Suicide Prevention and the Columbia – Suicide Severity Rating Scale

The ongoing national and international tragedy of suicide has spurred substantial prevention efforts. Lack of effective screening and identification of persons at risk is an obstacle to effective prevention. An evidence-supported, low-burden solution is The Columbia-Suicide Severity Rating Scale (C-SSRS), a screening tool developed by multiple institutions, including Columbia University, with NIMH support has predicted suicide attempts—one of the foremost national priorities for prevention.

Jeffrey Lieberman, M.D., president of the American Psychiatric Association (APA): "For the **first time in as long as anyone can remember, we may be actually able to make a dent in the rates of suicide** that have existed in our population and have remained constant over time. And that would be an enormous achievement in terms of public health care and preventing loss of life."

Key Points:

- Demonstrated ability to predict suicide attempts in suicidal and non-suicidal individuals (which is a national priority for prevention).
- **The CDC adopted Columbia definitions of suicidal ideation and behavior; link to C-SSRS in CDC document**
- Mental health training is not required to administer the scale.
- Gathers key data to help direct limited resources to persons most in need.
- Track record of many millions of administrations.
- Available in 110 languages.
- Electronic self-report is available and widely used (e-CSSRS).

The C-SSRS is used extensively in primary care, clinical practice, surveillance, research, and institutional settings. It is part of a national and international public health initiative involving the assessment of suicidal risk and behavior. **Numerous states and countries have moved towards system-wide implementation**. Users include: general medical and psychiatric emergency departments, hospital systems, managed care organizations, behavioral health organizations, medical homes, community mental health agencies, primary care, clergy, hospices, schools, college campuses, military, frontline responders (police, fire department, EMTs), crisis hotlines, substance abuse treatment centers, prisons, jails, juvenile justice systems, and judges. More reliable and valid risk assessment is likely to reduce unnecessary hospitalizations, so that limited resources may be targeted to those who most need them.

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

<u>Reduction in Unnecessary Interventions/Redirecting Scarce Resources:</u>

The C-SSRS has been associated with **decreased burden by reducing unnecessary interventions and redirecting limited resources**; **In the <u>Rhode Island Senate Commission hearing on emergency room overuse and diversion</u>, state senators discussed use of the C-SSRS** by the emergency medical service or police in the community**.**

Hospital systems

- **The Providence Center** - "The use of this scale can be **transformative for Rhode Island** because it will improve care and **allow us to focus resources where they most help people.** (Our staff has) found it **easy to use and effective. By tying it to our electronic health records**, it becomes that much more **streamlined into every day care." -** Dale K. Klatzker, President/ CEO

- **Reading Hospital, PA** - "[The C-SSRS] allowed us to identify those at risk and **better direct limited resources in terms of psychiatric consultation services and patient monitoring.** It has also given us

the unexpected **benefit of identifying mental illness in the general hospital population,** which allows us to better serve our patients and our community."

- **Office of Mental Health, NY** - "…the feeling is that **the C-SSRS has separated the wheat from the chaff**; it focuses attention where it needs to be."

Schools

- **NYC Department of Education:** "The great majority of children and teens referred by schools for psych ER evaluation are not hospitalized and **do not require the level of containment, cost and care** entailed in ER evaluation…Evaluation in hospital-based psych ER's is **costly, traumatic** to children & families, and may be **less effective** in routing children & families into ongoing care."

- **Crain's, NY:** 38 middle schools were administered the C-SSRS by nurses . An **estimated 100+ students were identified that would have otherwise been missed, while dramatically reducing unnecessary referrals.** "This **enhanced service** has made **more appropriate referrals for students** to see support staff in the school and referrals to community agencies as needed…"

Corrections

- California corrections department spent **$20 million on suicide-watch** in 2010, which they believe could have been **cut in half** by using the C-SSRS.

According to a **mental health attorney specializing in malpractice litigation**, Bruce Hillowe, the C-SSRS has the potential to aid practitioners in taking necessary liability precautions, stating, **"If a practitioner asked the questions**...It would provide some **legal protection**."

The C-SSRS is frequently requested or recommended by various national and international agencies such as the **Food and Drug Administration, the WHO, the Joint Commission Best Practices Library**, the **US Department of Education**, the American Medical Association**, Health Canada, the Korean Association for Suicide Prevention, and the Japanese National Institute of Mental Health and Neurology.** The C-SSRS has been administered several million times and has exhibited excellent feasibility for use in the field as **no mental health training is required** to administer it.

The C-SSRS is used extensively by US military facilities domestically and abroad and by non-US military forces (e.g. the Israeli Defense Forces). It has been used across research, clinical, and institutional settings within the US Army (including Child & Family Assistance Sites), National Guard, Veterans Affairs, Marine, Navy, and Air Force settings. Of note, the **CDC adopted the Columbia definitions for suicide-related phenomena**, and those definitions are now **required by the US Department of Defense and the Department of Veterans Affairs**. There is a link to the C-SSRS in the new CDC surveillance document.

In the past, typical screening has only identified suicide attempts, omitting some of the most important behaviors that are critical for risk assessment and prevention (e.g. collecting pills, buying a gun). The C-SSRS is the only evidence-based screening tool that assesses the full range of clinically important ideation and behavior, with criteria for next steps (e.g. referral to mental health professionals).

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Vital Signs
Suicide Attempts CAN Be Predicted

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

Based on an interview with Meena Dayak for National Council Magazine

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

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

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

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

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

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

HOW IT WORKS

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

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

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

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

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

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

The C-SSRS is available free of charge and no professional mental health training is required to administer it. However, brief training is required for clinical trials (and indicated/preferred for clinical practice) before administering the C-SSRS. Training is available online through a 30-minute interactive slide presentation followed by a question-answer session, or is alternatively available by DVD. Those completing the training are certified to administer the C-SSRS, and receive a training certificate, valid for two years.

To complete the C-SSRS Training for Clinical Practice, visit c-ssrs.trainingcampus.net/.

The C-SSRS not only helps to get the right patients into treatment and save lives, it also keeps money from being wasted on those who did not need such care.

WIDESPREAD USE

The easy-to-use tool has been welcomed by multiple organizations that have suicide prevention on their plate but did not really know how to implement it.

Today, the C-SSRS is used worldwide in intervention studies and clinical trials across a broad range of disorders and diseases, and by institutions from the U.S. and Israeli Military to the World Health Organization to local fire departments and public schools. Importantly, the scale has been used extensively to address the Joint Commission's National Patient Safety Goals, and is indicated as a best practice.

The C-SSRS is becoming a standard suicide screening tool for hospitals, correctional facilities, health plans, and programs like Medicaid and Medicare. "The use of this scale can be transformative for Rhode Island because it will improve care and allow us to focus resources where they most help people," said Dale K. Klatzker, President/CEO of The Providence Center, a large community behavioral health organization. "The scale is an easy way to save lives," said Deb O'Brien, Providence Center Vice President and Chief Operating Officer. "Our staff have been trained by Dr. Posner, the creator of the C-SSRS, and have found it easy to use and effective. By tying it to our electronic health records, it becomes that much more streamlined into everyday care." At Centerstone, one of the largest behavioral health organizations in the U.S., the C-SSRS is used as a screening tool throughout the system.

The ground swell in use of the C-SSRS over the last 8 years has elicited top-down approaches for dissemination by many systems. Numerous states and countries have moved towards system-wide implementation. For example, New York State's Office of Mental Health's plan is to utilize the C-SSRS in all adult and child behavioral health organizations across the state as a critical element of their systems approach to prevention – implementation has already begun, and the state of Georgia has put the C-SSRS "top-down" approach into policy. Furthermore, multiple nationwide implementation efforts have ensued across many facets of the military. C-SSRS is now the state crisis assessment tool in Tennessee and is being implemented throughout managed care. The C-SSRS is used by general medical and psychiatric emergency departments, hospital systems, managed care organizations, behavioral health organizations, medical homes, community mental health agencies, primary care, clergy, hospices, schools, college campuses, military, frontline responders (police, fire department, EMTs), crisis hotlines, substance abuse treatment centers, prisons, jails, juvenile justice systems, and judges.

Fifty percent of people who die by suicide visited a primary care doctor in the month preceding their death. If they had filled out a simple questionnaire in the waiting room, they could have gotten mental health care point out researchers. "We should be asking these questions the way we monitor for blood pressure," says Posner.

RESULTS

Jeffrey Lieberman, MD, president-elect of the American Psychiatric Association, says about C-SSRS "For the first time in as long as anyone can remember, we may be actually able to make a dent in the rates of suicide that have existed in our population and have remained constant over time..."

A tool like the C-SSRS not only helps to get the right patients into treatment and saves lives, it also keeps money from being wasted on those who do not need such care. With ever shrinking health resources and federal health reform focused on finding efficient ways to spend money, the C-SSRS points the way to big savings. For example, the California corrections department estimates spending $20 million on a suicide-watch in half if they had a better system of identify the prisoners at risk.

In the Rhode Island Senate Commission hearing on ER overuse and diversion, state senators discussed use of the C-SSRS by EMS or police in the community to address ER overuse and ER diversion.

Reading Hospital, PA says that the C-SSRS "allowed us to identify those at risk and better direct limited resources in terms of psychiatric consultation services and patient monitoring and it has also given us the unexpected benefit of identification of mental illness in the general hospital population which allows us to better serve our patients and our community."

Crain's NY (2012) recently reported that "[City schools' C-SSRS suicide training] has made more appropriate referrals for students to see support staff in the school and referrals to community agencies as needed." Education departments across many states have started to implement. As explained by the NYC Department of Education, "The great majority of children and teens referred by schools for psychiatric ER evaluation are not hospitalized and do not require the level of containment, cost and care entailed in ER evaluation."Four hospitals in New York found 61-97% of referrals unnecessary. After training, nurses in 38 NYC middle schools identified many children that would have otherwise been missed while addressing unnecessary referrals. –

For those who make treatment decisions, the C-SSRS provides both better peace of mind and possibly legal protection. "It usually takes some time to become an accepted procedure, but if it does, and a practitioner asked the questions and patients went on to kill themselves anyway, it would provide some legal protection," said Bruce Hillowe, a Long Island-based mental health attorney specializing in malpractice litigation. The C-SSRS also has been implemented by medical malpractice insurance companies, such as The Doctor's Company, to protect their insured doctors and facilitate patient safety.

The C-SSRS can also be tailored for population-specific data collection (e.g. a version has been created that addresses risk factors for suicide specific to the military).

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

Dr. Kelly Posner, a leading international expert in the areas of suicide and depression, is the founder and Principal Investigator of the Center for Suicide Risk Assessment at Columbia University/New York State Psychiatric Institute. Named one of New York Magazine's "Most Influential" people, Dr. Posner publishes and speaks internationally on the risks, benefits, and public health implications of recent drug safety controversies. In June 2008, she gave the invited presentation on tackling depression and suicide at the first European Union high level conference on mental health. Dr. Posner is the Founding Chair of the Board of Turnaround for Children, the groundbreaking model that is the first to fix failing schools in high-poverty communities. She is also co-founder of The Speyer Legacy School and Institute, the first independent school for advanced learners. In 2011, she received The Turnaround Impact Award and was named "Educational Philanthropist of the Year." She will also be the honoree for the Center Law and Economic Justice joining the ranks of Ted Kennedy.

Just One Death is a Failure
The Empire State Takes a Systems Approach to Suicide Prevention

Melanie Puorto Conte, Director, New York State Office of Mental Health, Suicide Prevention Initiative

Although New York has one of the lowest suicide death rates in the U.S., too many persons pass through its health and behavioral healthcare systems and tragically take their lives. Our view is that suicide deaths of persons in care are a system failure. Therefore, as part of its larger Suicide Prevention Initiative, which focuses on preventing suicide across the lifespan and across all communities, New York, led by The New York State Office of Mental Health, developed and is implementing a plan of action to effectively manage suicide risk, eliminate suicide deaths, and reduce suicide attempts by people receiving behavioral healthcare.

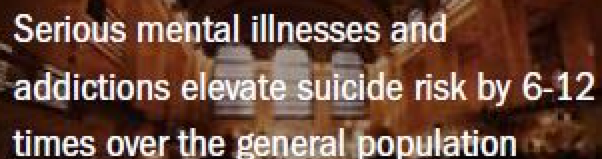
Some may ask why this special focus on people who are receiving behavioral healthcare. First, we know that serious mental illnesses and addictions elevate suicide risk by 6-12 times over the general population's. Second, we must elevate safety as the first responsibility of behavioral health settings. We have learned from many examples that comprehensive suicide care using a systems framework works. The Air Force, Henry Ford Health Service in Michigan, and Magellan Health Services of Arizona have experienced remarkable successes in reducing the number of suicide deaths, suicide attempts, and hospital visits by utilizing a comprehensive care framework.

Our plan is informed by the work of the National Action Alliance for Suicide Prevention. Its Clinical Care Task Force report, Suicide Care in Systems Framework, makes the new point that a systemic approach can comprehensively address suicide risk. The comprehensive framework includes three critical elements:

1. Leadership asserting core organizational values of safety and quality improvement, leading to a commitment that suicide deaths can and will be eliminated for people in care.
2. A management system that structures risk assessment and service protocols to achieve the goal of eliminating suicides.
3. Staff with the knowledge, skills, and confidence to deliver excellent care for patients with suicide risk.

Based on this framework of care, New York has begun employing comprehensive strategies to implement a systems approach in selected communities and systems. Initially, we are focusing on four areas:

- >> Taking all needed steps to reduce and hopefully eliminate suicide deaths in four state-operated psychiatric service systems, including both inpatient and outpatient care.
- >> Piloting our suicide care model in two county systems: Broome County and St. Lawrence County. In each county, the network will include county leadership, inpatient hospital care, residential providers, and outpatient providers bridging mental health and substance use care.



- >> Implementing a comprehensive approach to suicide care with Federated Employed Guidance Services, one of the largest non-profit behavioral healthcare providers in the U.S., which serves New York City and Long Island.
- >> Embedding suicide care in four major youth serving organizations across the state. Using federal Garrett Lee Smith Memorial Act funding, OMH has funded each organization to become youth suicide prevention training centers, beginning with their own operational environments and expanding to sister providers within each catchment area.

While New York has made suicide prevention a priority for over a decade, systematizing suicide care reflects an evolution in policy and practice. Our plan comprises a six-point strategy, collectively designed to comprehensively improve suicide care and eliminate suicide deaths in the four aforementioned sites.

We will work with each organization to assist them with setting an organizational vision of zero suicides, leading to "perfect suicide care." This includes helping them raise the level of staff support, and, with the assistance of Magellan Health Services, surveying staff on their knowledge and readiness for providing effective suicide care. Program performance in suicide care will be measured continuously and transparently in a quality improvement environment.

Each organization will receive assistance with creating management practices to achieve the vision of effective suicide care. This includes empowering clinicians to work with patients productively and as a team. It means each organization will create an expectation that suicide care is a shared responsibility delivered through team-based care. Suicide will be treated directly, not as a symptom of underlying mental health and/or substance use disorders. And, suicide care protocols will be incorporated within policies and procedures.

All patients will be screened for suicide risk. Positive screens will lead to specific suicide risk assessments that will trigger appropriate service responses in treatment plans. Staff will be trained in the Columbia Suicide Severity Rating Scale (C-SSRS), an evidence-based screening tool with robust predictive validity for future suicide attempts. Training for staff on C-SSRS will be provided by one of the instrument's developers.

Each patient with identified suicide risk will have a safety plan developed at intake and reviewed regularly. Using the model developed by Drs. Barbara Stanley at Columbia University and Greg Brown with the University of Pennsylvania, staff will receive training on how to develop and effectively use the safety plan. At the same time, OMH is working with Rennssalaer Polytechnic Institute to develop a telephone application safety plan that will allow patients that possess certain cellular phones to have their safety plan on their phones.

Clinical staff will be offered the opportunity to upgrade clinical skills, specifically in cognitive behavioral therapy, an evidence-based treatment modality for managing and treating suicide risk.

Staff will also be trained on appropriate follow-up protocols, including the critical importance of "warm handoffs" for patients with suicide risk – especially from inpatient to outpatient care. New York will also ensure that staff know the community and other resources available for patients with suicide risk, including the National Lifeline and crisis centers.

In addition to the targeted training activities described above, OMH will institutionalize educational opportunities through the development of online learning modules. To be developed in collaboration with Columbia and the New York State Psychiatric Institute, the first two modules (to be completed later this year) will address C-SSRS and safety planning. In early 2013, a third module will focus on follow-up after acute/emergency department care and "warm handoffs." New York will make these modules available nationally through the Suicide Prevention Resource Center

Many of the 1,500 persons who die by suicide each year in New York are not engaged in behavioral healthcare. We must also work to improve basic behavioral healthcare in primary care settings. Therefore, we are working with the New York State Department of Health to implement "collaborative care" in dozens of primary care settings. To reach additional persons at risk, we know expansion of specific suicide prevention competencies will be required in primary care and emergency departments. Yet, we believe that implementing the comprehensive suicide care framework described above in our behavioral health organizations will lead to safer, more effective care, and we believe it is our responsibility to start close to home. In turn, we expect to see fewer lives lost to suicide in New York.

Ms. Puorto Conte is the Director of Suicide Prevention Initiative for the New York State Office of Mental Health in Albany. She has statewide responsibility for planning, funding, and implementing a wide array of suicide prevention, intervention, postvention, and gatekeeper activities throughout the state. She is also an active member of the Statewide Veterans' and Families Advisory Work Group. Mrs. Puorto Conte is the Principal Investigator for New York's SAMHSA Garrett Lee Smith Youth Suicide Prevention grant and an adjunct professor at the Sage Graduate School's Forensic Mental Health program where she teaches a program in Suicide Prevention, Intervention, and Postvention to graduate students in Community Psychology, Forensic Mental Health, and Education.