Vital Signs
Suicide Attempts CAN Be Predicted

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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.