Suicide Assessment and Crisis Intervention in Children and Adolescents

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Objectives

- List vulnerability factors for risk of suicide using the Columbia Suicide Severity Rating Scale
- Recognize when a safety plan is indicated and how to help patient construct safety plan
- Incorporate knowledge of suicide screening and safety planning into care in behavioral health and medical settings

Questions

1. The following are warning signs of potential suicide except:

a. Delusions or hallucinations
b. Past suicide attempt
c. Recent loss
d. Loss of appetite

2. True or false:

The term “suicide gesture” is recommended because it confounds lethality with intent

3. The following statements are true:

a) Any or all suicidal statements or behaviors, regardless of how extreme, must be taken very seriously

b) Never use the term” successful suicide”

c) The Columbia Suicide Severity Rating Scale must be conducted by those with mental health background

d) a & b

Agenda

- Terminology Related to Suicide
- Epidemiology of Suicide in Children and Adolescents
- Assessment and Columbia Suicide Severity Rating Scale
- Safety Plan
- How to Incorporate into Health Care Setting

Terminology Related to Suicide

- ***Suicide*** means killing oneself.
  - The act constitutes a person willingly, perhaps ambivalently, taking his or her own life.
  - Several forms of suicidal behavior fall within the self-destructive spectrum.
- ***Completed suicide*** means the person has died.
  - NEVER use term successful suicide
  - GOAL to prevent suicide and provide treatment.
- ***Suicide attempt*** involves a serious act
  - Taking fatal dose of medication, shooting self
  - Someone intervening accidentally.
  - Without the accidental discovery, the individual would be dead.

Terminology Related to Suicide

- ***Suicide gesture*** denotes a person undertaking an unusual, but not fatal, behavior as a cry for help or to get attention.
- ***Suicide gamble*** is one in which patients gamble their lives that they will be found in time and that the discoverer will save them.
  - For example, an individual ingests a fatal amount of drugs with the belief that family members will be home before death occurs.
- ***Suicide equivalent*** involves a situation in which the person does not attempt suicide. Instead, he or she uses behavior to get some of the reactions that suicide would have caused.
  - For example, an adolescent boy runs away from home, wanting to see how his parents respond. (Do they care? Are they sorry for the way that they have been treating him?)
  - The action can be seen as an indirect cry for help.

Terminology Related to Suicide

- ***Suicidality***-
  - All suicide-related behaviors and thoughts
- *Suicidal Ideation*-Can be on continuum from passive to nonspecific ideation (e.g., "I wish I had never been born") to active specific ideation with intent and/or pan.
- ***Nonsuicidal self-injurious behavior (NSIB)-***
  - Any self-inflicted destructive act
  - Performed without intent to die
  - Full intent of inflicting physical harm to oneself (viewed as distinct from suicidal behavior)
  - The term "suicide gesture" is NOT recommended by the National Institute of Mental Health task force, nor is it included among the operational definitions because it confounds lethality with intent
- ***Parasuicidal Behavior-***
  - Suicidal gestures or self-harming behaviors in the context of suicidal ideation
  - For the purpose of alerting others to their emotional pain
  - Not typically behaviors which could have led to completed suicide.

U.S.A. SUICIDE: 2011 OFFICIAL FINAL DATA

	Number	**Per Day**	Rate	% of Deaths
• **Nation**	**39,518**	**108.3**	**12.7**	**1.6**
• **Males**	**31,003**	**84.9**	**20.2**	**2.5**
• **Females**	**8,515**	**23.3**	**5.4**	**0.7**
• **Whites**	**35,775**	**98.0**	**14.5**	**1.7**
• **Nonwhites**	**3,743**	**10.3**	**5.8**	**1.0**
• **Blacks**	**2,241**	**6.1**	**5.3**	**0.8**
• **Elderly (65+ yrs.)**	**6,321**	**17.3**	**15.3**	**0.3**
• **Young (15-24 yrs.)**	**4,822**	**13.2**	**11.0**	**16.3**
• **Middle Aged (45-64 yrs.)**	**15,379**	**42.1**	**18.6**	**3.0**

Source: McIntosh, J. L., & Drapeau, C. W. (for the American Association of Suicidology). (2014). *U.S.A. suicide 2011: Official final data.* Washington, DC: American Association of Suicidology, dated June 19, 2014, downloaded from http://www.suicidology.org.

Epidemiology of Suicide in Children and Adolescents

- 10th leading cause of death in the United States
- 3rd leading cause of death for children, adolescents, and young adults
- Western states have highest suicide rates, with the exception of Vermont.
- Rural areas carries a higher risk of suicide than living in urban areas

Macionis JJ. Sociology Special Custom Edition for SNHU (selected by Prof J Walter). 9th ed. Upper Saddle River, NJ: Prentice-Hall; 2003

Epidemiology of Suicide in Children and Adolescents

- 15 to 25% of adolescents endorse some degree of suicidal ideation
  - 2-6% specific and active ideation
- 3rd leading cause of death among youth and young adults
  - 13% of mortality in this age group in 2005
- The suicide rate in this age group increased by 8% from 2003 to 2004 (the largest single-year increase since 1990)
  - Rate decreased in last 10 years

Epidemiology of suicide in children and adolescents

Rates of attempted and completed suicide increase dramatically with age throughout childhood into adolescence due to:

Elevated risk for psychopathology incurred during adolescence

Increased capacity to prepare and execute a suicide plan with cognitive maturity

Decreased supervision with age

Prepubertal children do endorse suicidal ideation but:

Cognitive immaturity appears to limit ability to plan and execute lethal suicide attempts

Preschool children:

Suicidal behavior is rare

When present in this age group, *physical and/or sexual abuse is common*

EPIDEMIOLOGY of Suicide in Children and Adolescents

- ***Females*** *10% vs 4%* more likely to attempt suicide and have *specific ideation*
- ***Males*** *6:1 more likely* to complete suicide
  - use *more lethal* means such as hanging or firearms
  - substance use and antisocial behaviors
- Adoptees 4 x more likely to attempt suicide than those not adopted (Keyes, Malone, Sharma, Iacono, McGue, 2013)
- Children with parent who has attempted suicide almost 5x risk of attempting suicide (Brent, et al. 2015)

Ethnicity and Suicide in Children and Adolescents

- Suicide is prevalent in all ethnic groups
- Higher among non white
- American Indian highest rate
- Completed suicide in young African American males growing
- Hispanic higher rates and attempts
- *Little known* about Asian American youth who do *not disclose suicidal ideation* and *underutilize* mental health services
- LOWER SES except for African American males as completed suicide associated with higher SES

Why do they suicide?

Precipitating Circumstances of Suicide Among Youth Aged 10–17 Years by Sex: Data From the National Violent Death Reporting system 16 States 2005-2008

Most Common

- Relationship problems
- Recent crises
- Mental health problems
- Intimate partner violence
- School problems 25% of decedents
  - 30.3% drop in grades
  - 12.4% bullying related
- Died in a house or an apartment (82.5%).

Most Common co-morbid Psychiatric Disorders in Children and Adolescents who Attempt Suicide

Mood (61-76%)

- Substance Abuse (27-62%)
- Conduct/Disruptive Behavior
- Borderline or Antisocial Personality
- Post Traumatic Stress (PTSD)
- Chronic Medical Illnesses

- 90% of individuals who commit suicide have untreated mental illness---60% depression
- 50-75% of children with depression go undiagnosed and untreated
- < 20% of adolescent suicides receive any consistent treatment prior to their death.

Populations Most vulnerable to suicide

Higher risk for suicide or suicide attempts than the general population:

- American Indians and Alaska Natives
- People bereaved by suicide
- People in justice and child welfare settings
- People who intentionally hurt themselves (non-suicidal self-injury)
- People who have previously attempted suicide
- People with medical conditions
- People with mental and/or substance use disorders
- People who are lesbian, gay, bisexual, or transgender
- Members of the military and veterans
- Men in midlife and older men

Take home message

- Any or all suicidal statements or behaviors, regardless of how extreme, must be taken very seriously!

- ***ALL*** of our patients need to be screened for suicidality, even if we do not expect it in the least

How to Identify

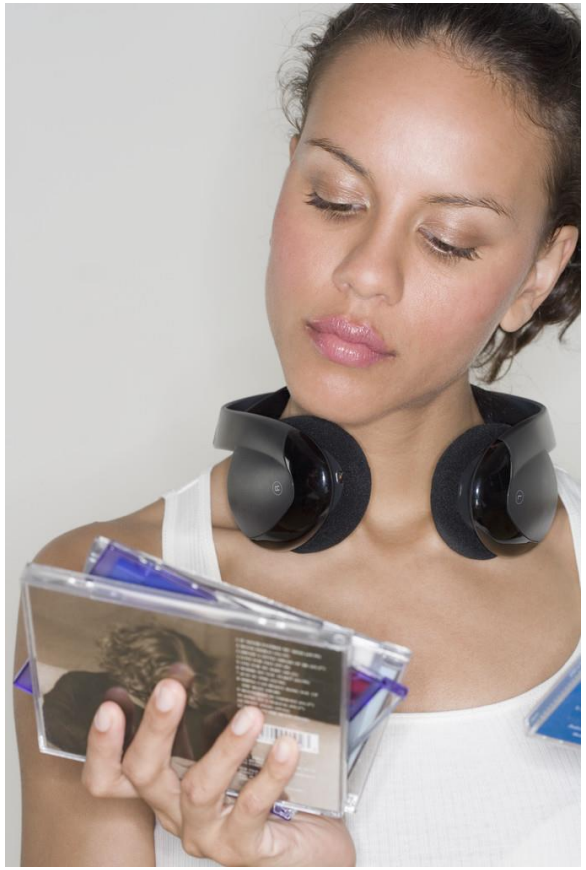
Why Assess Suicide Risk?

- Increases awareness
- Provides a common language about suicide
- Provides guidance for developing an action plan
- Helps to ensure that all staff are following a standardized, evidence based protocol to identify individuals at risk of suicide

Why Assess Suicide Risk?

- Evidence exists that screening actually
  - DECREASES referrals to behavioral health
  - Provides behavioral health resources to those who truly need them, not to those who weren't actually at high risk
  - May actually save lives

Alicia



- 15 yr AA/Hisp female. Father in service for years. High achiever, straight A's, attends parochial school. Likes to be 'unique' but inwardly low self esteem.

- Met older teen at driver's ed in the summertime and began hanging out with him and his friends. Just prior to breakup began cutting on wrist. After breakup attempted suicide by overdose.

Assisting Potential Suicidal Patients

- ✓Be attentive
- ✓Remain calm and do not appear threatened
- ✓Stress a partnership approach
- ✓Discuss suicide in a calm, reasoned manner
- ✓Listen to the patient
- ✓Emphasize that suicide causes a great deal of pain to family members

Warning signs or signs of vulnerability to suicide

- History of Impulsive Aggression
- Prior Suicide Attempts
- Hopelessness/Helplessness
- No Future Orientation
- Exposure to Recent Suicide
- Psychiatric Disorders
- Comorbid psychiatric disorders (e.g., disruptive disorders, substance abuse)
- Availability of lethal, agents (e.g., firearms), exposure to negative events (e.g., physical or sexual abuse, violence
- Family history of suicidal behavior

Suicide Assessment: Warning Signs

- ✓Pacing
- ✓Agitated behavior
- ✓Frequent mood changes
- ✓ Chronic episodes of sleeplessness
- ✓Actions or threats of assault, physical harm or violence
- ✓Delusions or hallucinations
- ✓Past suicide attempt
- ✓Recent loss

- ✓ Threats or talk of death (e.g., "I don't care anymore," or "You won't have to worry about me much longer.")
- ✓ Putting affairs in order, such as giving possessions away
- ✓ Unusually risky behavior (e.g., unsafe driving, abuse of alcohol or other drugs)

Columbia Suicide Severity Rating Scale (CSSRS)

A semi-structured interview

used to assess suicide risk

The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes.

Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Center for Suicide Risk Assessment

Video

Why use the Columbia suicide severity rating scale? (CSSRS)

- Don’t need mental health training
- Comes in multiple formats
  - Screener version appropriate for First Responders, gatekeepers, peer counselors
  - Full version appropriate for behavioral health clinicians
  - Versions for children, intellectually disabled
  - Available in 100+ languages
  - Versions to assess lifetime/recent/since last visit
  - Used for research, and clinically
- Flexible format, don’t need to ask all the questions if not necessary
- Integrate information given by collateral sources family, caregivers

Versions of Columbia Suicide Severity Rating Scale

The Lifetime/Recent version

- Practitioners gather lifetime history of suicidality
  - any recent suicidal ideation and/or behavior.
- For behavior it is used to capture all lifetime occurrences,
- For ideation (which is hard to average throughout a lifetime) the reference point used is "the time the person felt most suicidal." which has been shown to be the most predictive of completed suicide in the future (Beck, A.T., et al., 1999).

The version

- Assesses suicidality since the patient's last visit.
- Meant to assess patients who have completed at least one Lifetime/Recent C-SSRS assessment.
- Asks about any suicidal thoughts or behaviors the patient/participant may have had since the last time you have administered the C-SSRS.

Versions of Columbia Suicide Severity Rating Scale

The Screener version

- Shortened form of the Full Version.
- 3-6 questions long.
- Commonly used for clinical triage by first responders, in ER settings and crisis call centers, for non-mental health users like teachers or clergy or in situations where frequent monitoring is required (e.g. inpatient shift monitoring, day programs).
- Includes all the information necessary to make a decision about next steps.
- 1-5 questions about the severity of suicidal ideation (thoughts of suicide).
- 1 question on the full range of suicidal behaviors that is collapsed from the Full Version.

The

- Provides a checklist for protective and risk factors for suicidality.
- Developed to better account for common risk and protective factors in assessing suicidal ideation and behavior clinically.
- Designed to include all suicide-relevant variables and risk and protective factors on one page to assist the clinician in weighing these factors for determining overall risk and treatment planning.
- Used in conjunction with the Full or Screener versions of the scale.

Pediatric/cognitively impaired lifetime/Recent Ideation

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.

	Lifetime: Time He/She Felt Most Suicidal		Past 1 month	
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 thought about being dead or what it would be like to be dead?*** ***Have you wished you were dead or wished you could go to sleep and never wake up?*** ***Do you ever wish you weren't alive anymore?*** If yes, describe:	Yes ☐	No ☐	Yes ☐	No ☐
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/associated methods, intent, or plan during the assessment period. ***Have you thought about doing something to make yourself not alive anymore?*** ***Have you had any thoughts about killing yourself?*** If yes, describe:	Yes ☐	No ☐	Yes ☐	No ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"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."* ***Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?*** If yes, describe:	Yes ☐	No ☐	Yes ☐	No ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?*** ***This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.*** If yes, describe:	Yes ☐	No ☐	Yes ☐	No ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you ever decided how or when you would make yourself not alive anymore/kill yourself? Have you ever planned out (worked out the details of) how you would do it?*** ***What was your plan?*** ***When you made this plan (or worked out these details), was any part of you thinking about actually doing it?*** If yes, describe:	Yes ☐	No ☐	Yes ☐	No ☐

INTENSITY OF IDEATION

The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).

			Most Severe	Most Severe
Lifetime - Most Severe Ideation:	_____	_____		
	Type # (1-5)	***Description of Ideation***		
Recent - Most Severe Ideation:	_____	_____		
	Type # (1-5)	***Description of Ideation***		
Frequency ***How many times have you had these thoughts?*** (1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable	***Write response***	_____	___	___

INSTRUCTIONS

Ask questions 1 and 2 and if both are negative proceed to "suicidal behavior" section (next page),

If answer to question 2 is "yes", ask questions 3, 4, and 5.

If answer to question 1 and/or 2 is "yes", complete "intensity of Ideation " section below

Ask MINIMUM of 3 Questions

Pediatric/cognitively impaired version lifetime/Recent

Actual Attempt

Interrupted Attempt

Aborted or Self-Interrupted Attempt

Preparatory Acts or Behavior

Actual Lethality/Medical Damage

Potential Lethality: Only Answer if Actual Lethality 0

SUICIDAL BEHAVIOR
(Check all that apply, so long as these are separate events; must ask about all types)

	Lifetime	Past 3 Months
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is *any* intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm,*** just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Did you ever do anything to try to kill yourself or make yourself not alive anymore? What did you do?*** ***Did you ever hurt yourself on purpose? Why did you do that?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to make yourself not alive anymore when you _____?*** ***Or did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe:	Yes ☐ No ☐ Total # of Attempts ____	Yes ☐ No ☐ Total # of Attempts ____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	Yes ☐ No ☐	Yes ☐ No ☐
Has subject engaged in Self-Injurious Behavior, intent unknown?	Yes ☐ No ☐	Yes ☐ No ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?*** If yes, describe:	Yes ☐ No ☐ Total # of interrupted ____	Yes ☐ No ☐ Total # of interrupted ____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?*** If yes, describe:	Yes ☐ No ☐ Total # of aborted or self-interrupted ____	Yes ☐ No ☐ Total # of aborted or self-interrupted ____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?*** If yes, describe:	Yes ☐ No ☐ Total # of preparatory acts ____	Yes ☐ No ☐ Total # of preparatory acts ____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* ____	*Enter Code* ____	*Enter Code* ____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* ____	*Enter Code* ____	*Enter Code* ____

Pediatric/cognitively impaired Since Last visit

INSTRUCTIONS:

Ask questions 1 and 2 and 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

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.	**Since Last Visit**
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 thought about being dead or what it would be like to be dead?*** ***Have you wished you were dead or wished you could go to sleep and never wake up?*** ***Do you wish you weren't alive anymore?*** If yes, describe:	**Yes** ☐ **No** ☐
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/associated methods, intent, or plan during the assessment period. ***Have you thought about doing something to make yourself not alive anymore?*** ***Have you had any thoughts about killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"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."* ***Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?*** If yes, describe:	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?*** ***This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.*** If yes, describe:	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you decided how or when you would make yourself not alive anymore/kill yourself? Have you planned out (worked out the details of) how you would do it?*** ***What was your plan?*** ***When you made this plan (or worked out these details), was any part of you thinking about actually doing it?*** If yes, describe:	**Yes** ☐ **No** ☐
INTENSITY OF IDEATION	
The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation***	Most Severe
Frequency ***How many times have you had these thoughts?*** ***Write response*** _____ (1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable	____

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

Columbia Suicide Severity Rating Scale
Screening Version

Minimum of 3 Questions

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version - Recent

	Past Month	
Ask questions that are bold and underlined	**YES**	**NO**
Ask Questions 1 and 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. **Have you wished you were dead or wished you could go to sleep and not wake up?**		
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." **Have you actually had any thoughts of killing yourself?**		
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 thought of a 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 never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*" **Have you been thinking about how you might kill yourself?**		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" **Have you had these thoughts and had some intention of acting on them?**		
5) Suicide 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. **Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?**		

	Past 3 Months	
	YES	**NO**
6) Suicide Behavior **Have you done anything, started to do anything, or prepared to do anything to end your life?** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

When to Refer for further Psychiatric Evaluation or more restrictive treatment?

- Ideation: 4 or 5 in the past month
- Behaviors: any behavior in the past 3 months
- Score of 4 indicate some suicidal intent
- Risk doubles from 3 to 4

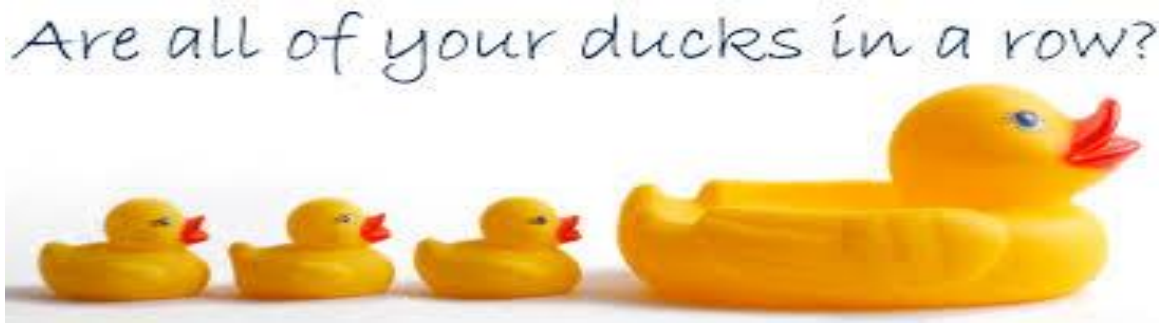
Reasons for Safety Planning

- Suicide risk fluctuates over time
- Problem solving capacity is lower during times of crisis so it helps to plan ahead
- Cognitive behavioral approaches reduce impulsive behaviors
- Learning to cope with suicidal crises without hospitalization helps increase a person's self-efficacy and self confidence
- Safety planning helps to instill hope!

Who Is Appropriate for Safety Planning & What Does it Do?

- Patients at increased risk for suicide who do not require immediate hospitalization
- Fills the gap between hospital or ED discharge and follow-up
- Provides an alternative for those who don’t want or don’t receive outpatient care

Safety Plan if suicidal and outpatient



- Get your ducks in a row LONG before client becomes suicidal!
- When initial assessment of child/adolescent, have baseline conversation about suicidality and how you and parent would keep child/adolescent safe.
- Collaborate with parent if good, reasonable protector
- If suicidal, depending on severity and intensity of ideation, and parents feel they can keep child/adolescent safe 24 hour monitoring, sleep with parent
- If parent does not feel they can keep child safe or the child will not cooperate at home, need for more restrictive setting (hospitalization)
- Speak with parent about removing potentially lethal weapons, poisons, ropes, knives from the home and document the conversation

How to Help Patient Construct Written SAFETY PLAN What is Included?

- This is an essential step in treating any patient in the community for whom suicide is or has been a concern
  - Lock up potentially hazardous materials
  - Increase family and peer supervision and support
  - Engage in treatment with easy access to providers
  - Emergency Plan: know when to call 911 or come to the emergency for an urgent evaluation

SAFETY PLAN What to include

Common questions that should be answered when creating a safety plan:

- What are common triggers for you?
- What is the first sign that you may be entering a crisis (thoughts, feelings, body sensations)?
- Which coping skills have been most useful in crisis?
- Who can you call when feeling upset (create a support network)?
- How do you know when things are getting out of control and you need help?

Safety Plan in Action

- Rehearse the safety plan
- Agreed upon location of safety plan
- Cues for patient to recall they have a safety plan
- Explore confidence of client that she or he will use the safety plan
- Discuss barriers to use, and ways to overcome these

Safety Plan in action

- Safety planning needs to be collaborative not coerced
- Needs to include items that have meaning to the individual and which she or he is likely to use
- When involving family/friends, the patient needs to have control over how/when they are told
- Safety plans change over time as people change/social support systems change
- Important to instill hope

SPECIAL ISSUES

- Copycat Suicides
  - Typically occur after a suicide
  - Peer to peer groups have been incredibly helpful
- Social Networking
  - New forum for bullying
  - Can be a trigger, but also can alert others to cries of help and even suicidal thoughts and attempts
- Ethnic, Socioeconomic, and Sexual Minorities
  - At risk for targeting by peers

Potential emergency

- Thought changes represent areas for major focus and concern.
  - Command hallucinations telling the patient to kill himself or herself. These are usually auditory in nature and often take the form of the deity's voice (eg, "I hear God commanding me to kill myself, because I am bad").
  - Delusions- e.g., "The world and my family would be better off with me dead" or "If I take my life, I will be reunited in heaven with my mother."
  - Obsession of a patient wanting to take his or her own life. Some patients focus their lives on their suicide.

TREATMENT

Treatment of Co-Morbid Psychiatric Conditions

- Psychotherapies aimed at specific conditions
- Medications aimed at symptom reduction (SSRI's for depression)
- Lithium has shown some benefit in adults for reducing persistent suicidality

Dialectical Behavior Therapy

- The only therapy to date which has been shown to reduce suicidal and self harming behaviors in adolescents

How to incorporate suicide screening and safety planning into Primary care and behavioral health care settings

- ZERO Suicide is one program that advocates the screening of every patient that walks into the clinic.
- Provides short and long term view of client's suicidal features
- Quality assurance tool
- Buy in by staff, clinicians and administration
- Must have good referral list and appropriate resources-emergency room/hospital
- Agency emergency crisis plan developed by staff, clinicians, administrators
- Re-evaluate effectiveness

Questions

1. **The following are warning signs of potential suicide except:**

d. Loss of appetite

2. **True** or false:

3. The following statements are true:

a) Any or all suicidal statements or behaviors, regardless of how extreme, must be taken very seriously

b) Never use the term" successful suicide"

c) The Columbia Suicide Severity Rating Scale must be conducted by those with mental health background

d) a & b

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Resources

- Suicide Prevention Resource Center - http://www.sprc.org/
  - American Indian and Alaska Native Suicide Prevention Programs
  - Garrett Lee Smith State/Tribal Suicide Prevention Program
- Action Alliance for Suicide Prevention- http://zerosuicide.actionallianceforsuicideprevention.org/
- Suicide Prevention Life Line 1-800-273-TALK (8255)
- SAMHSA – Substance Abuse and Mental Health Services Administration
- Military One Source http://www.militaryonesource.mil/
- Columbia-Suicide Severity Rating Scale Training http://www.cssrs.columbia.edu/
- CALM-Counseling on Access to Lethal Means http://www.sprc.org/library_resources/items/calm-counseling-access-lethal-means

Resources

- Free, e-learning workshop from Columbia, NY OMH: Safety Planning Intervention for Suicidal Individuals www.zerosuicide.com
- Safety planning: A quick guide for clinicians http://www.sprc.org/sites/sprc.org/files/SafetyPlanningGuide.pdf
- Safety Plan template, manual and other resources: www.suicidesafetyplan.com