Building A Better Suicide Risk Assessment:
The Nuts and Bolts of the Columbia Protocol

Adam Lesser, LCSW
Deputy Director for Implementation
Before We Begin

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

Please take care of yourself during and after this training
Suicide is a Global Public Health Crisis and Kills…

More Americans than Car Crashes

More Soldiers than Combat (and 20 Veterans per day)

More Fire Fighters than Fire

More People across the World than Natural Disasters, War and Homicide

#1 Cause of Death in Teenage Girls across the Globe

More Police than Crime

Suicide Touches Everyone -- 135 People Are Affected for Every Death And Effects Linger Across Generations Because of the Silence that Often Follows
Suicide Ideation and Attempts in Youth and Young Adults

IN ALL U.S. HIGH SCHOOLERS
17% seriously considered in the past year
   - 50% students identifying as Bisexual
8% attempted in the past year
   - 24% students identifying as Bisexual

2nd Leading Cause of Death Among Youth and Young Adults 10-34
150% Rate Increase 8-12 year-olds 2012-18

Within a typical classroom, it is likely that 3 students (1 boy and 2 girls) have attempted in the past year.
Relationship to School Violence
(Safe Schools Initiative, 2002)

- 78% of attackers exhibited a history of suicide attempts or suicidal thoughts prior to their attack
- 27% reported suicide as a motive in their attack - a “suicide in disguise”
- 60% had a documented history of extreme depression or desperation
- Only 34% had received a mental health evaluation
- Just 17% had been diagnosed
Pyramid of Suicidal Behaviors (Adults)

- 45,861 Suicides*
- 1.4 Million Suicide Attempts**
- 3.5 Million Made a suicide plan**
- 12 Million Seriously considered suicide**

**Substance Abuse and Mental Health Services Administration, Results from the 2019 National Survey on Drug Use and Health, 2019.
Chronic Medical Illness and Suicide

Studies indicate at least 10% suicide deaths connected to chronic medical conditions

Young people 15 and 30 who live with a chronic illness, such as an inflammatory bowel disease (IBD), are three times more likely to attempt suicide than their healthy peers. (Ferro 2017)

17 chronic medical conditions linked to increased risk for suicide (back pain, brain injury, cancer, CHF, COPD, Epilepsy, HIV/AIDS, migraine, sleep disorders) (Ahmedani 2017)

In cancer, suicide most common in first 3 months after diagnosis. Overall risk twice that of the general population, this risk can be as much as 13 times the average suicide risk in those newly diagnosed with cancer. (Saad 2019)

Among cancer patients, elderly white non-married males with head and neck, prostate or lung cancers are at highest risk (Zaorsky 2019)
Rural Areas: One of Our Greatest Challenges

- Highest rates of suicide
- Populations spread out across great distances
- Less consistent access to medical and mental healthcare
- Closest physicians may be several hours away and overburdened
- High rates of gun ownership (panic buying in early days of COVID)

(Miller et al., 2013)
Data on 2011-2015 Suicides in States with the Highest and Lowest Rates of Gun Ownership

<table>
<thead>
<tr>
<th></th>
<th>high</th>
<th>low</th>
<th>ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>person years</td>
<td>189 million</td>
<td>189 million</td>
<td></td>
</tr>
<tr>
<td>percent of households with guns</td>
<td>56%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>firearm suicides</td>
<td>16487</td>
<td>3921</td>
<td>4.2</td>
</tr>
<tr>
<td>nonfirearm suicide</td>
<td>8125</td>
<td>8757</td>
<td>0.9</td>
</tr>
<tr>
<td>total</td>
<td>24612</td>
<td>12678</td>
<td>1.9</td>
</tr>
<tr>
<td>female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>firearm suicides</td>
<td>3015</td>
<td>335</td>
<td>9.0</td>
</tr>
<tr>
<td>nonfirearm suicide</td>
<td>3495</td>
<td>3586</td>
<td>1.0</td>
</tr>
<tr>
<td>total</td>
<td>6510</td>
<td>3921</td>
<td>1.7</td>
</tr>
</tbody>
</table>

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

Up to 40% of patients seeking treatment for substance abuse dependence report a history of suicide attempt(s).

A diagnosis of alcohol misuse or dependence is associated with a suicide risk that is 10 times greater than for suicide.

Individuals who inject drugs are at about 14 times greater risk for suicide.

22% of deaths by suicide in the US involve alcohol intoxication.

Acute alcohol intoxication is present in about 30-40% of suicide attempts.

Opiates, including heroin and prescription painkillers, are present in 20% of suicide deaths in the United States.
Desperately Self-Medicating in Lieu of Proper Treatment: Large Portion of Overdoses Are Suicides
Unintended COVID Consequences
The Next Public Health Crisis of Mental Health & Suicide

National economic downturn trended at the SAME RATE AND PACE as the suicide rate.

A CDC survey in August reported that 40% of people felt anxious or depressed or had increased substance abuse during COVID, 10.7% reported suicidal ideation.
Crisis Line Surge: A Good Thing In Disguise

• The National Crisis Text Line is getting 6,000/week, double the usual

• Most recent data from Crisis Text Line: paramedics, nurses, cashiers, unemployed workers, domestic violence victims, and grieving family show:
  o 80% of COVID texts came from people feeling lonely and isolated
  o 74% of people said they were distressed because of uncertainty about the future
  o 47% of people feeling financial distress related to the pandemic.
  o 44% more likely to be more fearful about their loved ones contracting the virus compared to themselves becoming infected with it
  o 84% of people who texted and identified as essential workers in food, retail, health care, or construction reported experiencing coronavirus-related stress and anxiety

• In March/April 2020, SAMHSA’s Disaster Distress Helpline saw a 1000% increase in call volume compared with 2019
Unintended COVID Consequences

For Teens and Youth in Particular

• Studies of adolescents this year have found increases in depression, anxiety and PTSD

• In June the CDC reported higher rates of suicidal ideation in teens, at a time when school-based mental health services have been disrupted

• In Texas there were significantly more youth with ideation and attempts during March and July – peaks in COVID cases.
Unintended COVID Consequences

Compounded Effects for Groups Already Vulnerable

• Low-income families hit hardest
• With less resources and access to care, rates of suicide and attempts have been rising faster among black youth
• JAMA Pediatrics: Children age-19 were 37% more likely to die by suicide if they were from communities where >20% lived below the poverty line
• Limited access to community support and lack of in-school counseling has also disproportionately impacted LGBTQ youth, especially if their family is unsupportive
Suicide’s Biggest Cause: a Heritable, Treatable Medical Illness

85-90% of people who die by suicide have an untreated mental health problem, most often of which is depression.

Depression is the result of changes in brain chemistry.
The Global Mental Health Crisis
Depression #1 Cause of Global Disability

Suicide costs $300 billion a year globally
Depression $1 trillion
Yet devastatingly underfunded: Suicide received less NIH funding than the West Nile Virus with 137 annual deaths
A Vital Part of Health and Wellness for Employees and Their Families

Depression - #1 cause of work related absence and costs US workplaces $23 billion annually in lost productivity

45-98% of costs of depression treatment could be offset by gains in work productivity

Memorial Sloane Kettering
Stigma and Misunderstanding: “This isn’t a real illness; I’m weak if I ask for help”

“…it's the stigma attached to admitting you have any kind of problems that gets in the way of beating depression. But when you see a real person up there... they know they're not alone and can go out and get help.”

“We obviously have a peer-to-peer stigma, the machismo that ‘I can’t admit that I have to see a counselor or psychiatrist, that makes me weak and we’re at war, and there can’t be any chinks in the armor.’”

– Command Sgt. Maj. Chris Faris, 18-year veteran of Delta Force

The Culture of Machismo from Baseball to Border Protection

“That’s the thing with athletes, like you’re not really supposed to show your weaknesses kind of thing, ‘cause that like lets your competitors know, so that’s why a lot of the time you wouldn’t go see the psychologist or whatever, just ‘cause that becomes your weakness.”

“When you try to talk to the psychologist about other things, they always relate it back to sport, and they relate it back to goals... even if you want to know about something else.”
Misunderstanding Can Be Lethal: Netflix Drama *13 Reasons Why* Sends Opposite Message

Suicide Contagion:
The exposure to suicide or suicidal behaviors through media, within one's family, or peer group increases suicidal behaviors. *Especially in adolescents and young adults*
Antidepressants Save Lives

Not Treating Depression is What Kills People

Autopsy studies associated with *no treatment or non-compliance*

Antidepressants are #1 Prescription in U.S.: “The fact that people are getting the treatments they need is encouraging. **We worry more about under-treatment than over-treatment**”

Suicide dropped dramatically since *modern anti-depressants (SSRIs)*
Unfortunately…

Those Who Need Treatment Do Not Get It

Under-treatment of mental illness is pervasive:

• 50-75% of those in need receive no or inadequate treatment

• Over 80% of adolescents and college students who die by suicide never received any consistent treatment prior to their death

• Now during COVID-19 crisis, many people can’t afford or access their prescriptions
MYTHS ABOUT SUICIDE
“If someone is really suicidal, they are probably going to kill themselves at some point no matter what you do”

**FALSE**

- Multiple studies have found that \(>90\%\) of attempt survivors including those who make highly lethal attempts **do not go on to die by suicide**
- Most people are suicidal only for a short amount of time
- So, helping someone through a suicidal crisis **can** be life-saving
“Asking a depressed person about suicide may put the idea in their heads”

FALSE

- Does **not** suggest suicide, or make it more likely
- Open discussion is more likely to be experienced as relief than intrusion
- Risk is in not asking when appropriate
“Someone making suicidal threats won’t really do it, they are just looking for attention”

FALSE

– Those who talk about suicide or express thoughts about wanting to die, are at risk for suicide and need your attention

– Take all threats of suicide seriously. Even if you think they are just “crying for help”—a cry for help, is a cry for help—so help
“There’s no point in asking about suicidal thoughts…if someone is going to do it they won’t tell you”

- Many will tell clinician when asked, though might not have volunteered it – often a relief
- **Ambivalence** is characteristic in 95%
- Contradictory statements/behavior common
- 80% give some kind of hints/warnings to friends or family, even if don’t tell clinician
People Want to Be Asked

- Makes a pact with himself “If one person asks me…
- Goes to Golden Gate Bridge
- Approached by a German tourist
- “I instantly realized that everything in my life that I’d thought was unfixable was totally fixable – except for having just jumped.”
- “Most people considering suicide want someone to save them. What we need is a culture in which no one is afraid to ask.”
“If you stop someone from killing themselves one way, they’ll probably find another”

- “Means safety” – reducing a suicidal person’s access to highly lethal means - has strong evidence as effective suicide prevention strategy

<table>
<thead>
<tr>
<th>Method</th>
<th>Lethality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firearm</td>
<td>85%</td>
</tr>
<tr>
<td>Suffocation</td>
<td>69%</td>
</tr>
<tr>
<td>Fall</td>
<td>31%</td>
</tr>
<tr>
<td>Poisoning/overdose</td>
<td>2%</td>
</tr>
<tr>
<td>Cuts</td>
<td>1%</td>
</tr>
</tbody>
</table>
Means Safety Works
Very Little Method Substitution in All Cases

- **United Kingdom 1958** – replacing coal gas with natural gas—suicide rate by carbon monoxide poisoning was cut by 1/3 (Kreitman 1976)

- **New Zealand 1992** – stricter gun licensing and required locked storage reduced gun suicide in youth by 66% (Beautrais et al. 2006)

- **England 1998** – introduced individual blister packaging for Tylenol = 44% reduction in Tylenol overdose over next 11 years (Hawton 2002)

- **Israeli military 2006** - restricted gun access for off-duty soldiers, suicide rate dropped 40% in military (Lubin et al. 2010)
Putting it in All the Places Where People Acquire Means

- Pharmacies
- Transit Workers
- Gun shops
Empowering Everyone to Make a Difference

Medical Model
- Narrow approach
- Targeted screening
- Mental health treatment by clinicians in hospitals & clinics
- Problem: Majority do not seek specialized treatment

Public Health Model
- Broad approach
- Universal Screening
- Target: whole community
  - teachers
  - community counselors
  - religious leaders
  - law enforcement
  - firefighters
  - EMTs
  - parents
  - peers
Must Go Beyond the Medical Model:
Marines Reduce Suicide by 22%

Undersecretary of Defense Urgent Memo

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

SUBJECT: Use of the Columbia-Suicide Severity Rating Scale

- Total force roll-out
- In the hands of whole community
- ALL support workers: lawyers, financial aid counselors, chaplains
Everyone, Everywhere Can Ask and Needs to Ask

Marines may not go to their leadership to talk about these things but they may talk to a bartender or their barber… or at the gym with a trainer. So I think everybody who is in that community needs to ask the [C-SSRS].

Kim Ruocco – Tragedy Assistance Program for Survivors (TAPS)

VT - Policy recommendation and roll play for school janitors

Zero suicide community workshop for custodians and receptionists

Upcoming VA stand-down: canteen worker to cemetery worker
Community Cards

**COMMUNITY CARD**

ASK YOUR SPOUSE
CARE FOR YOUR SPOUSE
EMBRACE YOUR SPOUSE

See Reverse for Questions that Can Save a Life

**COMMUNITY CARD**

ASK YOUR FRIENDS
CARE FOR YOUR FRIENDS
EMBRACE YOUR FRIENDS

See Reverse for Questions that Can Save a Life

**COMMUNITY CARD**

ASK YOUR KIDS
CARE FOR YOUR KIDS
EMBRACE YOUR KIDS

See Reverse for Questions that Can Save a Life
Whole Community Systems Approach in the Air Force: Zero Suicide

Support Workers
- Clergy
- Legal Assistants
- Financial Aid Counselors
- Advocates
- Case Managers

Spouses

Primary Care, Dentistry

Schools, Child & Family Services

When A Community Comes Together There is Hope

Peers & Leadership

Security/Safety
- Overnights
- Explosive Ordinance Disposal
- Military Police

Behavioral Health
Air Force Chaplains Peer-to-Peer

https://youtu.be/MfBXroY5doo
SCREENING
Screening Programs are Successful

- Meta-analysis concluded that screening results in lower suicide rates in adults (Mann et al., JAMA 2005)
- Elderly primary care screenings - 118% increase in rates of detection and diagnosis of depression (Callahan et al., 1996)
Screening Programs in Schools Are Also Successful

High school screening identified 69% of students with significant mental health issues.

Clinical professionals identified only 48%.

When both screening and professional referral were used, 82% were identified.

Data suggest screening brings high-risk students into treatment:

Only 1 suicide in 4 years post screening vs.
3 suicides in 4 years pre-screening program.

Scott et al., 2009

Haas et al., 2008
Vital Part of Saving Lives: Need to Ask Like Blood Pressure to Find People Suffering in Silence

Nearly 50% of people who die by suicide see their primary care doctor the month before they die.

2/3 of adolescent attempters in ER are not present for psychiatric reasons.

VITAL OPPORTUNITIES FOR PREVENTION:
Imagine every school nurse, physical therapist or EAP asking about mental health alongside physical checkups. If we ask, we can find those suffering in silence.
PREVENTING SUICIDE REQUIRES ACCURATE IDENTIFICATION: THE COLUMBIA TOOLS
How to Fix the Problem...
Columbia - Suicide Severity Rating Scale

- Developed in NIMH study of adolescent suicide attemptors – 1\textsuperscript{st} scale to assess full range of ideation and behavior, severity, density, track change
- Many leading experts - collaboration with Beck’s group
- 10s of millions administrations
- Available in over 140 languages
- Very brief administration time

- Deemed “most” evidenced supported
- Excellent acceptance in practice by patients and providers
- **Age:** suitable across the lifespan for use with adults, adolescents, and young children.
- **Special Populations:** indicated for cognitively impaired (e.g. Alzheimer's, Autism)
Adopted by CDC: Importance of a Common Language

“The C-SSRS is changing the paradigm in suicide risk assessment in the US and worldwide” – Alex Crosby

Also from CDC: “Unacceptable Terms”
- Completed suicide
- Failed attempt
- Parasuicide
- Successful suicide
- Suicidality
- Nonfatal suicide
- Suicide gesture
- Manipulative act
- Suicide threat

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

1. Screen everyone at every service delivery point
2. Enter Suicide Safe Pathway: name changes color in EHR
3. Weekly appointment means restriction education safety plan
4. If client DOES NOT SHOW, clinician attempts and documents phone-call
5. If unable to contact, referred to Follow-Up specialist who attempts to contact for brief telephone risk assessment and encouragement to re-engage
6. Crisis line never shuts down until they are tracked down
C-SSRS is a Semi-structured Interview

- Questions are provided as helpful tools – it is not required to ask any or all questions – just enough to get the appropriate answer
- Most important: gather enough clinical information to determine whether to call something suicidal or not
Multiple Sources:  
*Don’t Have to Rely solely on Individual’s Report*

- Most of the time person will give you relevant info, but when indicated,…..
- Allows for utilization of *multiple sources* of information
  - Any source of information that gets you the most clinically meaningful response (subject, family members/caregivers, records)
- Very helpful for children and adolescents who may not give the same info as parents or other caregivers
Assessment of Suicidal Ideation and Suicidal Behavior

- **Ideation Severity** - 1-5 rating, of increasing severity from a wish to die to an active thought of killing oneself with plan and intent (Full and Screener C-SSRS)
- **Ideation Intensity** – 5 intensity items (Full C-SSRS Only)

- **Behaviors** - All relevant behaviors assessed and all items include definitions for each term and standardized questions for each category are included to guide the interviewer for facilitating improved identification (Full and Screener C-SSRS)
- **Lethality of Actual Suicide Attempts** (Full C-SSRS Only)
SUICIDAL IDEATION
This is the Full C-SSRS Ideation Page

Typical Administration Time=Few Minutes
C-SSRS Full & Screener Ideation

<table>
<thead>
<tr>
<th>Question</th>
<th>Past</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask questions that are bolded and underlined.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Ask Questions 1 and 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) <em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) <em>Have you actually had any thoughts of killing yourself?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) <em>Have you been thinking about how you might do this?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.g. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) <em>Have you had these thoughts and had some intention of acting on them?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As opposed to “I have the thoughts but I definitely will not do anything about them.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) <em>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Psychosis: Auditory hallucinations count as suicidal ideation
Ideation Severity Demo

http://youtu.be/2kpB3Tq2mqU
Intensity of Ideation

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

- Frequency
- Duration
- Controllability
- Deterrents
- Reasons for ideation (stop the pain or make something else happen)
Clinical Guidance

For Intensity of Ideation, risk is greater when:

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

- Gives you a 2-25 score that will help inform clinical judgment about risk
- Duration found to be most predictive in adolescents (King, 2009)
SUICIDAL BEHAVIOR
### C-SSRS Suicidal Behavior Section

<table>
<thead>
<tr>
<th>Actual Attempt</th>
<th>Lifespan</th>
<th>Past 3 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Suicidal Behavior</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Check all that apply, as long as there are separate events: must ask about all types)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Actual Attempt:**
A potentially self-injurious act registered with at least some wish to die, as a result of an act itself. There is minimal concern to be associated with the act, and 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 a person pulls triggers while gun is in possession but gun is in another’s possession, the act is considered an attempt.

**Inferring Intent:** Even if an individual desires to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not accidental or on other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor). Also, if a person desires to die, but they thought that what they did was 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?
- Did you use a gun or other dangerous thing to attempt suicide?
- Were you trying to end your life when you did this?

**Interrupted Attempt:**
When the person is interrupted (by an outside circumstances) from starting the potentially self-injurious act if not, for this attempt would have occurred.

**Attempted:**
Person has pulled trigger, but stopped from injuring. Once they stop pulling the trigger, it is an attempt. If they pull the trigger, even if the gun fails to fire, it is an attempt. If they pull the trigger, even if the gun fails to fire, it is an attempt. If they pull the trigger, even if the gun fails to fire, it is an attempt. If they pull the trigger, even if the gun fails to fire, it is an attempt.

**Aborted or Self-Interrupted Attempt:**
When someone begins to make an attempt to end their life, but someone or something stops them before you actually did anything.

**Preparatory Act or Behavior:**
Acts or preparations towards attempting a suicide attempt. This can include anything beyond a vocalization or thought, such as purchasing a gun, preparing for a suicide attempt, or attempting to end their life in a similar fashion.
Suicide Attempt Definition

A self-injurious **act** undertaken with at least **some** intent to die, **as a result of** the act

- There does not have to be any injury or harm, just the **potential** for injury or harm (e.g., gun failing to fire)
- Any “non-zero” intent to die – does not have to be 100%
- Intent and behavior must be linked
Inferring Intent

• Intent can sometimes be inferred clinically from the behavior or circumstances
  – e.g., if someone denies intent to die, but they thought that what they did could be lethal, intent can be inferred
  – “Clinically impressive” circumstances; highly lethal act where no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story, setting self on fire, or taking 200 pills)
Suicide Attempt

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

• Questions:
  – Have you made a suicide attempt?
  – Have you done anything to harm yourself?
  – Have you done anything dangerous where you could have died?
As Opposed To Non-suicidal Self-injurious Behavior

• Engaging in behavior PURELY (100%) for reasons other than to end one’s life:
  – Either to affect:
    • Internal state (feel better, relieve pain etc.) - “self-mutilation”
    - and/or -
    • External circumstances (get sympathy, attention, make angry, etc.)
Other Suicidal Behaviors.... Interrupted Attempt

**Definition:**
- When person starts to take steps to end their life but someone or something stops them

**Examples**
- Bottle of pills or gun in hand but someone grabs it
- On ledge poised to jump
## Aborted/Self-Interrupted Attempt

### Definition:
- When person begins to take steps towards making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior

### Examples
- Man plans to drive his car off the road at high speed at a chosen destination. On the way there, he changes his mind and returns home
- Man walks up to the roof to jump, but changes his mind and turns around
- She picks up a gun, but then puts it down
Preparatory Acts or Behaviors

**Definition:**
- Any other behavior (beyond saying something) with suicidal intent

**Examples:**
- Acquiring the means to kill self
- Giving away valuables
- Writing a suicide note
Preparatory Behaviors

By asking about all types of ideation and behaviors maybe we can find kids like Dylan Klebold who mentioned suicide more than 5 times in his journals: “I don’t fit in here, thinking about suicide gives me hope.”

Santa Fe shooter wrote in his journals that he wanted to kill people then kill himself
All Behaviors Are Prevalent

472 Interrupted, Aborted and Preparatory (87%)
vs.
70 ActualAttempts (13%)
Lethality
(Compilation of Beck Medical Lethality Rating Scale)

What actually happened in terms of medical damage?
For example if there was a cut, did it require a Band-Aid or a bandage? Did it bleed a little bit or profusely?

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

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

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

Potential Lethality: Only Answer if Actual Lethality=0

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

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

http://youtu.be/2Fk0XuQwcMc
Suicidal Behavior Administration

• Select (check) all that apply

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

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

• Listen to what the person believed would happen not what you think regarding lethality
## SCREENER

### Combined Behaviors Question

<table>
<thead>
<tr>
<th>Question</th>
<th>Past month</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask questions that are bolded and underlined.</td>
<td>YES/NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ask Questions 1 and 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) <strong>Have you wished you were dead or wished you could go to sleep and not wake up?</strong></td>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>2) <strong>Have you actually had any thoughts of killing yourself?</strong></td>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Past month</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>3) <strong>Have you been thinking about how you might do this?</strong></td>
<td>YES/NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.g. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) <strong>Have you had these thoughts and had some intention of acting on them?</strong></td>
<td>YES/NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>As opposed to “I have the thoughts but I definitely will not do anything about them.”</td>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>5) <strong>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</strong></td>
<td>YES/NO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Past month</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>6) <strong>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</strong></td>
<td>YES/NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If YES, ask: <strong>Was this within the past three months?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Timeframes

**Lifetime**

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

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

<table>
<thead>
<tr>
<th><strong>SUICIDAL IDEATION</strong></th>
<th><strong>Lifeline: Time He/She Felt Most Suicidal</strong></th>
<th><strong>Past 1 month</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wish to be Dead</td>
<td>[Check if yes, then go to question 2]</td>
<td>Yes No</td>
</tr>
<tr>
<td>2. Non-Specific Active Suicidal Thoughts</td>
<td>[Check if yes, then describe]</td>
<td>Yes No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SUICIDAL BEHAVIOR</strong></th>
<th><strong>Lifetime</strong></th>
<th><strong>Past 3 months</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual Attempt:</td>
<td>[Check if yes, then describe]</td>
<td>Yes No</td>
</tr>
<tr>
<td>Total # of Attempts</td>
<td>[Check if yes, then describe]</td>
<td>Yes No</td>
</tr>
</tbody>
</table>

Has subject engaged in Non-Suicidal Self-Injurious Behavior? [Check if yes, then describe]
Monitoring is Critical

Capture all events and types of thoughts since last assessment:

“Since I last saw you have you had any thoughts about suicide or done any of those behaviors?”

Recommended EVERY visit

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

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

Indicated clinical management response

Scientific data informs clinical judgment

Indicates Need For Most Extreme Next Step
Flexible Toolbox: 
Same Triage Points – Unique Next Steps

ACE Card

Primary Care/ED

USAF Medical Service Screener with Triage Points
Screener Demo

http://youtu.be/fx3N3uDUQbo
Flexible Toolbox –

**Tennessee Crisis Assessment Tool**

- Risk Assessment page and screener for all crisis evaluations

### Indicators of High Risk from the C-SSRS

<table>
<thead>
<tr>
<th></th>
<th>Past 3 Months</th>
<th>Suicidal and Self-Injurious Behavior (from C-SSRS)</th>
<th>Lifetime</th>
<th>Clinical Status (Recent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal ideation (from C-SSRS) Check Most Severe in Past Month</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suicidal thoughts (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suicidal thoughts with method (but without specific plan or intent to act) (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suicidal ideation (without specific plan) (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suicidal intent with specific plan (4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suicidal intent without specific plan (5)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Activating Events (Recent)

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal ideation (from C-SSRS) Check Most Severe in Past Month</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Treatment History

<table>
<thead>
<tr>
<th></th>
<th>Protective Factors (Recent)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Risk Factors

<table>
<thead>
<tr>
<th></th>
<th>Other Protective Factors</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**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.
### The C-SSRS can be Tailored to Address Population-Specific Risk

#### Gang-Related Suicide Cluster in Schenectady County

**Preliminary Information**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you involved in a gang?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Information:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you recently been in a fight?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Additional Information:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Additional Questions**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Troubles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you currently facing any legal troubles?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Within military structure or outside</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, how have these circumstances impacted you/your family?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Troubles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you experiencing any financial troubles?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do these concerns feel overwhelming or unmanageable?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes a person can feel that others close to them (e.g., family) would be better off financially if the person were no longer alive. Have you experienced this?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is this financial stress or hardship the worst crisis you have ever experienced?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**State of Service**

- Pre-deployment
- Post-deployment
- Active duty

**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.

- A “Situation/Stressor” could include, but is not limited to, sexual/physical assault, rape, trauma, trouble with the law, or a romantic break-up.

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:

<table>
<thead>
<tr>
<th>Since Last Visit</th>
<th>Situation/Stressor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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/associates methods, intent, or plan during the assessment period.
   - Have you actually had any thoughts of killing yourself?
   - If yes, describe:

<table>
<thead>
<tr>
<th>Since Last Visit</th>
<th>Situation/Stressor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Just as Important to have Flexible and Innovative Delivery as to Have the Right Questions

Are You or a Colleague Experiencing Emotional Distress?

Just Ask. You Can Save a Life.

Finding People Where They Live with the Columbia Mobile App:
With Individualized Community Crisis Information

Electronic delivery, automatic risk notification

Now on the app store! Just search for Columbia Protocol

Posters in Workplaces

Telehealth: Research shows it is equivalent to in-person care in diagnostic accuracy, tx effectiveness, quality of care, and patient satisfaction

University of Tennessee Chattanooga “Badge Buddies”
IMPACT ON CARE
Improved Identification with Decreased False Positives

Improved Suicide Screening at the Cleveland Clinic through Electronic Self-Reports: PHQ-9 and the Columbia-Suicide Severity Rating Scale (C-SSRS)

Irene L. Katzan¹, M.D.; Adele C. Vigueria¹, M.D., M.P.H; Taylor Burke², B.A.; Jacqueline Buchanan², A.B.; Kelly Posner², Ph.D.
¹Cleveland Clinic ²Columbia University Medical Center

PHQ-9 Suicide Item: Thoughts that you would be better off dead or of hurting yourself in some way

Outpatient Psychiatry Pilot – Self Report Computer Version (523 Encounters)

- 6.2% positive screen on C-SSRS vs.
- 23.8% endorsed item #9 of PHQ-9

Not all positive Columbia patients endorsed #9 of PHQ9
Better Service Utilization

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

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

Centerstone – Reduced ED recidivism from 40% - 7%
Optimizing Care Delivery with Universal Screening

- Policy: used in every soldier-soldier and leadership-soldier interaction
- Periodic Health Assessment: Over 38,000 screenings completed in PHA, identifying 17 soldiers needing assistance (.045%)
- No suicides in any of those screened

First-Ever Universal Screening uses the C-SSRS at Parkland Memorial Hospital: Only 1.8% positives of 100,000 patients
Only 14 out of 2962 screened positive (0.47%)
Only 5 (0.17%) required more acute care

VA SAFE-VET demonstration project – First large-scale study of C-SSRS in the VA. Bridget Matarazo and Lisa Brenner. Severity, Intensity and Behavior subscales predict suicidal behavior 6 months later.
Previously, it was “simply an officer, ambulance relying on their gut feeling and maybe sometimes transporting somebody to the emergency because of liability reasons. We don’t want to leave somebody. This [The C-SSRS] changes the game to the extent that now they have something to hang their hat on.”

Fargo Police Department Article

Protecting Against Liability

Protects against liability: Internal and External

“If a practitioner asked the questions... It would provide some legal protection”

–Mental Health Attorney, Crain’s NY

• Approx. 100 studies supporting across cultures, properties and sub-populations
• Close to 1000 published studies in last 5 years alone
The Magnitude of Connecting and Using a Common Language

Devastating Health Effects of Loneliness Equal to 15 Cigarettes a Day:
More Lethal than Heart Disease and Obesity

Columbia Protocol is more than just a method to identify when someone is at risk.

It’s a framework for normalizing the tough conversations and reducing stigma around talking about suicide and promotes connectedness.
For questions and other inquiries, email: kelly.posner@nyspi.columbia.edu

Website address for more information: cssrs.columbia.edu
Risk and Protective Factors

- **Risk Factors** – people possessing these are at greater potential for suicidal behaviors
- **Protective Factors** – reduce the likelihood of suicidal behaviors
- Many may be altered through treatment to either reduce risk or enhance resilience
- Risk and protective factors do not balance each other out 1:1 and should be weighted according to clinical judgment
Risk Factors

Biological/Psychological

- Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
- Homicidal ideation or perpetrator of violence
- Aggressive/Disruptive
- Sexual or physical abuse (lifetime)
- Family history of suicide (lifetime)
- Previous psychiatric diagnoses and treatments
- Hopelessness
- Major depressive episode
- Mixed affective episode (e.g. Bipolar)
- Command hallucinations to hurt self
- Highly impulsive behavior or recklessness
- Substance abuse or dependence
- Agitation, severe anxiety or panic
- Self-Injurious behavior 

without suicidal intent
Risk Factors
Social/Environmental

• Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)
• Pending incarceration or homelessness
• Current or pending isolation or feeling alone
• Perceived burden on family or others
• Poor parent/child attachment (youth)
• Refuses or feels unable to agree to safety plan
• Hopeless or dissatisfied with treatment
• Non-compliant or not receiving treatment
• Method for suicide available (gun, pills, etc.)
• Exposure to suicide of a peer (youth)
• Truancy or runaway (youth)
Protective Factors

- Identifies reasons for living
- Responsibility to family or others; living with family
- Supportive social network or family
- Fear of death or dying due to pain and suffering
- Belief that suicide is immoral; high spirituality
- Engaged in work, school or sports
- High academic achievement (youth)
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
Case Example

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

1. Actual suicide attempt
2. Interrupted attempt
3. Aborted attempt
Case Example

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

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

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

1. Actual suicide attempt
2. Aborted attempt
3. Interrupted attempt
Case Example

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

1. Aborted attempt
2. Interrupted attempt
3. Actual suicide attempt
Case Example

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