Separating the Wheat from the Chaff:

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

Administration Training

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

- Every 15 minutes someone dies by suicide in the U.S.
- 2nd leading cause of death: *children 10-16*
  - Bully victims 2-9x more likely to consider suicide
- 3rd leading cause of death: *adolescents*
- *10% of High School students attempt suicide each year*
- 4th leading cause of death: *adults*
- #1 cause of injury mortality in U.S.; more people die by suicide than motor vehicle crashes
- Majority of suicide decedents see their doctor prior to their death
  - 45% in the month prior to their death; excellent opportunity for prevention
- 1st or 2nd leading cause of death in *law enforcement officers*
  - In 2011, nearly 3x as many policepersons died by suicide as were killed in the line of duty
- Most common cause of death in *incarcerated persons*
  - Suicide rates 3x general population
  - ~60% of inmate suicides have no psychiatric illness & no clear warning signs

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

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

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
  - Systems all throughout Tennessee/Integrated with Mobile Crisis Teams
- International Mission Organizations
- Drug and Alcohol Addiction Centers
- National Institute on Alcohol Abuse and Alcoholism: NIAAA
- Commissioned by VA to do online training for clinical trials
- Center of Excellence for Research on Returning War Veterans
- Fire Departments
- Police Departments
- Judges/legal/police – to help reduce unnecessary hospitalization
- Primary care
- Worker's Compensation Administration
- Surveillance Efforts; CDC Definitions are Columbia Definitions
- Prisons / juvenile justice
- Suicide Section of **SCID**
- Clinical Practice, nationally and internationally
- Crisis negotiation teams
- Schools (Middle Schools, High Schools, and College Campuses)
- Homeless populations
- Claims/HMOs
- Clergy (ex: Hindu priests and priestesses)
- EAPs

Counties…States…Countries

Linking Systems

Inpt → Bridge → Outpt

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

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

State-Wide Dissemination of C-SSRS

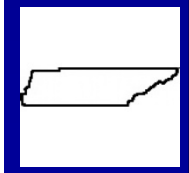
Some examples…

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

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

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

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



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

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

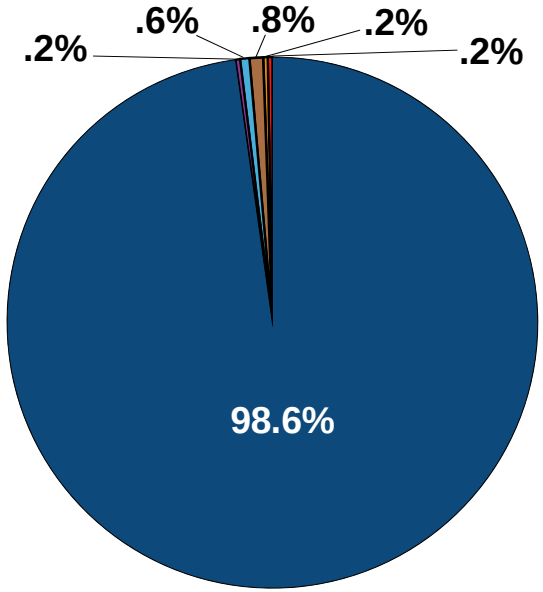
- Relevant behaviors assessed in one additional question
- All items include definitions for each term and standardized questions for each category are included to guide the interviewer for facilitating improved identification

Research Supported Items

- **Preparatory Behavior**
  - Those with recent preparatory behavior (e.g., collecting pills, razors, or loaded weapon) **8x** 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

n = 28,699 administrations



No Behavior: 28,303

Actual Attempt: 70

Interrupted Attempt: 178

Aborted Attempt: 223

Preparatory Behavior: 71

Each behavior is EQUALLY PREDICTIVE to an attempt

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*

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

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

Example….

Rater: "Have you made a suicide attempt?"

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

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

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)

Example…

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

Suicidal Ideation

1. **Wish to die**
   - *Have you wished you were dead or wished you could go to sleep and not wake up?*
2. **Active Thoughts of Killing Oneself**
   - *Have you actually had any thoughts of killing yourself?*

**** If "NO" to both these questions Suicidal Ideation Section is finished.****

**** If "YES" to 'Active thoughts' ask the following three questions.****

3. **Associated Thoughts of Methods**
   - *Have you been thinking about how you might do this?*
4. **Some Intent**
   - *Have you had these thoughts and had some intention of acting on them?*
5. **Plan and Intent**
   - *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*

Auditory hallucinations qualify as ideation

Ask the first two questions. If the answer to *both* is NO, skip to Suicidal Behavior section on next page. If the answer to *both* or only question 2 is YES, ask questions 3, 4, and 5.

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 ☐
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 ☐
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 ☐	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 ☐	Yes ☐ No ☐

Identification of Ideation Severity

Only check yes to the level of severity that best describes the suicidal thought experienced

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**
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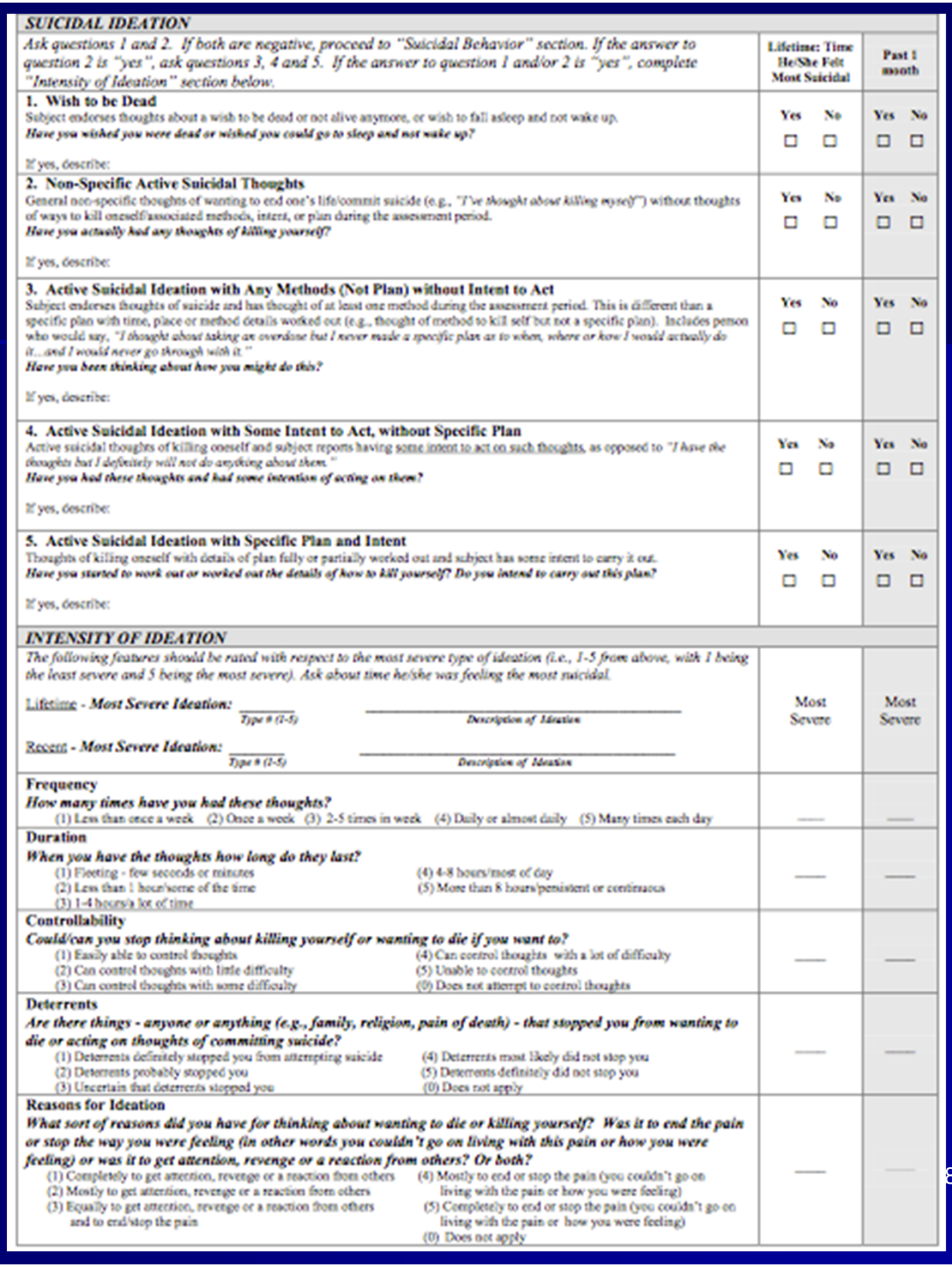
Only circle the type(s) of ideation indicated

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
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 ☐
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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). 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	____	____

Intensity of Ideation

- Once types of ideation are determined, few follow-up questions about most severe thought
  - Frequency
  - Duration
  - Controllability
  - Deterrents
  - Reasons for ideation (stop the pain or make someone angry—stop the pain is worse)
- Gives you a 2-25 score that will help inform clinical judgment about risk

All these items significantly predictive of suicide (on SSI)/minimum amount of info needed for tracking and severity

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 Ideation: _____ _____

Type # (1-5) *Description of Ideation*

Most Severe

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

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 Ideation: _____ _____

Type # (1-5) *Description of Ideation*

Most Severe

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

_____

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 Ideation: _____ _____

Type # (1-5) *Description of Ideation*

Most Severe

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
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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

_____

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 Ideation: _____ _____

Type # (1-5) *Description of Ideation*

Most Severe

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

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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).
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INTENSITY OF IDEATION

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Type # (1-5) *Description of Ideation*

Most Severe

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?

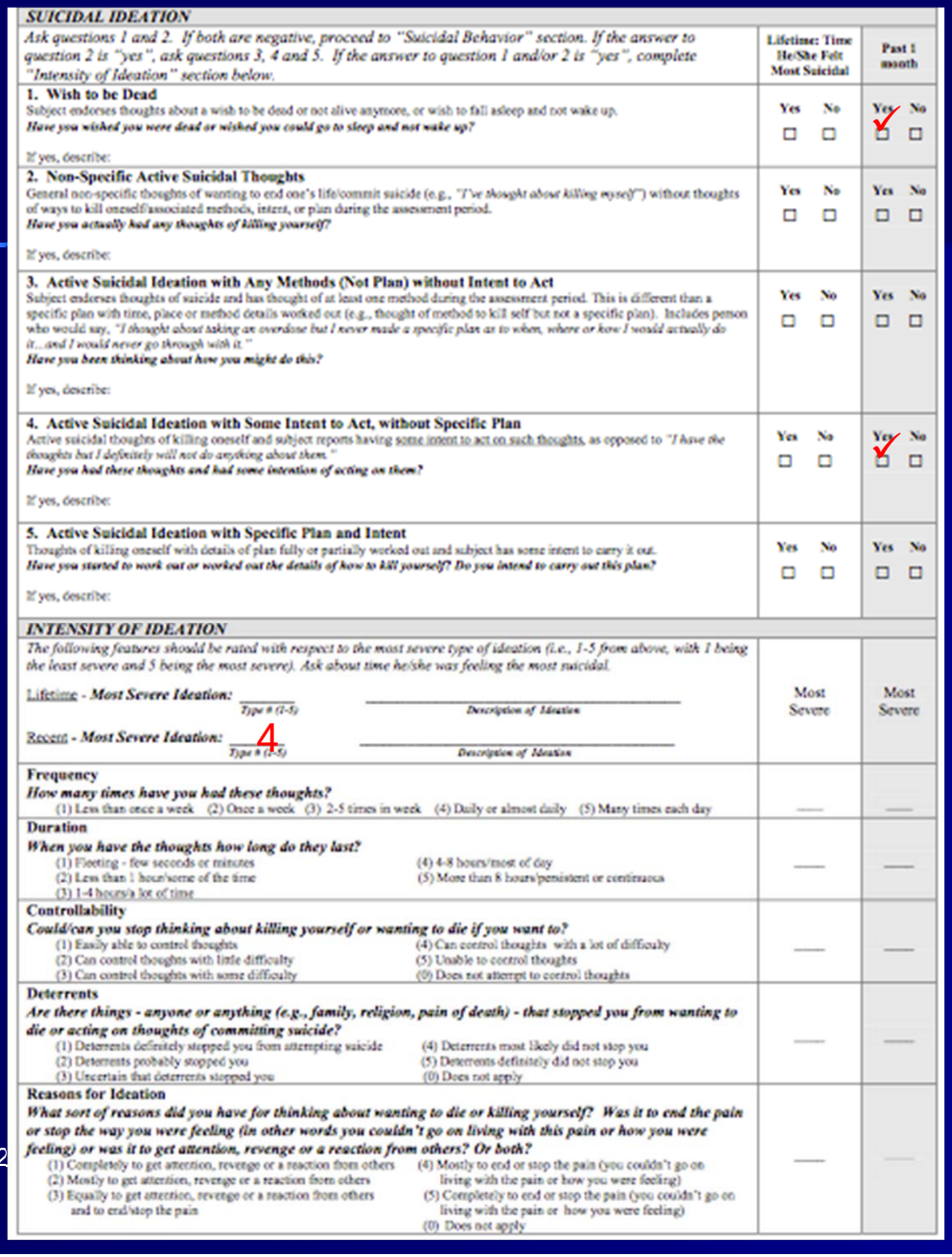
(1) Deterrents definitely stopped you from attempting suicide
(2) Deterrents probably stopped you
(3) Uncertain that deterrents stopped you
(4) Deterrents most likely did not stop you
(5) Deterrents definitely did not stop you
(0) Does not apply

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



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 ☐
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 ☐
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 ☐	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 ☐	Yes ☐ No ☐

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:*** 4 (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	____	____

If Yes to a 1 and a 4, answer Intensity Questions only about the 4 – These follow up questions only refer to the most severe ideation reported

Question	Answer	Proceed to…
1	no	Suicidal Behavior Section
2	no	
1	yes	Intensity of Ideation Section
2	no	
1	no	Questions 3, 4, 5, then Intensity of Ideation Section
2	yes	
1	yes	Questions 3, 4, 5, then Intensity of Ideation Section
2	yes	

Clinical Monitoring 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

Duration found to be predictive in adolescents (King, 2010)

Same Screening Questions

If 1 and 2 are no, ideation section is done

This is the C-SSRS Screener

***Minimum of 3 Questions**

COLUMBIA-SUICIDE SEVERITY RATING SCALE

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

Screen Version

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

Suicidal Behavior

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: **Has subject engaged in Non-Suicidal Self-Injurious Behavior?**	Yes ☐ No ☐ Total # of Attempts _____ Yes ☐ No ☐	Yes ☐ No ☐ Total # of Attempts _____ 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 ☐

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)

Suicide Attempt (con't)

- 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

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. ***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 _____
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

Other Suicidal Behaviors….
Interrupted Attempt

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

- 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 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
- Example:
  - 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)?*

Classification, at Times Feels Like Splitting Hairs…

Military case: woman drives her car to the side of the bridge with the intention of jumping off in order to end her life. She gets out of the car, goes to the side of the bridge, but when she gets there she changes her mind. However, she accidentally trips and falls over the side.

Is this a:

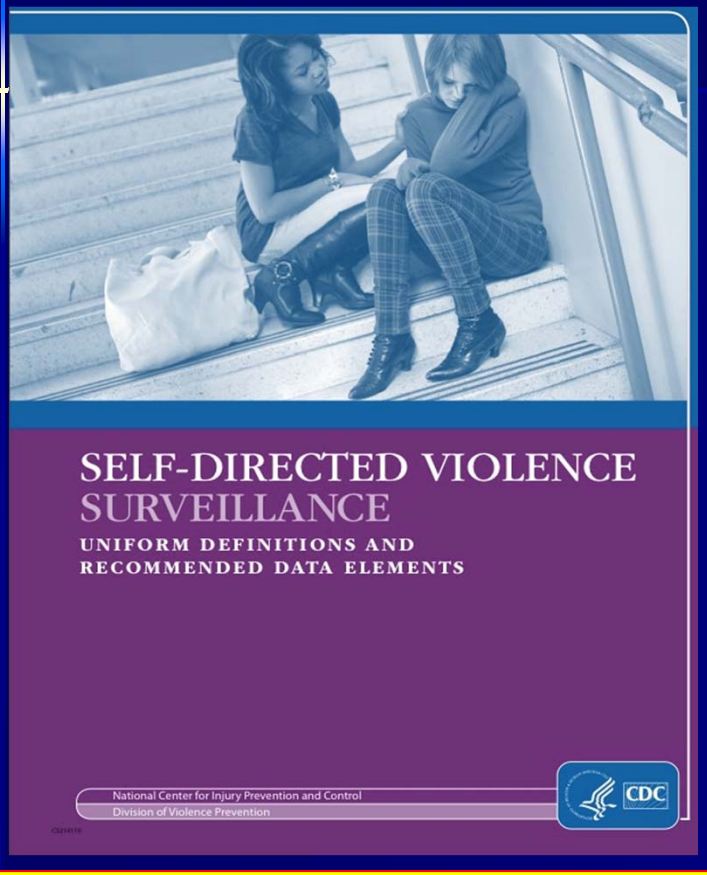
-Suicide Attempt? Because she fell over

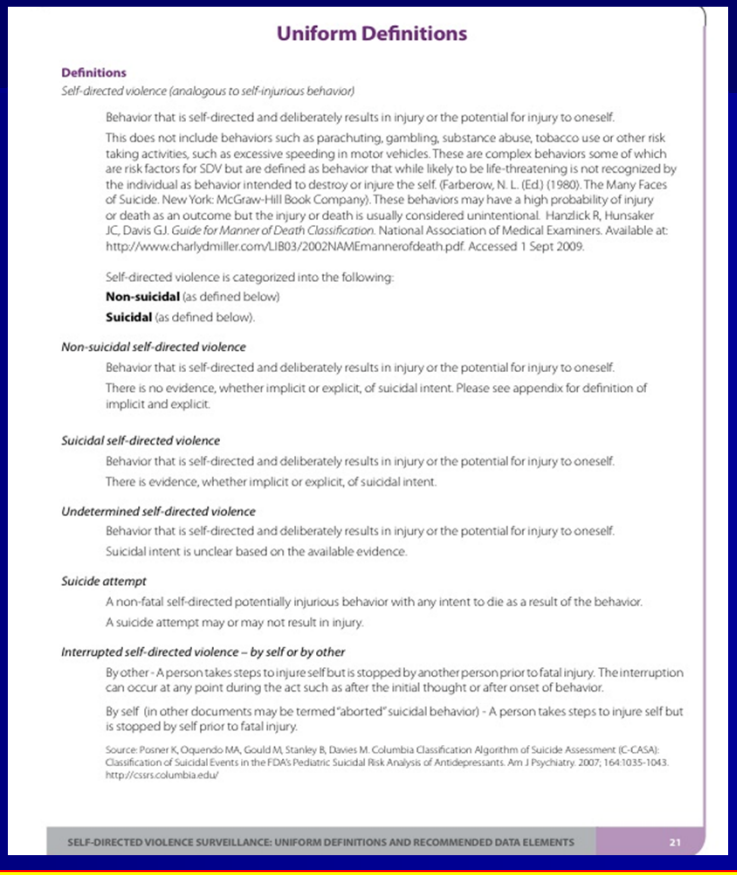
-Aborted Attempt? Because she changed her mind

In either case, a suicidal behavior would be indicated

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. (Farberow, N. L. (Ed.) (1980). 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 Manner of Death Classification*. National Association of Medical Examiners. Available at: http://www.charlydmiller.com/LIB03/2002NAMEmannerofdeath.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 unclear 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

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 *Attempted Suicide* and *Died by Suicide*

* Not in CDC document

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)**
- ***When ideation is part of behavior only select behavior***
- Every potential event should be described

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?		

Lethality Section

	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* _____

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

Why 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

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

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	Lifetime: Time He/She Felt Most Suicidal	Past 1 month
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 ☐	Yes ☐ No ☐ Total # of Attempts ___ Yes ☐ No ☐	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
Has subject engaged in Non-Suicidal Self-Injurious Behavior?				

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 ☐

- **What to Write in Free Text / Narrative:**
  Suicidal Event Narratives describe the following when available:
  - What did they do?
  - Why did they do it?
  - What was the outcome of the 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
  - You need to ask about suicide attempts regardless of a lack of ideation

Further Case Examples

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

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

Further Case Examples

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

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

Further Case Examples

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

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

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. 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. It was determined that the patient was a risk to himself. Study medication was discontinued on admission.

1. Aborted attempt
2. Interrupted attempt
3. 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

Once I score everything, how do I interpret? As in, what's considered worrysome?

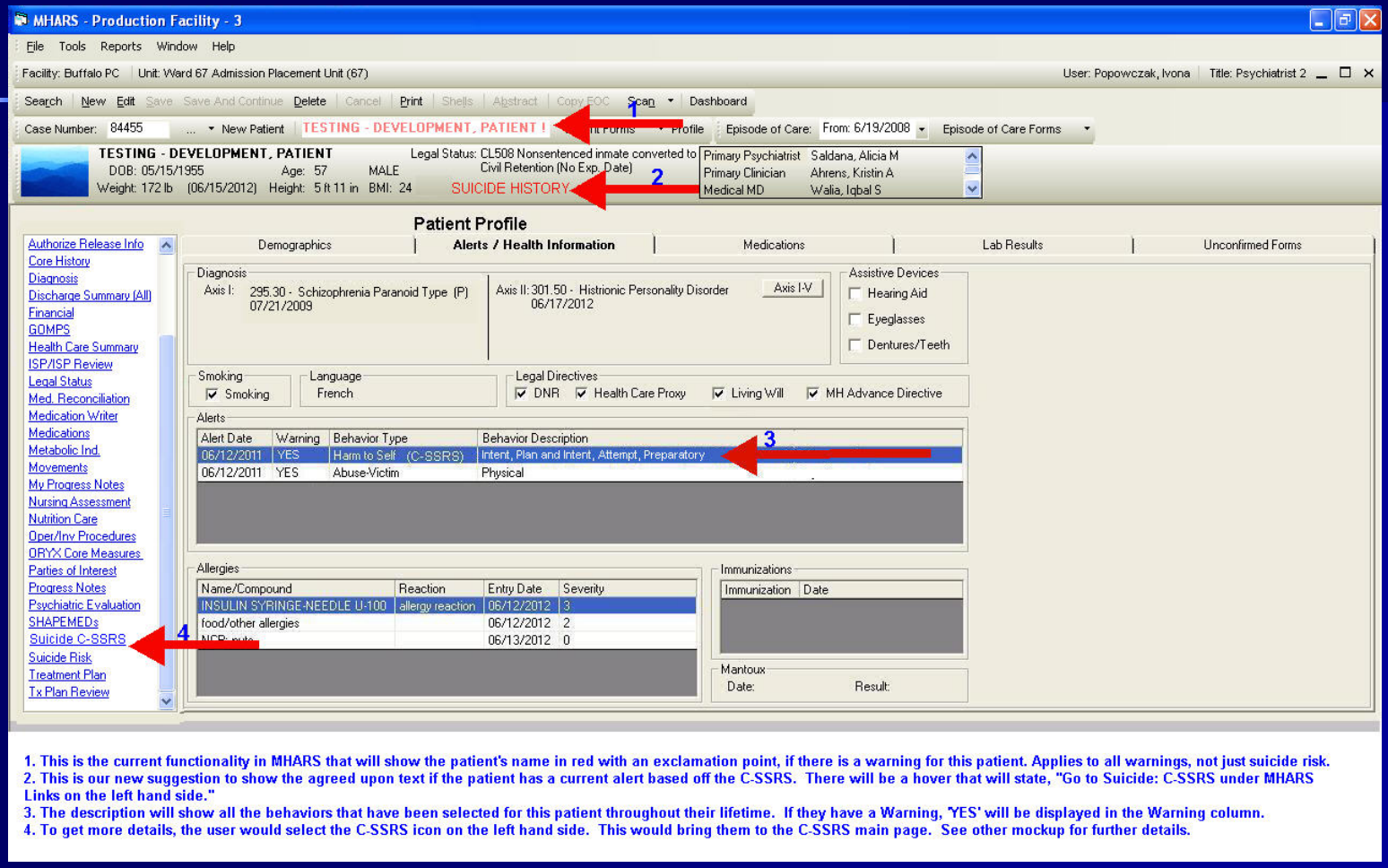
Advantages….Operationalized Criteria for Next Steps

- 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 **<u>any</u> 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

Clinical Monitoring Guidance: Threshold for Next Steps

SUICIDAL IDEATION	
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes," ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	Lifetime: Time He/She Felt Most Suicidal
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	Yes ☐ No ☐
2. Non-Specific Active Suicidal Thoughts General, non-specific thoughts of wanting to end one's life/commit suicide (e.g. *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐ No ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g. thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it.....and I would never go through with it".* ***Have you been thinking about how you might do this?*** If yes, describe:	Yes ☐ No ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them".* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	Yes ☐ No ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	Yes ☐ No ☐

Indicates Need for Next Step

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)

Centerstone Alert and Monitoring System

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

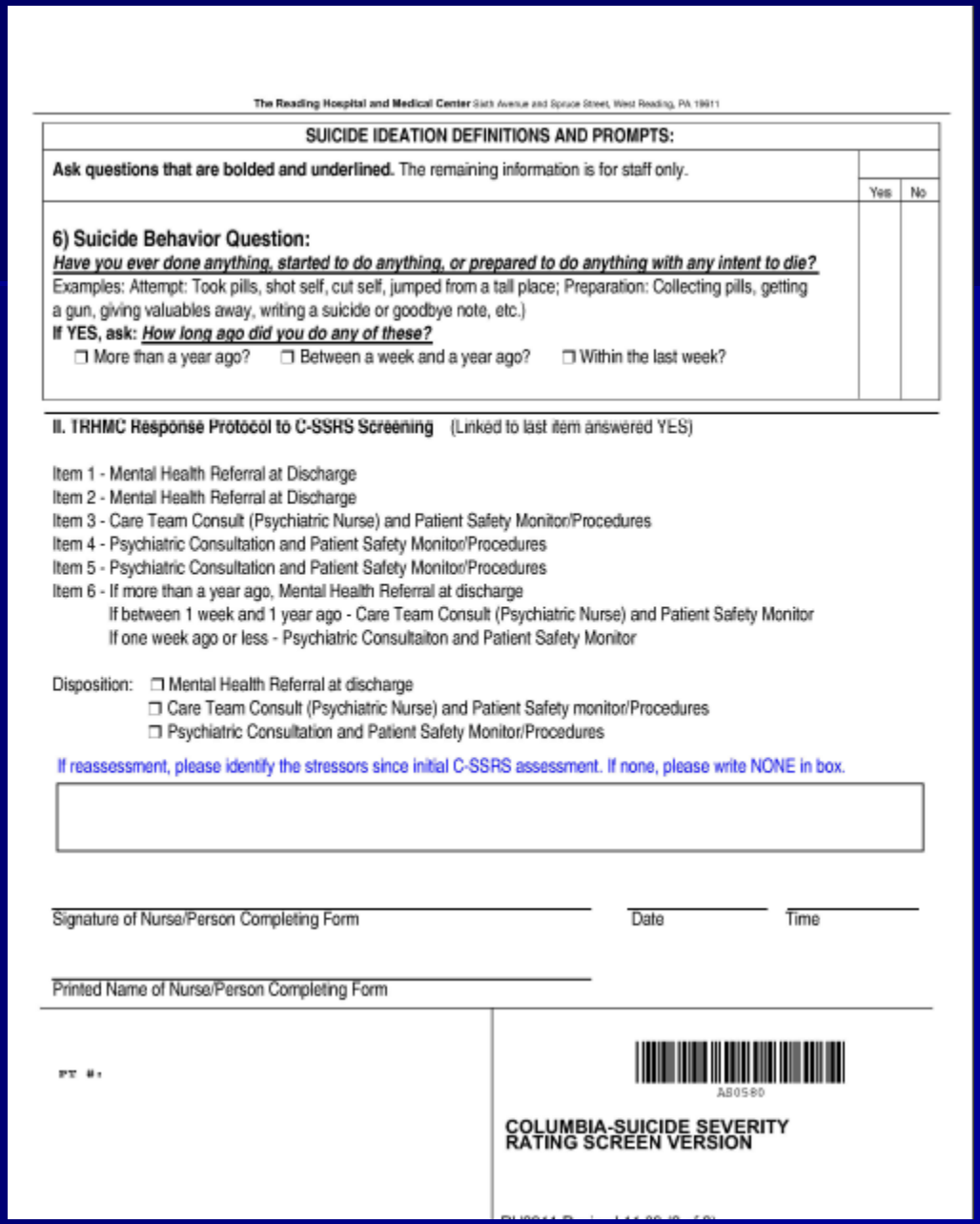
Alert and Monitoring System

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?).

This is the C-SSRS Screener 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		MANAGEMENT PROTOCOL
LEVEL	**SEVERITY**	
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.

Interpreting C-SSRS Scores

Integrating Suicidal Ideation and Suicidal Behavior

Example from Fort Carson

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

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)

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 ☐
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):

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

Suicide Prevention Resources

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

on't

A word about screening… also critical to prevention

- A significant proportion of adolescent attempters in the ER did not present for psychiatric reasons
- 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)
- 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)

Finally. . . . .

Some Answers...?

Centralized Data Repository

Additional Reliability Cases

After a fight with her friends at school in which they stopped talking to her, the patient ingested approximately 16 aspirin, and 8 other pills of different types on school grounds. She said she deserved to die and that's why she took the pills.

- 1) Suicide Attempt
- 2) Non-suicidal self-injurious behavior
- 3) Not enough information/ undetermined

A depressed man had been having thoughts about killing himself for several weeks. He recently updated his will and gave his beloved pictures and pocket knife collection to his nephew.

- 1) Aborted suicide attempt
- 2) Preparatory suicidal behaviors
- 3) Suicide ideation

The patient was feeling overwhelmed with feelings of guilt and depression. She didn't feel like anyone cared how she felt or was going to help her. She drank a half bottle of Nyquil in order to sleep for a while and then told her mom what she had done. She denied any wish to die.

- 1) Suicide attempt
- 2) Suicidal Ideation
- 3) Would not be rated on the C-SSRS

A woman fills her monthly prescription for a tricyclic antidepressant every two weeks. She says she is saving her extra medication for the future in case she needs a "way out" – way to kill herself.

- 1) Suicide Attempt
- 2) Preparatory suicidal behaviors
- 3) Not enough information/ undetermined

The patient was feeling extremely angry and depressed and wanted to die. She took a razor blade and superficially cut her forearm. She said the blood "freaked her out" and she stopped after making one cut.

- 1) Suicide Attempt
- 2) Non-suicidal self-injurious behavior
- 3) Aborted suicide attempt

A patient in a research study was rushed to the emergency room after drinking a bottle of whiskey and taking "a few" sleeping pills. She had fallen asleep in her chair and her husband found her when he came home from work; he was very worried and called 911.

- 1) Suicide Attempt
- 2) Not enough information/ undetermined
- 3) Non-suicidal self-injurious behavior

The patient reported feeling agitated and anxious after a fight with her parents. She went into her room, locked the door and made several superficial cuts on the inside of her arms. She stated she felt relieved after cutting herself and that she did not want to die. She reported that she had done this before during times of distress, and that it usually helped her feel better.

- 1) Suicide Attempt
- 2) Not enough information/ undetermined
- 3) Non-suicidal self-injurious behavior

The patient was feeling very upset after her boyfriend was in a serious car accident. She said she felt life was not worth it without him and impulsively took 5 Tylenol pm. She fell asleep for several hours and woke up slightly groggy. She later said she was glad that she didn't die but at the time she wanted to and thought that the medicine could have killed her.

- 1) Suicidal Ideation
- 2) Aborted suicide attempt
- 3) Suicide Attempt

Patient described feeling overwhelmed and alone. As she sat in her bedroom smoking a cigarette, she was overcome by the feeling that she was not sure who she was and felt like she was watching a movie of herself. She took the cigarette and burned her forearms with it, twice on each side. She reported that she intended just to feel something real, like pain

- 1) Non-suicidal self-injurious behavior
- 2) Would not be rated on the C-SSRS
- 3) Suicide Attempt

The man was poised to jump off of the bridge when a bystander ran up and pulled him away from the side. He kept him there until the police came.

- 1) Interrupted suicide attempt
- 2) Other preparatory suicidal behaviors
- 3) Aborted suicide attempt

The patient said that she was feeling depressed about her problems with her boyfriend. She said she wished that one day she would just die in her sleep and not wake up in the morning.

- 1) Suicidal ideation – with method or plan or intent
- 2) Suicidal ideation – with plan and intent
- 3) Suicidal ideation – wish to be dead

The girl was in her room with a bottle of her mother's antidepressants in her hand. She was planning to take the bottle in hopes she would die. Her mother came in, saw the pills, and stopped her before she ingested any.

- 1) Suicidal Ideation
- 2) Aborted suicide attempt
- 3) Interrupted suicide attempt

The patient reported to the doctor that he intended to hang himself in the closet on Thursday when he knew no one would be home.

- 1) Suicidal Ideation – with plan and intent
- 2) Preparatory suicidal behaviors
- 3) Suicidal ideation – with method but no plan

The patient had the gun in his hand, poised to shoot himself. Just before he pulled the trigger he thought of his daughter and quickly changed his mind.

- 1) Preparatory suicidal behaviors
- 2) Suicide Attempt
- 3) Aborted suicide attempt

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/