Wisconsin Public Psychiatry Network Teleconference (WPPNT)

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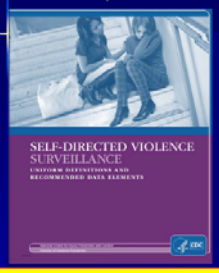
The Columbia Suicide Severity Rating Scale (C-SSRS): Improved Risk Assessment and the Positive Impact on Suicide Prevention

Jeffrey Garbelman, Ph.D.

Suicide prevention efforts depend upon appropriate identification & screening

CDC Self-Directed Violence: Uniform Definitions Adopted Columbia Definitions

(link to C-SSRS in CDC document)



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

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

Severity of Ideation Subscale

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

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

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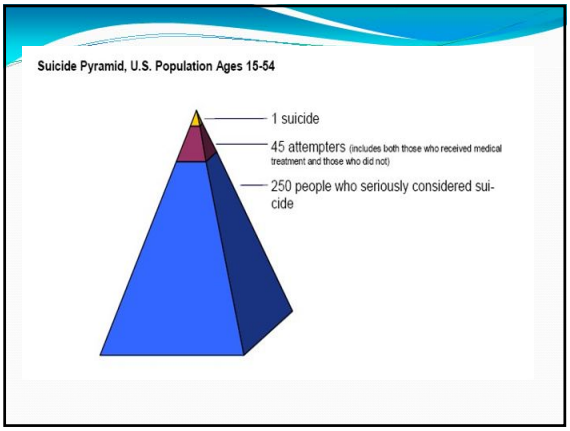
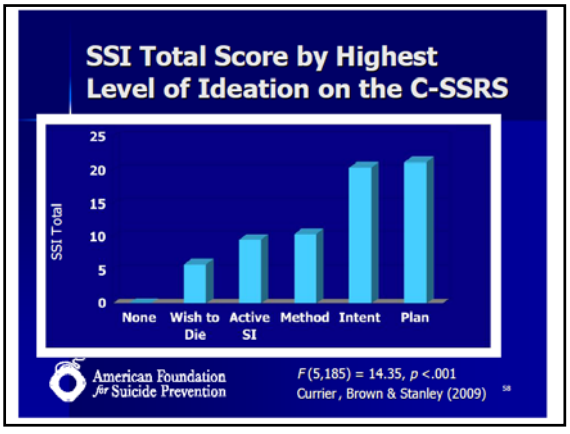
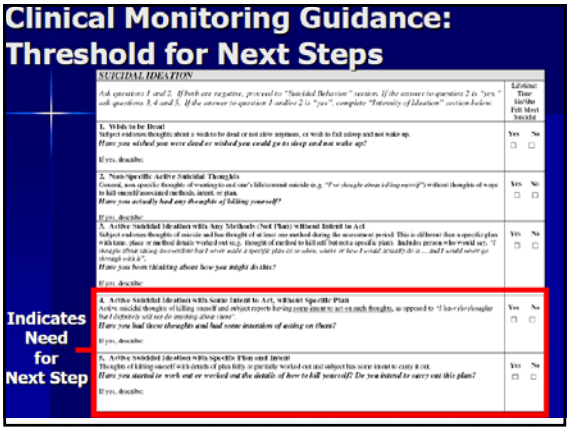


Transition Data

- Cumulative Probabilities of transition:
- Ideation to Plan 34 %
- **Plan to Attempt 72 %**

Fowler, 2012;





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

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

- C-SSRS Lifetime Ideation at baseline, types 4 and 5, predicted suicide attempts in adolescent suicide attempters, followed over a year
  - OR = 3.26, 95% CI: 1.02-10.45, p = 0.047
  - **Beck SSI NOT predictive**
- C-SSRS Lifetime Ideation, types 4 and 5, predicted actual, interrupted or aborted attempts on CSHF
  - OR = 2.76, 95% CI: 1.07-7.12, p = 0.036

Advantages….Operationalized Criteria for Next Steps

- Allows for setting parameters for triggering next steps whatever they may be
  - e.g., 4 or 5 on ideation item to indicate need for immediate referral
  - Decreases unnecessary referrals, interventions, exclusions, etc.

In the past, people didn't know what to manage, so they would hear **any answer and intervene…* 62

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) 65

Suicidal Behavior Subscale

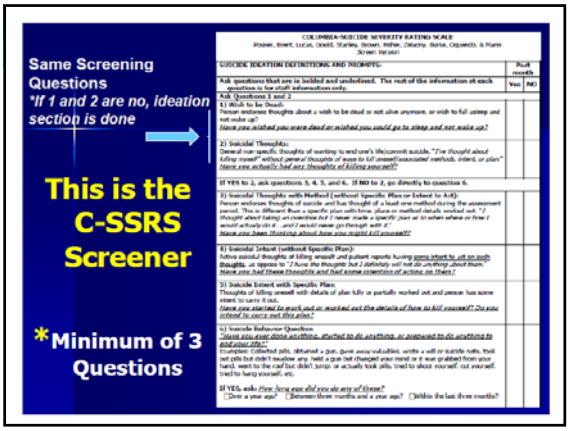
Suicidal Behavior section and the C-SSRS screening version

Same Screening Questions

**If 1 and 2 are no, ideation section is done*

This is the C-SSRS Screener

***Minimum of 3 Questions**



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?

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?*

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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)?*

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Research Supported Items/Criteria

- **Preparatory Behavior**
  - Those with recent preparatory behavior (e.g., collecting pills, razors, or loaded weapon) **8x** more likely to commit suicide (Brown & Beck, unpublished)
  - Those who reported at worst point **10x** more likely to commit suicide (Brown & Beck, unpublished)
  - Preparatory Behavior on SSI predicted completed suicide and history of suicide attempts (Joiner et al., 2003)
- **Interrupted Suicide Attempts**
  - **3x** more likely to commit suicide (Steer, Beck & Lester, 1988)
  - No difference in levels of intent
- **Aborted Suicide Attempts**
  - 29-50% of samples report aborted attempts (Marzuk et al., 1997; Barber et al., 1998)
    - Evidencing this as common suicidal behavior
  - Subjects who made aborted attempts **2x** as likely to have made a suicide attempt (Barber et al., 1998)
  - Intent scores similar with suicide attempters

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

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

Suicidal Behavior Section and non – screening versions of C-SSRS

*Lifetime/Recent C-SSRS Version
* Since Last Visit Clinical Version

SUICIDAL BEHAVIOR (Check all that apply; so long as these are separate events; must ask about all types)	Lifetime	Recent
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act*. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is *any* intent/desire to die associated with the act, then it can be considered an actual suicide attempt. *There does not have to be any injury or harm*, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.	Yes No ☐ ☐	Yes No ☐ ☐
Have you made a suicide attempt?		
Have you done anything to harm yourself?	Total # of Attempts	Total # of Attempts
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 ☐ ☐	Yes No ☐ ☐
Has subject engaged in Non-Suicidal Self-Injurious Behavior?		

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 ☐ ☐

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_____?

Lethality

	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

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Adding Suicidal Behaviors to Outcome Decisions or 'triage points'- Example

Prediction in Non-Suicidal Adults & Adolescents

- Confirmed By e-CSSRS data: 35,007 (3776 subjects) across depression, epilepsy, insomnia, fibromyalgia
  - Patients with baseline **prior ideation of 4 or 5** or **prior behavior** are 4-5x more likely to report suicidal behavior at follow up than patients with negative baseline report.
  - Patients with **both** are 8x more likely to report suicidal behavior
- Prediction in non-suicidal adolescents – emergency department follow-up study (King et al.)

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?)

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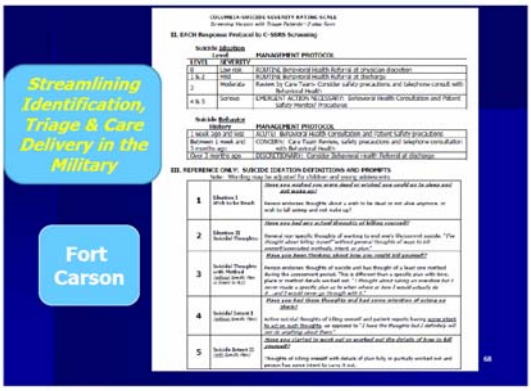
Streamlining Identification, Triage & Care Delivery in the Military

Fort Carson



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Intensity of Ideation Subscale

Intensity of Ideation Subscale

- Is not a part of the C-SSRS screen version
- Available in the Lifetime/Recent and Since Last Visit Clinical Version
- Can be used as a part of informing clinical judgment
- Or it can be incorporated into formal triage points

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

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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

… systematically assessing using the C-SSRS decreases burden

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