



Columbia Suicide Severity Rating Scale

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Why Use the Columbia Suicide Scale?

- ▶ I will be referring to the Columbia Suicide Severity Rating Scale through out this presentation as C-SSRS.
 - ▶ We use an abbreviated version of the C-SSRS.
 - ▶ Research suggests that suicidal ideation and behavior is a better predictor of risk than using static risk factors such as age, gender, ect.
 - ▶ Integrated with suicide assessment tool being used by psychiatry and even providers outside of Kaiser system.
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What is different about the Columbia?

- ▶ Questions designed to elicit more elaborate responses from the patient.
- ▶ Questions focused directly on suicidal thoughts and behaviors.
- ▶ Follows a progression of increasingly active suicidality:
 - ▶ 1. Have you wished you were dead or could go to sleep and not wake up?
 - ▶ 2. Had you actually had thoughts of killing yourself?
 - ▶ 3. Have you been thinking about how you might do it?
 - ▶ 4. Have you had these thought and had some intention of acting on them?
 - ▶ 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?
 - ▶ 6. a) Have you ever done anything, started to do anything, or prepared to do anything to end your life? b) Were any of these in the past three months?

Columbia Scale

Here is picture of the Columbia Scale color coded with increasing risk level. We administer the C-SSRS in both outpatient and Emergency Department settings. This scale is given to patients in the Emergency Department by nurses at the intake screen when they state that they have had suicidal thoughts recently and then given again by the evaluator during the psychiatric assessment.

Each affirmative answer counts as one point. Any score above three triggers thorough risk assessment.

Columbia-Suicide Severity Rating Scale (C-SSRS)

Screen Version – Recent

Suicide Ideation Definition and Prompts	Past Month	
	YES	NO
Ask questions that are bolded and underlined.		
Ask Questions 1 & 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <i>Have you <u>wished you were dead or wished you could go to sleep and not wake up?</u></i>	{X and Blank:227360}	{X and Blank:227360}
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. <i>Have you <u>actually had any thoughts of killing yourself?</u></i>	{X and Blank:227360}	{X and Blank:227360}
If YES to 2, ask questions 3, 4, 5 and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thoughts of at least one method during the assessment period. This is different than a specific plan with time, place, or method details worked out. "I thought about taking an overdose but I would never go through with it." <i>Have you <u>been thinking about how you might do it?</u></i>	{X and Blank:227360}	{X and Blank:227360}
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as opposed to "I have the thoughts but I definitely will not do anything about them." <i>Have you <u>had these thoughts and had some intention of acting on them?</u></i>	{X and Blank:227360}	{X and Blank:227360}
5) Suicidal Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. <i>Have you <u>started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u></i>	{X and Blank:227360}	{X and Blank:227360}
6) Suicidal Behavior Question: <i>Have you <u>ever done anything, started to do anything, or prepared to do anything to end your life?</u></i> 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: <u>Were any of these in the past 3 months?</u>	Lifetime	
	{X and Blank:227360}	{X and Blank:227360}
	Past 3 Months	
	{X and Blank:227360}	{X and Blank:227360}

Low Risk
 Moderate Risk
 High Risk



Time Frame Addressed

- ▶ The first five questions of the Columbia scale are asking about suicidality that the patient has experienced in the past month.
 - ▶ Question 6a focuses on lifetime and 6b focuses on the past three months.
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Question # 1 Have you wished you were dead or could go to sleep and not wake up?

- ▶ Question #1 is aimed at more persistent thoughts of suicide rather than a momentary feeling due to embarrassment.
- ▶ Commonly referred to as passive suicidal ideation.



Question #2 Had you actually had thoughts of killing yourself?

- ▶ Question #2 focuses on a more active level of suicidal ideation but there is no method for the suicide at this time.
- ▶ A positive answer to either this question or the prior question place the patient in a low level of suicide risk.



Question #3: Have you been thinking about how you might do it?

- ▶ Once again the level of active engagement in the suicidal ideation is increasing.
 - ▶ A positive answer to this question places the patient in at a moderate level of suicide risk.
- 



Question #4: Have you had these thoughts and had some intention of acting on them?

- ▶ Question #4 wants to know if they feel that they might act on the specific methods of ending their life.
- ▶ “Some intention” is asking the patient to view intentionality as a spectrum rather than a yes or no answer.
- ▶ Sometimes this will come out as a percentage “I am 70% sure that I would never act on these thoughts”.
- ▶ A positive response to this question places the patient at a high level of suicide risk.



Question #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?

- ▶ People often gravitate to one specific plan at this point and have often gone through the pros and cons of other methods of suicide.
- ▶ People might still have multiple plans that they are considering.
- ▶ A positive response to this question places the patient at a high level of suicide risk



Question #6: Have you ever done anything, started to do anything, or prepared to do anything to end your life? Were any of these in the past three months?

- ▶ This question is directly focused on suicidal behavior i.e. Hoarding pills, purchasing a gun, creating a noose, holding pills in your hand but not swallowing them, climbing on a chair to hang yourself, ect.
- ▶ Past behavior is often a good indicator of possible future behavior.
- ▶ The behavior is a risk factor regardless of whether the patient went through with the attempt or not.
- ▶ Pts who might have made a suicide attempt 30 years ago might not be at risk currently but it is important to record this nonetheless.
- ▶ A positive answer to the having engaged in this behavior in the past three months places the patient at a high level of suicide risk.



Drawbacks to the Columbia

- ▶ Time- this tool takes time to administer because the questions often need to be explained to the patient and the question often lead to a discussion about their suicidality.
- ▶ Self reporting- all the information in this tool is being self reported by patients although the Columbia does allow for collateral contacts or documents to factor into the assessment. When administering this risk scale we use the most reliable source of information and document that source if it is other than the patient.



Conclusion

- ▶ The Columbia risk assessment tool helps us to better evaluate the suicide risk of our patients in a targeted manner.
 - ▶ The Columbia risk assessment tool is better recognized both within and outside of Kaiser allowing as a common metric to evaluate suicidality.
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Assessment



Columbia Suicide Severity
Rating Scale (CSSRS)

The answers help to:

- Identify whether someone is at risk for suicide
- Assess the severity and immediacy of that risk
- Gauge the level of support that the person needs

Intervention/Treatment

Follow-Up



Safety Planning Intervention



Treatment Plan



Follow-Up

Incorporates elements of four evidence based suicide risk reduction strategies:

- Reducing access to lethal means
- Teaching brief problem solving and coping skills
- Enhancing social support and identifying emergency contacts
- Using motivational enhancement to increase likelihood of engagement in further treatment

Joint Commission

For all patients with suicide ideation:

- **Conduct safety planning** by collaboratively identifying possible coping strategies with the patient and by providing resources for reducing risks. Review and reiterate the patient's safety plan at every interaction until the patient is no longer at risk for suicide.
- Restrict access to lethal means.

Joint Commission Sentinel Alert 56: Detecting and treating suicide ideation in all settings (2016)



Evidence for Safety Planning Intervention

High quality safety plans are associated with:

- decreased suicide attempts (Miller et al. 2017, Stanley et al, 2018)
- fewer inpatient hospital days (Bryan et al., 2017)
- faster decline in suicide ideation
- fewer subsequent hospitalizations (Gamarra et al., 2015)
- increased suicide-related coping
- increased use of mental health services (Brenner et al., 2015)
- 61% of Veterans said it helped to reduce their suicide risk (Stanley et al, 2016)

SPI+ was associated with 45% fewer suicidal behaviors, approximately halving the odds of suicidal behaviors over 6 months
Stanley, B., Brown, G.K., Brenner, L.A. et al. (2018). JAMA Psychiatry



What is a Safety Plan?

- A collaborative intervention
- A prioritized list of written coping strategies and resources to use during a suicidal crisis
 - Helps provide a sense of control
 - Uses brief, easy-to-read format in the individual's own words
 - Can be used as single-session intervention or incorporated into ongoing treatment
 - Usually takes 20-40 minutes

A safety plan IS NOT:

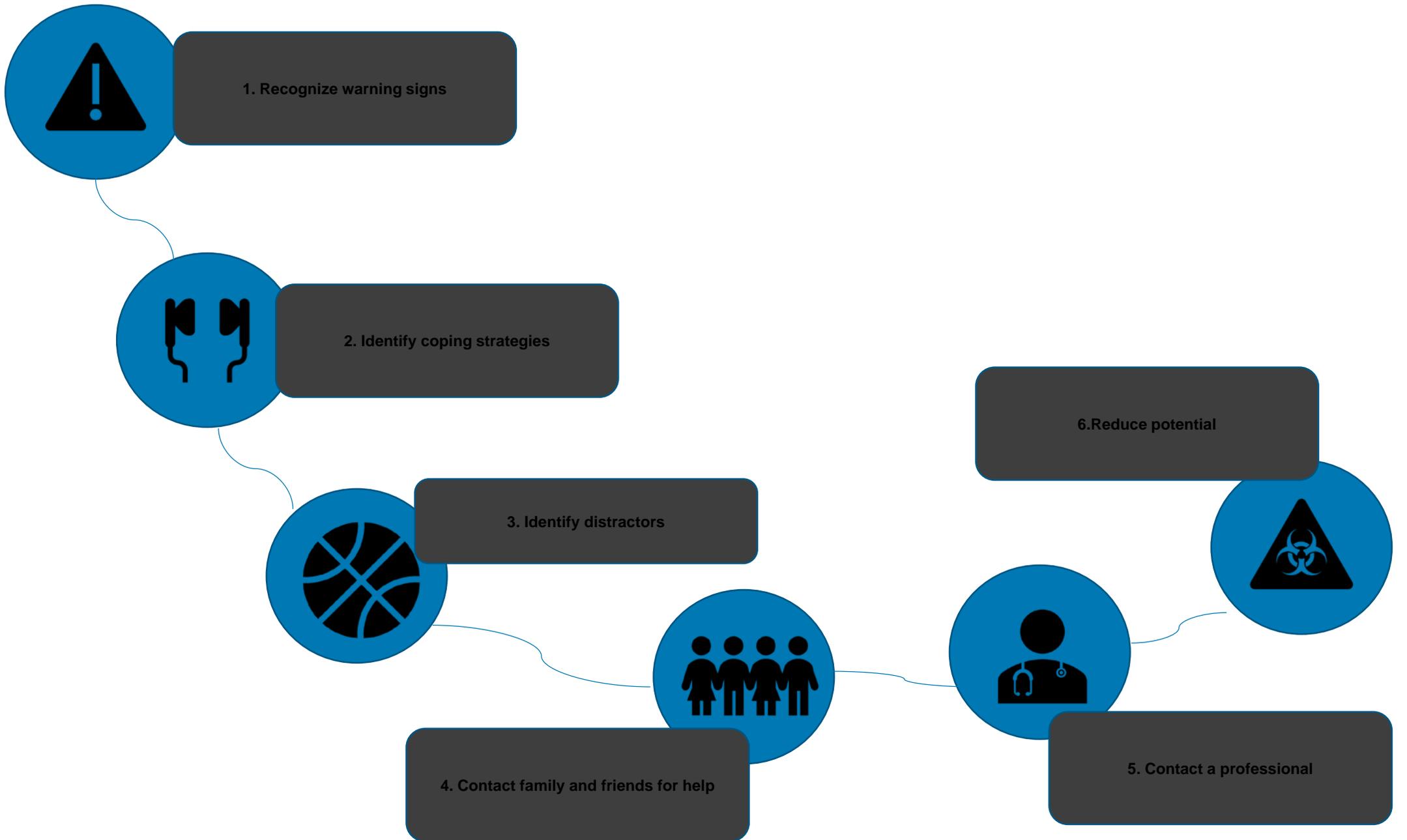
A no-suicide contract! No-suicide contracts ask patients to promise to stay alive without helping them figure out HOW to stay alive



When Is Safety Planning Used:

- Typically developed after a suicide risk assessment
- Safety planning can fill important gaps in care for individuals who are at risk of suicide
- **Individual in treatment:** reduces risk of suicide between meetings
- **Individual not yet in treatment:** reduces risk of suicide between assessment and beginning of treatment
- **Individual who may not receive further treatment:** keeps person safe and prevent a suicide crisis

*Safety planning should not be used when the individual: requires immediate rescue, or is significantly cognitively impaired



Stanley Brown Safety Plan

Starts “within self”
strategies and builds to
seeking help from external
resources including EDs

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____
2. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services _____
Urgent Care Services Address _____
Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

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The one thing that is most important to me and worth living for is:



Reducing Access to Lethal Means

- Many suicide attempts occur with little planning during a short-term crisis
- Intent isn't all that determines whether an attempter lives or dies; means also matter
- 90% of attempters who survive do NOT go on to die by suicide later
- Access to firearms is a risk factor for suicide
- Firearms used in youth suicide usually belong to a parent

Reducing access to lethal means saves lives

<https://www.hsph.harvard.edu/means-matter/>