-12 schools
- Social service agencies
- Juvenile justice facilities
- Religious organizations
- Military facilities
- Primary care offices
- Colleges and universities across the state

Tennessee

Policy of DOMH to use in all divisions and contract vendors

- K-12 schools
- Colleges, & Universities
- Indian Health Services
- Legal facilities
- Hospitals
- TN Suicide Prevention Network
- Managed Care (statewide)
- State Crisis Assessment Tool
- Catholic Charities
- Military facilities

County-Wide Dissemination

One Example: Lapeer County, Michigan

"Complete Top-Down Dissemination"

- Court workers
- Mental health workers
- K-12 school staff: teachers, bus drivers, cafeteria workers, etc.
- Clergy
- Law enforcement
- ER staff
- Child welfare workers
- Police Officers, Sheriff, Road Patrol, Village & State Troopers

In rural communities blanket coverage becomes even more critical for public health

Need to expand and systematize suicide screening efforts
Implement via EMTs, first responders
Telemedicine; (e.g. virtual check-ups, eC-SSRS)

National Council Magazine

"Ultimately, the C-SSRS serves as an effective mobile crisis tool which gets to the right people at the right time and right place and helps to save lives and save public dollars."

Kelly Posner, PhD, Director, Center for Suicide Risk Assessment, Columbia University/New York State Psychiatric Institute

Based on an interview with Meena Dayak for National Council Magazine

What if suicide screening was as easy as checking your blood pressure? And what if it could be done by anyone, anywhere?

A universal, easily accessed and administered tool to screen for suicidal risk, the Columbia-Suicide Severity Rating Scale has been proven to predict suicidal behavior and suicide attempts. The tool includes resources to connect people at risk to professional help. The C-SSRS was developed by a team of researchers from Columbia University, the University of Pennsylvania, and the University of Pittsburgh with support from the National Institute for Mental Health and the American Foundation for Suicide Prevention.

The lack of a scientifically validated tool to assess suicidal behavior and suicide risk has been a major obstacle to lower the nation's suicide rate in all age groups. The Institute of Medicine noted in 2002 the lack of definitions and standardization as one of the major impediments to suicide prevention. Subsequently, the Food and Drug Administration requested a standardized assessment tool for suicidal behavior and selected Columbia Psychiatry researchers to lead that initiative.

Prevention depends upon appropriate screening and identification. It's about saving lives and directing limited resources to the people who actually need them.

"Having a proven method to assess suicide risk is a huge step forward in our efforts to save lives," said Office of Mental Health Commissioner Michael Hogan. "Dr. Posner and her colleagues have established the validity of The Columbia-Suicide Severity Rating Scale (C-SSRS). This is a critical step in putting this tool in the hands of healthcare providers and others in a position to take steps for safety. We congratulate them on their efforts."

The screening methods developed through C-SSRS been recommended or mandated across numerous areas of medicine.

HOW IT WORKS

The C-SSRS has shown successful suicide attempt prediction not only in suicidal adolescents, but in non-suicidal adults as well. In the past, typical screening has only identified suicide attempts, omitting some of the most important behaviors that are critical for risk assessment and suicide prevention (e.g. collecting pills, buying a gun). The C-SSRS is the only evidence-based screening tool that assesses the full range of clinically important ideation and behavior, with criteria for next steps – such as referral to mental health. In turn, it streamlines triage and facilitates care delivery to those at highest risk.

The C-SSRS questionnaire asks people whether they have ever wished they were dead or had thoughts of killing themselves. If they say no, that's that. But if they say yes, the test takes them further, asking if they had ever thought about how they might do it, and then probing for details.

The test uses an algorithm, taking the interviewer and the subject along a decision tree until a patient's risk level can be determined.

In a study, the results of which were published in *The American Journal of Psychiatry* in November 2011, Columbia Psychiatry researchers compared the effectiveness of several questionnaires used to assess more than 500 patients. One group was adolescents who had already attempted suicide, the next was a pharmaceutical study of depressed teenagers getting a new medication, and the third was a study of adults who came to an emergency department in mental distress. There was a 24-week follow up to track patients. The C-SSRS demonstrated the unique ability to predict suicide attempts.

In a study utilizing a self-report phone version of the C-SSRS, approximately 35,000 administrations have provided initial evidence that every type of behavior and ideation assessed on the C-SSRS is predictive of future suicidal behaviors. This research has confirmed the notion that every piece of information gathered on the C-SSRS is imperative in quantifying a patient's level of risk.

The test has already been in use a few million times and has been translated into more than 100 languages.

THE TENNESSEAN
A GANNETT COMPANY

Hope at last to break suicide's silence

March 25, 2012

Kelly Posner, Ph.D., principal investigator for Columbia's Center for Suicide Risk Assessment, earlier this month brought this information to Middle Tennessee, in a meeting of health professionals at Nashville's Oasis Center for troubled teens, and a separate briefing with authorities at Fort Campbell."

Other methods that use imprecise terminology and have variable concepts of what constitutes suicidal behavior… **often hinder communication about an individual that could prevent suicide."**

The new system is gradually being implemented by the **Army, Navy, Air Force and National Guard; by police and fire departments; drug and alcohol addiction centers; and public schools and colleges.**

Commentary on Article:

- **"**A leading cause of death"? I have my doubts about that assertion." **"**Maybe in some third-world, oppressed countries - or among some teenagers, but certainly not in the US."
- **"**Hope at last to break suicide's silence. I was not aware there was any." -Retired Mental Health Editor
- *"Suicide is very much preventable. I applaud the development of an instrument to help identify those in need of help…"*

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

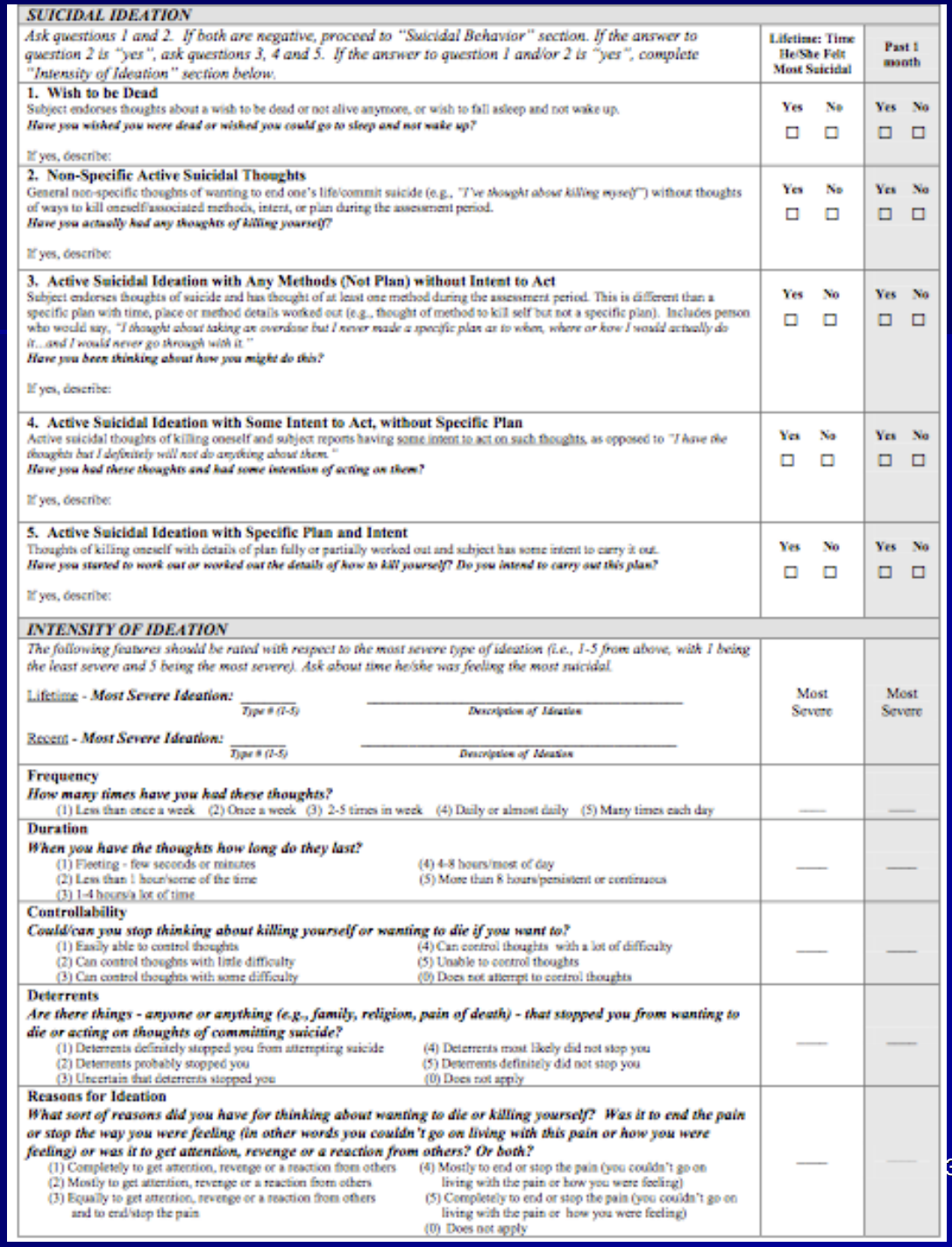
- *Have you wished you were dead or wished you could go to sleep and not wake up?*
- *Have you actually had any thoughts of killing yourself?*

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

This is the Full C-SSRS

Typical Administration Time = Few Minutes



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		Past 1 month	
	Yes	No	Yes	No
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:	☐	☐	☐	☐
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 during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	☐	☐	☐	☐
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:	☐	☐	☐	☐
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:	☐	☐	☐	☐
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:	☐	☐	☐	☐

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). Ask about time he/she was feeling the most suicidal.

	Most Severe	Most Severe
Lifetime - ***Most Severe Ideation:*** _____ *Type # (1-5)* _____ *Description of Ideation*		
Recent - ***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 (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 (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 committing 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	____	____

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

Research Supported Items

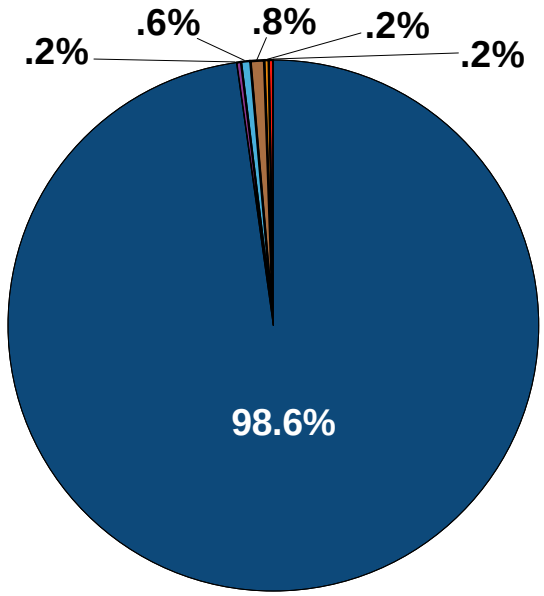
- **Preparatory Behavior**
  - Those with recent preparatory behavior (e.g., collecting pills, razors, or loaded weapon) **8-10x** more likely to die by suicide (Brown & Beck, unpublished)
- **Interrupted Suicide Attempts**
  - **3x** more likely to die by suicide (Steer, Beck & Lester, 1988)
- **Aborted Suicide Attempts**
  - Subjects who made aborted attempts **2x** as likely to have made a suicide attempt (Barber et al., 1998)

eC-SSRS…Depressed Subjects… *ALL* Behaviors Are Prevalent and Predictive

Each behavior is EQUALLY PREDICTIVE to an attempt

- No Behavior: 28,303
- **Actual Attempt: 70**
- Interrupted Attempt: 178
- Aborted Attempt: 223
- Preparatory Behavior: 71

n = 28,699 administrations



Multiple behaviors = greater risk

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

472 Interrupted, Aborted and Preparatory (87%)
vs. 70 Actual Attempts (13%) *Mundt et al., 2011*

Data Supports Importance of Full Range:
Lifetime Different Suicidal Behaviors Predict Suicidal Behavior

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)***

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

Total Number of Behaviors Matters!

Number of Different Lifetime Suicidal Behaviors Predict Suicidal Behavior

	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)***

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

C-SSRS Suicidal Behavior Subscale

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
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/desire 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) If yes, describe:	Yes ☐ No ☐ Total # of Attempts _____	Yes ☐ No ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	Yes ☐ No ☐	Yes ☐ No ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***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?*** If yes, describe:	Yes ☐ No ☐ Total # of interrupted _____	Yes ☐ No ☐ Total # of interrupted _____
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 attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	Yes ☐ No ☐ Total # of aborted or self-interrupted _____	Yes ☐ No ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***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)?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
Suicidal Behavior: Suicidal behavior was present during the assessment period?	Yes ☐ No ☐	Yes ☐ No ☐

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
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	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
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	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

This is the C-SSRS Screener

Combined Behaviors Question →

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?		

… systematically assessing using the C-SSRS decreases burden

Decreases False Positives and False Negatives

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

---

C-SSRS reduces false positives and avoids false negatives

Hospital Screening: Cleveland Clinic

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 eg. Cases were missed

C-SSRS Findings: Obesity Patients

Comparison of Retrospective and Prospective Data

	Retrospective	Prospective C-SSRS
Trial Phase [2]	Double-blind	Extension
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

Impact on Care Delivery and Service Utilization…

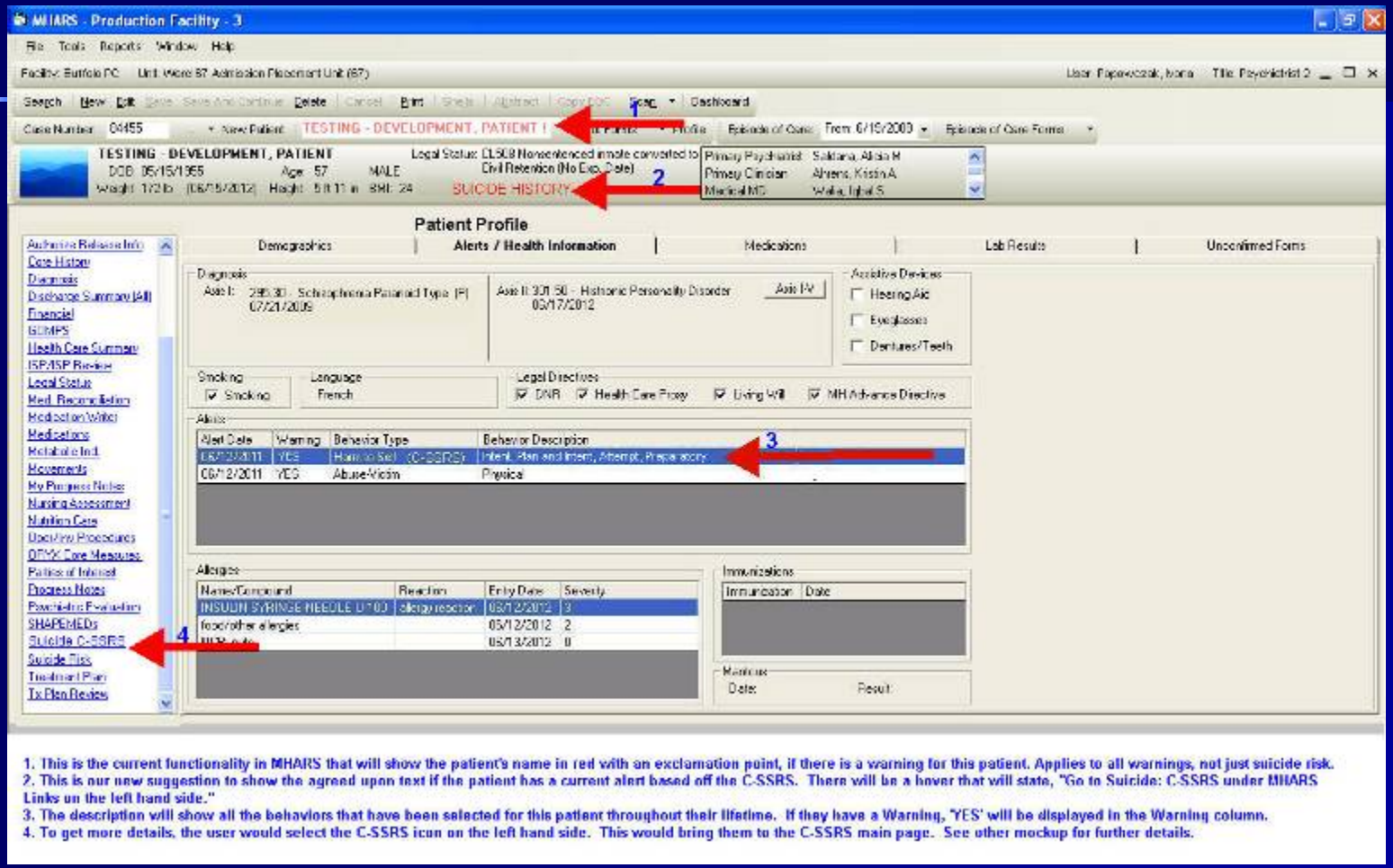
Advantages….Operationalized Criteria for Next Steps

- Allows for setting parameters for triggering next steps whatever they may be
  - 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 **any answer and intervene…*

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 Alert and Monitoring System

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

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?).

Thresholds facilitate identification of those at highest, triage, and care delivery

4/5 → Psych consult

3 → Consult to Care team

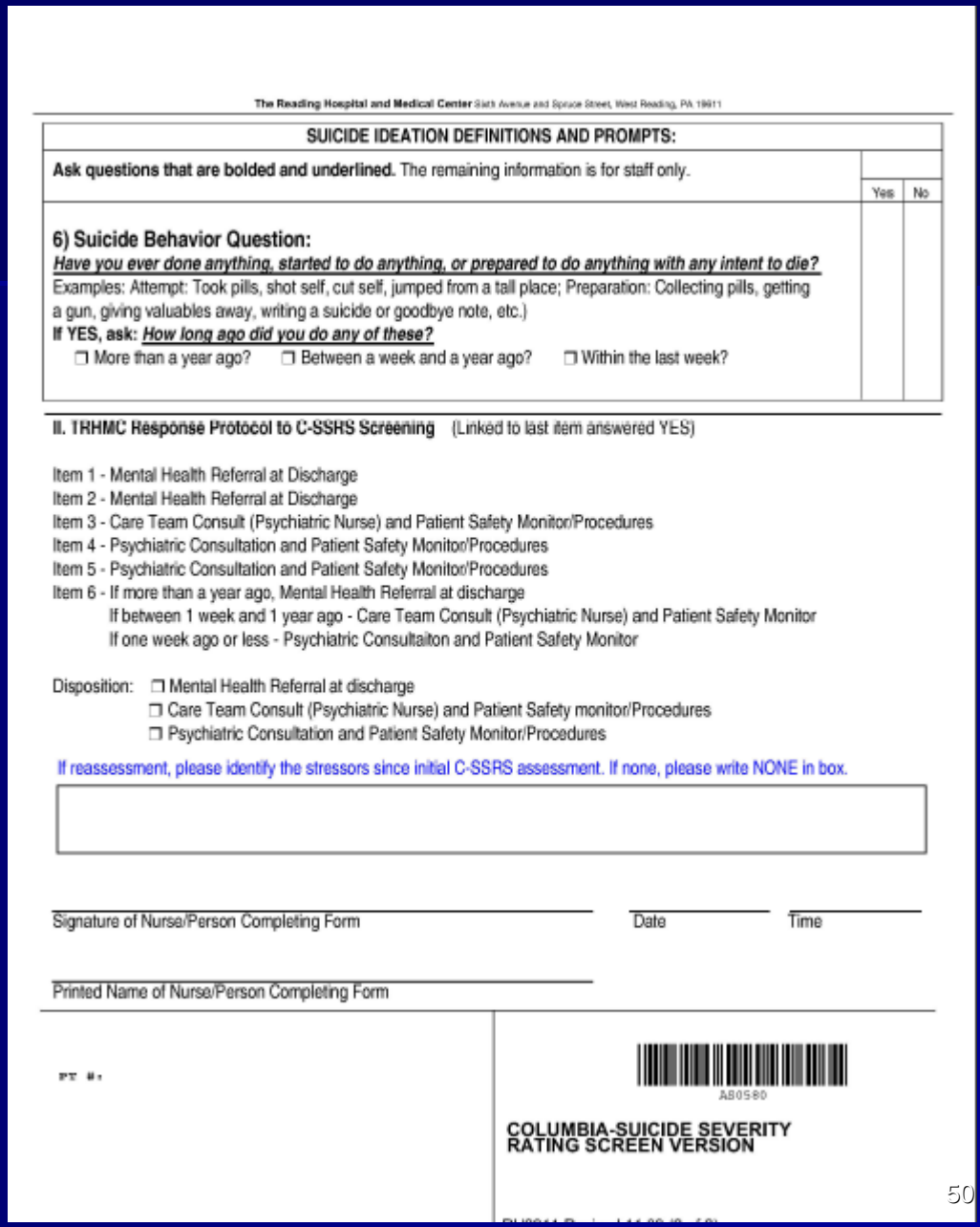
Example: Streamlining Care in Hospital Policies

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)

Screening 2012 with Triage Points (Reading Hospital)



The Reading Hospital and Medical Center Sixth Avenue and Spruce Street, West Reading, PA 19611

SUICIDE IDEATION DEFINITIONS AND PROMPTS:

Ask questions that are bolded and underlined. The remaining information is for staff only.

	Yes	No
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything with any intent to die?*** Examples: Attempt: Took pills, shot self, cut self, jumped from a tall place; Preparation: Collecting pills, getting a gun, giving valuables away, writing a suicide or goodbye note, etc.) **If YES, ask:** ***How long ago did you do any of these?*** ❒ More than a year ago? ❒ Between a week and a year ago? ❒ Within the last week?		

II. TRHMC Response Protocol to C-SSRS Screening (Linked to last item answered YES)

Item 1 - Mental Health Referral at Discharge
Item 2 - Mental Health Referral at Discharge
Item 3 - Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor/Procedures
Item 4 - Psychiatric Consultation and Patient Safety Monitor/Procedures
Item 5 - Psychiatric Consultation and Patient Safety Monitor/Procedures
Item 6 - If more than a year ago, Mental Health Referral at discharge
If between 1 week and 1 year ago - Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor
If one week ago or less - Psychiatric Consultaiton and Patient Safety Monitor

Disposition: ❒ Mental Health Referral at discharge
❒ Care Team Consult (Psychiatric Nurse) and Patient Safety monitor/Procedures
❒ Psychiatric Consultation and Patient Safety Monitor/Procedures

If reassessment, please identify the stressors since initial C-SSRS assessment. If none, please write NONE in box.

Signature of Nurse/Person Completing Form Date Time

Printed Name of Nurse/Person Completing Form

PT #:

AB0580

COLUMBIA-SUICIDE SEVERITY RATING SCREEN VERSION

Streamlining Identification, Triage & Care Delivery in the Military

Fort Carson

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version with Triage Patients—3-step form

II. EACH Response Protocol to C-SSRS Screening

Suicide Ideation Level

LEVEL	SEVERITY	MANAGEMENT PROTOCOL
0	Low risk	ROUTINE Behavioral Health Referral at physician discretion
1 & 2	Mild	ROUTINE Behavioral Health Referral at discharge
3	Moderate	Review by Care Team- Consider safety precautions and telephone consult with Behavioral Health
4 & 5	Serious	EMERGENT ACTION NECESSARY: Behavioral Health Consultation and Patient Safety Monitor/ Procedures

Suicide Behavior History

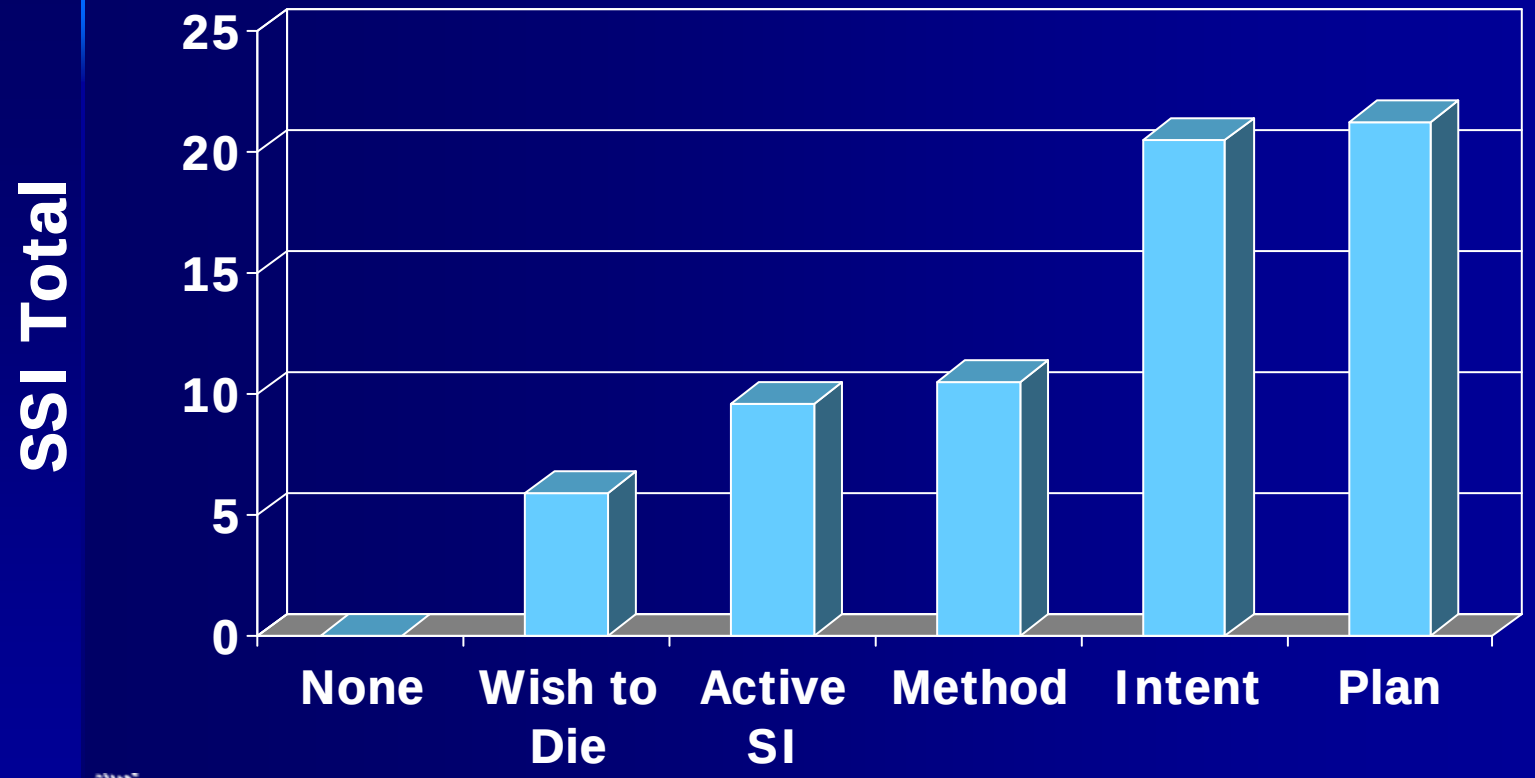
	MANAGEMENT PROTOCOL
1 week ago and less	ACUTE: Behavioral Health Consultation and Patient Safety precautions
Between 1 week and 3 months ago	CONCERN: Care Team Review, safety precautions and telephone consultation with Behavioral Health
Over 3 months ago	DISCRETIONARY: Consider Behavioral Health Referral at discharge

III. REFERENCE ONLY: SUICIDE IDEATION DEFINITIONS AND PROMPTS

Note: Wording may be adjusted for children and young adolescents

1	**Ideation I Wish to be Dead:**	***Have you wished you were dead or wished you could go to sleep and not wake up?*** Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up?
2	**Ideation II Suicidal Thoughts:**	***Have you had any actual thoughts of killing yourself?*** 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.*"
3	**Suicidal Thoughts with Method** *(without Specific Plan or Intent to Act):*	***Have you been thinking about how you might kill yourself?*** 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.*"
4	**Suicidal Intent I** *(without Specific Plan):*	***Have you had these thoughts and had some intention of acting on them?*** 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.*"
5	**Suicide Intent II** *(with Specific Plan)*	***Have you started to work out or worked out the details of how to kill yourself?*** Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.

SSI Total Score by Highest Level of Ideation on the C-SSRS



American Foundation for Suicide Prevention

$F(5,185) = 14.35$, $p<0.001$

Currier, Brown & Stanley (2009)

Data Confirmation... 4 and 5 Predicts Attempts in National Attempter Study

(Posner et al., *AJP* December 2011)

- C-SSRS Lifetime Ideation, types 4 and 5, predicted suicide attempts in adolescent suicide attempters, followed over a year
  - **Beck SSI NOT predictive**
- C-SSRS Lifetime Ideation, types 4 and 5, predicted actual, interrupted or aborted attempts on CSHF

Prediction in Non-Suicidal Adults and Adolescents

- Confirmed By eC-SSRS data: 35,007 (3776 subjects) across depression, epilepsy, insomnia, fibromyalgia
  - Patients with baseline prior ideation of 4 or 5 or prior behavior are 4-5x more likely to report suicidal behavior at follow up
  - Patients with both are 9x more likely to report suicidal behavior
- Prediction in adolescent emergency department follow-up study (King et al)
  - Duration predictive
  - Attempt and lifetime attempt not predictive, reinforcing ideation assessment
  - NSSI not predictive

Decreased Unnecessary Intervention & Getting Care to Those Who Need It

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

Presented by: Debra Haas Stawarski, 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 Stawarski, 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

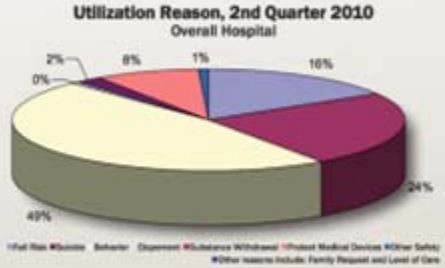
NURSE INTER-RATER RELIABILITY

Intra-rater Reliability Broken Down by Experience

Two-Way Random Intra-Rater Reliability

	No. Raters	Consistency: Single Measure	Consistency: Average Measure	Absolute Agreement: Single Measure	Absolute Agreement: Average Measure	Cronbach's Alpha
Experience Unknown	32	0.843	0.963	0.833	0.962	0.963
Experience 0 to 10 years	408	0.808	0.944	0.807	0.944	0.945
Experience 11 years and above	313	0.818	0.948	0.817	0.948	0.948
Experience 0 to 20 years	862	0.874	0.966	0.873	0.966	0.966
Experience 21 years and above	319	0.845	0.957	0.843	0.951	0.956

PATIENT SAFETY MONITOR UTILIZATION



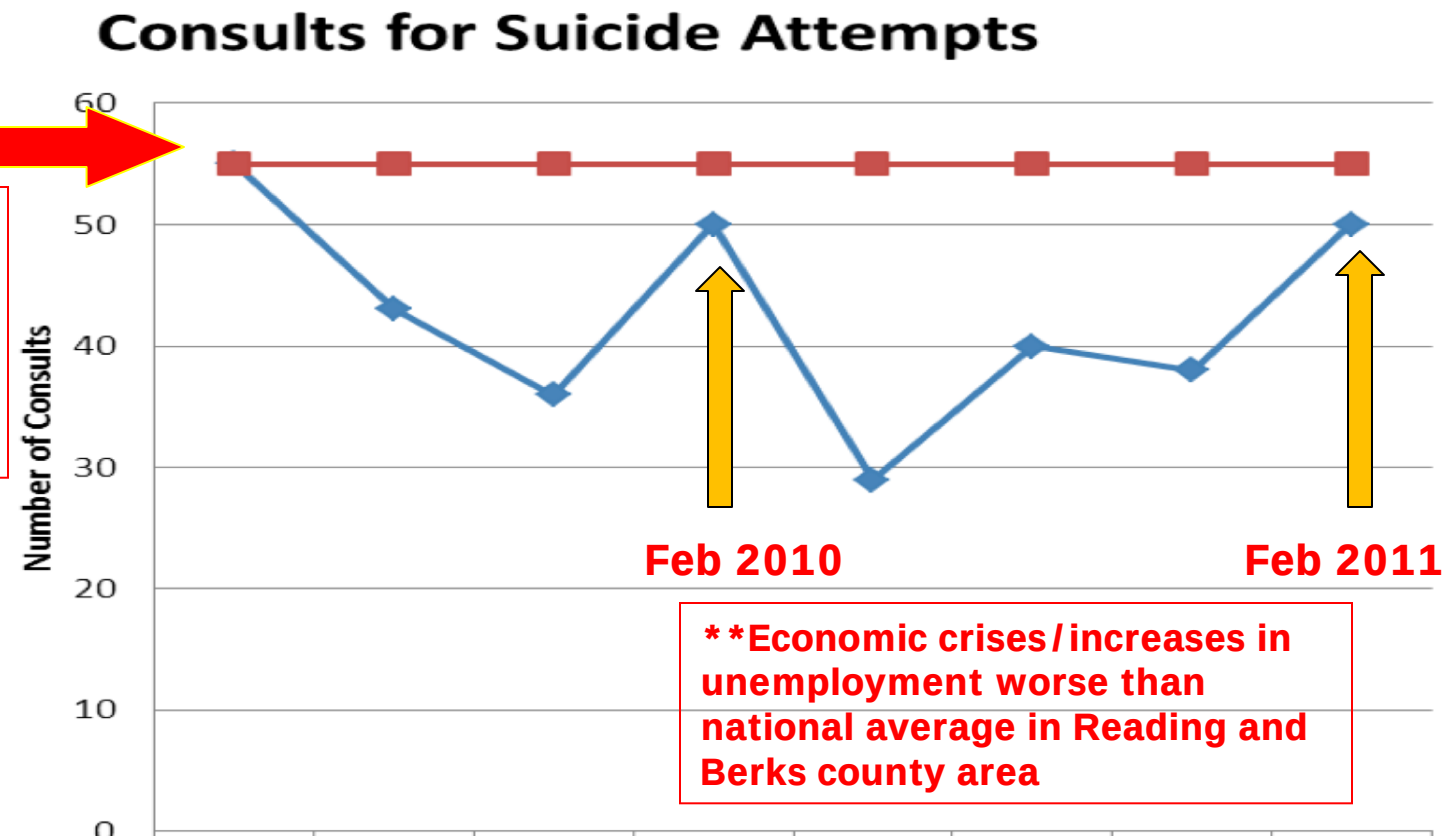
IMPLICATIONS FOR PRACTICE

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.

The Reading Hospital and Medical Center
www.readinghospital.org

Psychiatric Consultations for Suicide Attempts

July, 2009 to June, 2011 (Reading Hospital)



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

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

	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

Rhode Island Senate Commission Hearing Report for State Wide Implementation:

Recommendation:

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

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

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.**

Tennessee School (2 weeks post-training): "Their use of the C-SSRS may have already saved a life"

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)

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)

Examples...

- A loved one accompanies a family member to their MD. The patient denies suicidal thoughts, but the family member shares that the he has been talking about suicide for the past two weeks and wrote a note yesterday

- A friend of a student comes to your office and reports that the student posted on Facebook that he has been feeling like he wants to die

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

Inferring Intent

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.)

Suicidal Behavior

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	Since Last Visit
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/desire 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.	Yes ☐ No ☑
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_____?***	Total # of Attempts _____
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) If yes, describe:	
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	Yes ☑ No ☐

May help to infer intent

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

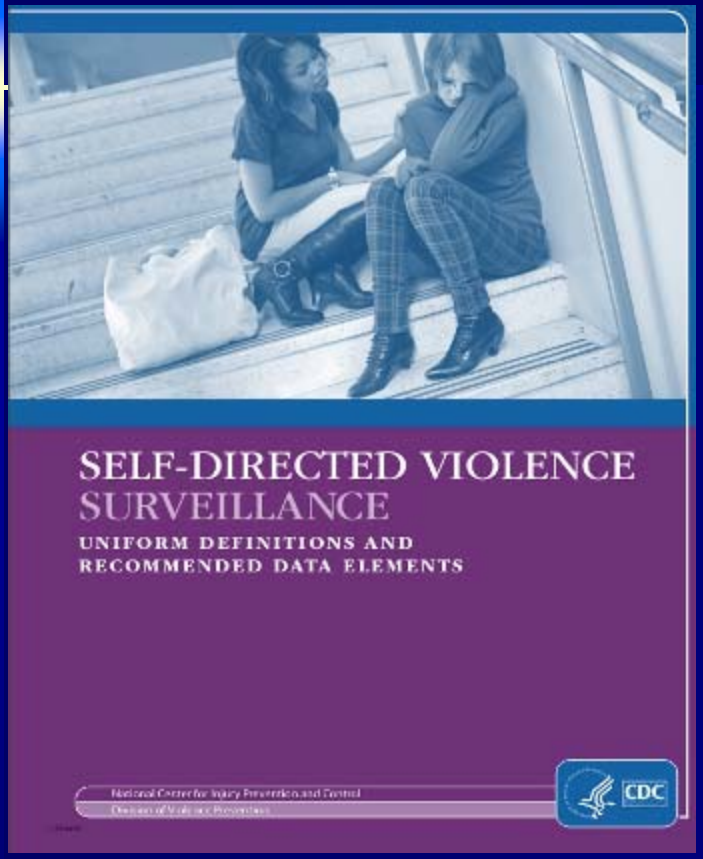
Suicide Attempt? Yes or No

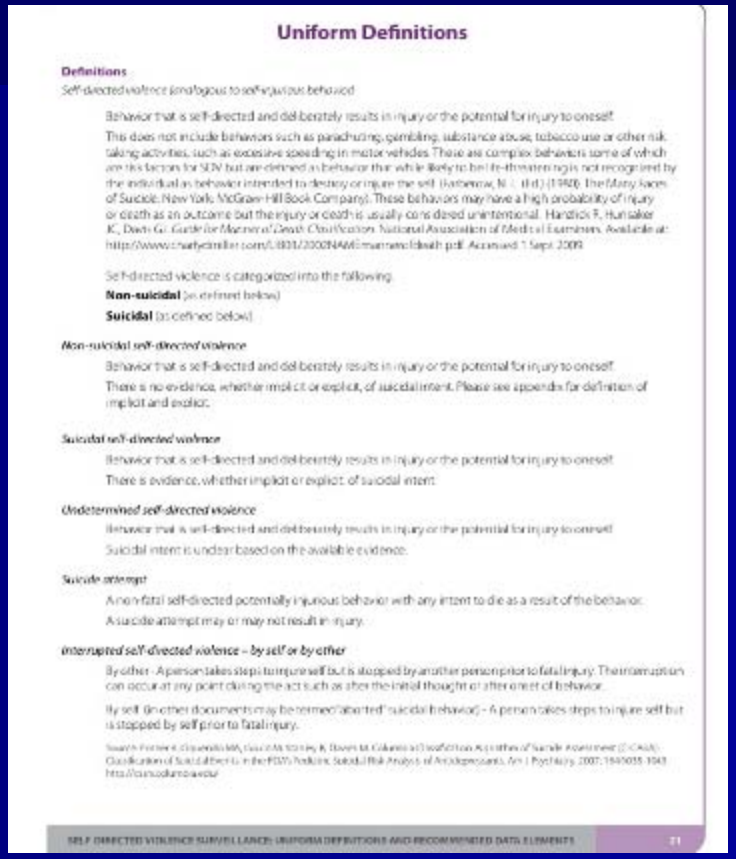
The patient wanted to escape from her mother's home. She researched lethal doses of ibuprofen. She took 6 ibuprofen pills and said she felt certain from her research that this amount was not enough to kill her. She stated she did not want to die, only to escape from her mother's home. She was taken to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

1. Yes
2. No
3. Not enough information

CDC Self-Directed Violence: Uniform Definitions Adopted Columbia Definitions

(link to C-SSRS in CDC document)





Uniform Definitions

Definitions

Self-directed violence (analogous to self-injurious behavior)

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

This does not include behaviors such as parachuting, gambling, substance abuse, tobacco use or other risk-taking activities, such as excessive speeding in motor vehicles. These are complex behaviors some of which are risk factors for SDV but are defined as behavior that while likely to be life-threatening is not recognized by the individual as behavior intended to destroy or injure the self. (Lawrence, M. C. et al.) (1920). The Many Faces of Suicide. New York: McGraw-Hill Book Company). These behaviors may have a high probability of injury or death as an outcome but the injury or death is usually considered unintentional. Hanzlick R, Hunsaker JC, Davis GJ. Guide for Manners of Death Classification. National Association of Medical Examiners. Available at: http://www.charleymiller.com/L/831/20080NAME/manners/death.pdf. Accessed 1 Sept. 2009.

Self-directed violence is categorized into the following:

Non-suicidal (as defined below)

Suicidal (as defined below)

Non-suicidal self-directed violence

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

There is no evidence, whether implicit or explicit, of suicidal intent. Please see appendix for definition of implicit and explicit.

Suicidal self-directed violence

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

There is evidence, whether implicit or explicit, of suicidal intent.

Undetermined self-directed violence

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

Suicidal intent is undetermined based on the available evidence.

Suicide attempt

A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior.

A suicide attempt may or may not result in injury.

Interrupted self-directed violence – by self or by other

By other - A person takes steps to injure self but is stopped by another person prior to fatal injury. The interruption can occur at any point during the act such as after the initial thought or after onset of behavior.

By self (In other documents may be termed "aborted" suicidal behavior) - A person takes steps to injure self but is stopped by self prior to fatal injury.

Source: Posner K, Oquendo MA, Gould M, Stanley B, Davies M. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of Antidepressants. Am J Psychiatry. 2007; 164:1035-1043. http://cssrs.columbia.edu/

SELF-DIRECTED VIOLENCE SURVEILLANCE: UNIFORM DEFINITIONS AND RECOMMENDED DATA ELEMENTS 21

Also from CDC:
Glossary items of "unacceptable terms"

- Completed suicide
- Failed attempt
- Parasuicide
- Successful suicide
- Suicidality
- Nonfatal suicide
- *Suicide gesture*
- Manipulative act
- *Suicide threat*
- Committed Suicide *

Only appropriate terms are *Attempt Suicide* and *Died by Suicide*

* Not in CDC document

Optimal Timeframes to Assess

- 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)
- Recent
  - For Ideation: During the past month
  - For Behavior: During the past 3 months

C-SSRS: Lifetime / Recent

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		Past 1 month	
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 ☐	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 during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐	No ☐	Yes ☐	No ☐

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	Lifetime		Past 3 months	
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/desire 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_____?***	Yes ☐	No ☐	Yes ☐	No ☐
	Total # of Attempts _____		Total # of Attempts _____	
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) If yes, describe:	Yes ☐	No ☐	Yes ☐	No ☐
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	Yes ☐	No ☐	Yes ☐	No ☐

Follow-up: Since Last Visit

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***
  - Remember, can be just 3 questions

SUICIDAL IDEATION	Since Last Visit
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.	
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 during the assessment period. *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 ☐

Who can we use the C-SSRS with?

Age: the C-SSRS is suitable across the lifespan for use with adults, adolescents, and young children.

Special Populations: indicated for cognitively impaired (e.g. Alzheimer's, Autism)

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)

Gatekeepers and more…

Military Example:
National Guard
- **Clergy**
- **Fellow soldiers**
- **Commanding officers**
- **Primary care**

- **Hindu Temple Example:**
- **Priests**
- **Grandparents**
- **High School Students**

Innovative Delivery:

Implementation by First Responders / Gatekeepers

Examples of utilization:

- Laminated cards
- Metal key chains
- Apps on phone
- Portable printers in EMT

By healthcare professionals:

-Electronic records
-Piece of paper in a chart
-Phone kiosks

Have the Courage to Help a Buddy

Have you or someone you know:

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

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

One Suicide is one too many.

For assistance:

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

DPH, Michelle Hammond-Susten: 770-846-2891
Chaplain: _____
SIO: _____

Don't wait, call them now.

Suicide Prevention Resources

USAPHC

U.S. Army Public Health Command
phc.amedd.army.mil

Good Acceptance in Practice by Providers and Patients

- **Good Acceptance in Practice**:
  - 1,000 sites across the country (nurses, coordinators, physicians) – overwhelming majority said “easy to incorporate”, “has improved safety”, “is beneficial”
  - Patient Satisfaction Study at Cleveland Clinic:
    - 80% felt electronic tablet was easy to use
    - 98% did not think suicide screening increased thoughts of suicide
    - 45% found that using tablet made reporting sensitive topics easier

The C-SSRS can be tailored for Population Specific Data Collection

Pediatric C-SSRS / Cognitively Impaired

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**
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/desire 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. ***Did you ever do anything to try to kill yourself or make yourself not alive anymore? What did you do?*** ***Did you ever hurt yourself on purpose? Why did you do that?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to make yourself not alive anymore when you _____?*** ***Or did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, o get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe: **Has subject engaged in Non-Suicidal Self-Injurious Behavior?** **Has subject engaged in Self-Injurious Behavior, intent unknown?**	Yes ☐ No ☐ Total # of Attempts _____ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?*** If yes, describe:	Yes ☐ No ☐ Total # of interrupted _____
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 attempts, except that the individual stops him/herself, 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 you changed your mind (stopped yourself) before you actually did anything? What did you do?*** If yes, describe:	Yes ☐ No ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***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?*** If yes, describe:	Yes ☐ No ☐
Suicidal Behavior: Suicidal behavior was present during the assessment period?	Yes ☐ No ☐

Suicide Cluster - Schenectady County

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**		**Recent**		**Situation/ Stressor***	
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 ☐	Yes ☐	No ☐	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 during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐	No ☐	Yes ☐	No ☐	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 ☐	Yes ☐	No ☐	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".*	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

Military Version

Tailored for Population Specific Data Collection

Additional Questions	
Legal Troubles *Are you currently facing any legal troubles?* *Within military structure or outside *If yes, how have these circumstances impacted you/your family?* Additional Information:	Yes ☐ No ☐
Financial Troubles *Are you experiencing any financial troubles?* If yes: *Do these concerns feel overwhelming or unmanageable?* *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?* *Is this financial stress or hardship the worst crisis you have ever experienced?*	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
State of Service (pre-deployment, post-deployment, etc) Pre-deployment ___ Post-deployment ___ Multiple deployments ___ *Are the thoughts/behaviors we talked about related to your _____?* (e.g., pending deployment)	Yes ☐ No ☐
Marital or Relationship Stress *Are you having any marital or relationship stress or problems?* *Ask about domestic violence.	Yes ☐ No ☐
Drug or Alcohol Use *Do you use drugs or alcohol?* *Do you have a history of drug or alcohol abuse?* Additional Information:	Yes ☐ No ☐ Yes ☐ No ☐
Pain *Are you experiencing pain – chronic or intermittent?* Additional Information:	Yes ☐ No ☐

Child and Family Assistance Center
(CAFAC Version)

Developed and implemented at Fort Carson, Colorado

Military Family Member Version C-SSRS Suicide Risk Assessment

	Yes	No
1. Legal Troubles ***Are you, or is anyone in the family, facing any legal troubles (military or civilian)?*** ***If yes, how have these circumstances impacted you/your family?***		
2. Financial Troubles ***Are you or your immediate family members experiencing any financial troubles?*** ***Do these concerns feel overwhelming or unmanageable?*** ***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 or anyone in the family experienced this?*** ***Is this financial stress or hardship the worst crisis you, or your family, have ever experienced?***		
3. State of Service (Deployment Cycle) Service Member is: ___deployed ___predeployment (within 3 months) ___postdeployment (within 3 months) ___Other ___# of deployments ***Are the thoughts/behaviors we talked about related to SM's deployment?***		

C-SSRS Suicide Risk Assessment Version (Excerpt)

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.

	Suicidal and Self-Injurious Behavior (Past 3 months)		**Clinical Status (Recent)**
☐	Actual suicide attempt ☐ Lifetime	☐	Hopelessness
☐	Interrupted attempt ☐ Lifetime	☐	Major depressive episode
☐	Aborted or Self-Interrupted attempt ☐ Lifetime	☐	Mixed affective episode
☐	Other preparatory acts to kill self ☐ Lifetime	☐	Command hallucinations to hurt self
☐	Self-injurious behavior without suicidal intent ☐ Lifetime	☐	Highly impulsive behavior
	Suicidal Ideation (Most Severe in Past Month)	☐	Substance abuse or dependence
☐	Wish to be dead	☐	Agitation or severe anxiety
☐	Suicidal thoughts	☐	Perceived burden on family or others
☐	Suicidal thoughts with method (but without specific plan or intent to act)	☐	Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
☐	Suicidal intent (without specific plan)	☐	Homicidal ideation
☐	Suicidal intent with specific plan	☐	Aggressive behavior towards others
	Activating Events (Recent)	☐	Method for suicide available (gun, pills, etc.)
☐	Recent loss or other significant negative event	☐	Refuses or feels unable to agree to safety plan
	Describe:	☐	Sexual abuse (lifetime)
		☐	Family history of suicide (lifetime)
☐	Pending incarceration or homelessness		**Protective Factors (Recent)**
☐	Current or pending isolation or feeling alone	☐	Identifies reasons for living
	Treatment History	☐	Responsibility to family or others; living with family
☐	Previous psychiatric diagnoses and treatments	☐	Supportive social network or family
☐	Hopeless or dissatisfied with treatment	☐	Fear of death or dying due to pain and suffering
☐	Noncompliant with treatment	☐	Belief that suicide is immoral; high spirituality
☐	Not receiving treatment	☐	Engaged in work or school
	Other Risk Factors:		**Other Protective Factors:**
☐		☐	

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

A word about screening… also critical to prevention

- Primary Care: Opportunity for Prevention
  - Majority of suicides see their doctor prior to their death
    - 45% in the month prior to their death
    - 80% in the year prior
  - Excellent opportunity for prevention!
  - A significant proportion of adolescent attempters in the ER did not present for psychiatric reasons

NEED TO SCREEN!

Screening Programs are Successful!!

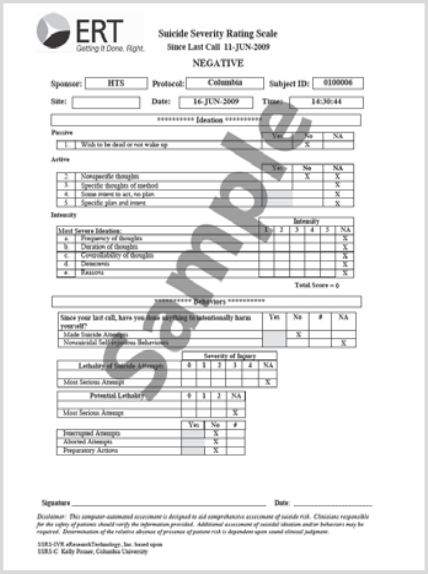
- High-school screening programs associated with 2x in detection of at-risk individuals (Scott et al., 2004)
- Meta-analysis concluded that **screening results in lower suicide rates in adults** (Mann et al., JAMA 2006)
- Columbia Teen-Screen demonstrated 88% sensitivity and 76% specificity
- College 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)
- Adult primary care screenings - **47% increase in rates of detection and diagnosis of depression**

Where Can Screening Occur?

- **School-wide screening** – e.g. before entry to school (prior attempt is #1 risk factor)
  - Use of systematic screening enables schools to identify those at-risk for future suicidal behavior BEFORE the behavior occurs, thus decreasing liability.
- **Targeted screening** - students identified as at-risk
- **Screening within specific settings** – student health center, counseling center
- **Gatekeeper training** – faculty, coaches, cafeteria workers, bus drivers, administrators
- **Peer to Peer** – Students can be taught the questions to ask their friends

The eC-SSRS – A Critical Piece of an Optimal Prevention Plan

Patient contacts the system



Findings Report to Site - Immediately

If Positive

ERT Customer Service Calls the Site

Site follows up per protocol

Site uses report in review with patient

If Negative

Site Review

eC-SSRS Benefits and Uses

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

- Reliability
- Coordinated data – like pilot, surgeon and anesthesiologist *checklists*
- Cleaned, locked database
- Increased Patient Candor
- Immediate suicide risk notification
- Computers and clinicians are complementary
- Reduced site burden
- Scalability

- NY – Post Discharge
  - Most at-risk time
  - Can call from home
- NJ – Youth in Schools
  - Summertime vulnerability
  - Reduced burden on school personnel
- Veteran's Administration Hospital

Why it's good to do one thing… Science and the Public Health Demand Uniformity

(Gibbons, NCDEU 2010)

- Moving away from a single instrument inherently degrades the precision of the signal
- The impact of imprecision ***grows when incidence rates are low***
- Multiple measures increase noise, decrease precision and weaken rigor of epidemiological and research data

"It should be noted that the use of different instruments is likely to increase measurement variability…decreasing the opportunity to identify potential signals in future meta-analyses…this type of imprecision is particularly problematic in dealing with events that have a low incidence, as is the case for suicidal ideation and behavior occurring in clinical trials." –2012 FDA Guidance

Finally. . . . .

Some Answers...?

Centralized Data Repository

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/