CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

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

April 23, 2025

Host

Nikki Harris, MA, CBHC-BS

Training and Education Lead

Nikki serves as the training and education lead for the Center of Excellence for Behavioral Health in Nursing Facilities (COE-NF). For the past 20 years, Nikki has provided program implementation, development, management, external and internal trainings, policy development, quality assurance, and managed training coordination and technical support throughout the southeast region.

Previously, she served as the program manager for the Division of Behavioral Health and Substance Use Services within the South Carolina Department of Corrections.

She has a B.A. in psychology from the University of South Carolina, a M.A. in counseling from Webster University and is a certified behavioral specialist.

Presenter

Adam Lesser, LCSW

Deputy Director

Columbia Lighthouse Project

at the New York State Psychiatric Institute

Adam is a licensed clinical social worker, an assistant professor of clinical psychiatric social work in the Division of Child and Adolescent Psychiatry at Columbia University Vagelos College of Physicians and Surgeons, a lecturer at the Columbia University School of Social Work and the deputy director of the Columbia Lighthouse Project at the New York State Psychiatric Institute where he assists with all suicide prevention activities related to public health including the international dissemination and implementation of the Columbia Suicide Severity Rating Scale (C-SSRS).

Adam has published, presented internationally and consulted to state and local governments on best practices for suicide risk identification and prevention and trained over 100,000 individuals on these methods. His work has been featured in *Social Work Today* magazine and on Atlanta National Public Radio (NPR), CNN-espanol, Univision and other local media outlets.

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

Adam Lesser, LCSW
Deputy Director for Implementation

Before We Begin

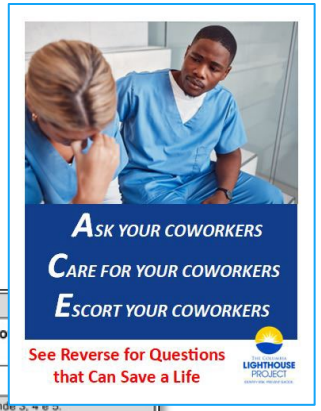
- Suicide is very personal.
- Many of us are survivors, who miss our clients, friends or relatives.
- Some may be attempt survivors.
- You shouldn't hold yourself responsible for something you didn't do/say in the past based on what you will learn today.

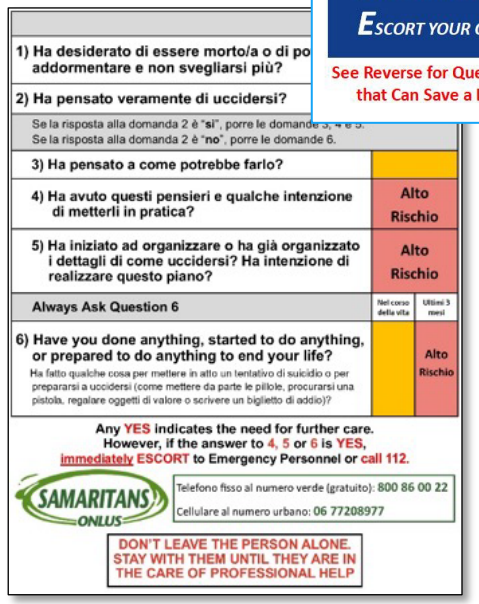
Please take care of yourself during and after this training.

Caring for Ourselves *and Each Other*

- Clinicians and healthcare workers feel an obligation to appear healthy or invincible – may be hesitant to ask for help for fear of hurting their career .
- The biggest risk for employees is vicarious or secondary traumatization – hearing difficult stories can traumatize the social worker/psychologist.
- Human service workers are also vulnerable to Compassion Fatigue, which can affect mental health and work performance if unaddressed.
- Studies show depressed clinicians are more prone to making errors and have a higher risk of chronic illness.

#1 cause of death for nurses and male medical residents

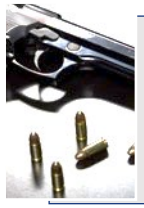




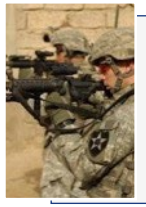
- **Mental Health providers are uniquely positioned to recognize depression in their peers**

Suicide is a Global Public Health Crisis and Kills…

More Americans than Car Crashes



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



More Soldiers than Combat (and 20 Veterans per day)

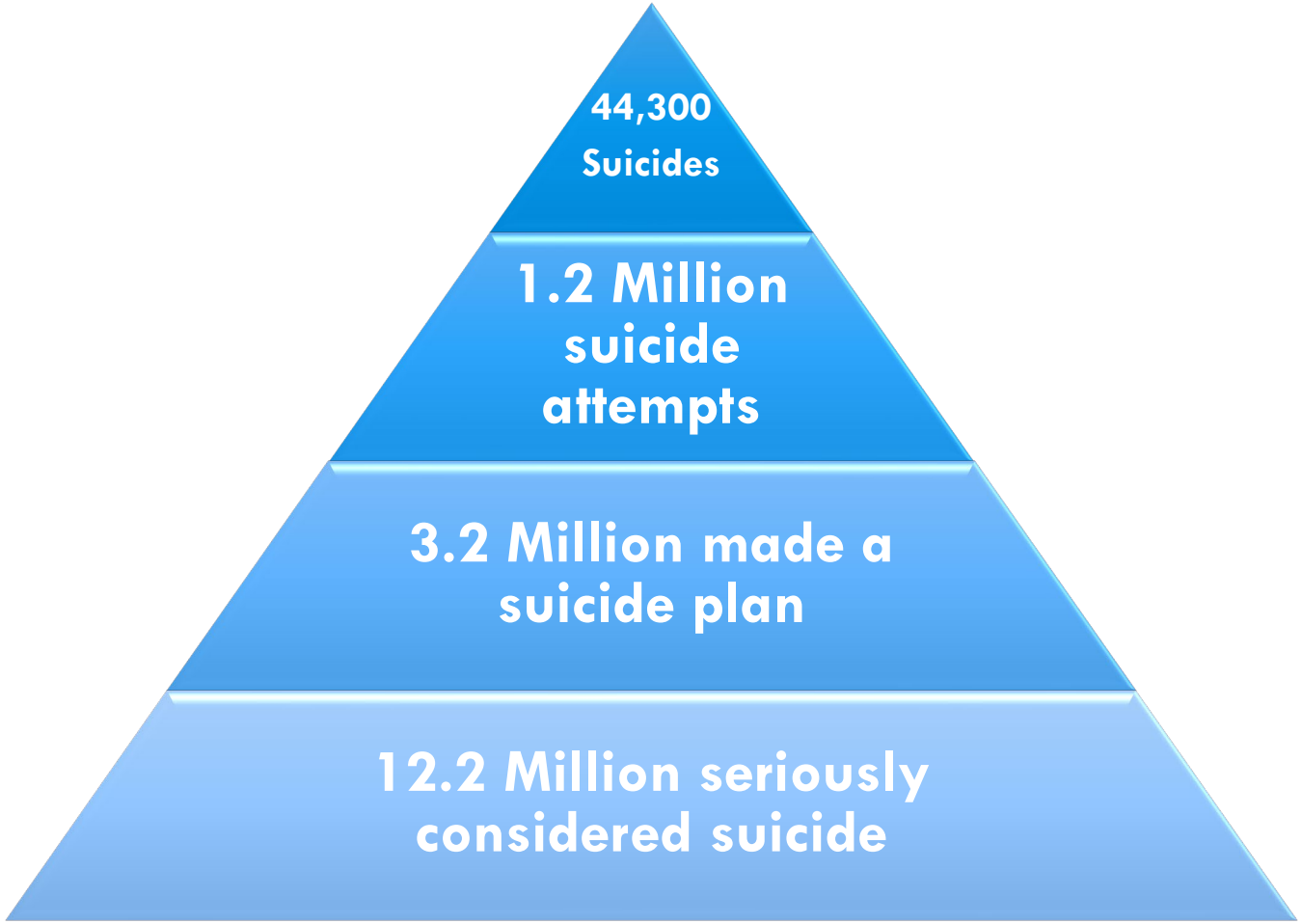
More Teenage Girls across the Globe than anything else

More Firefighters than Fire

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

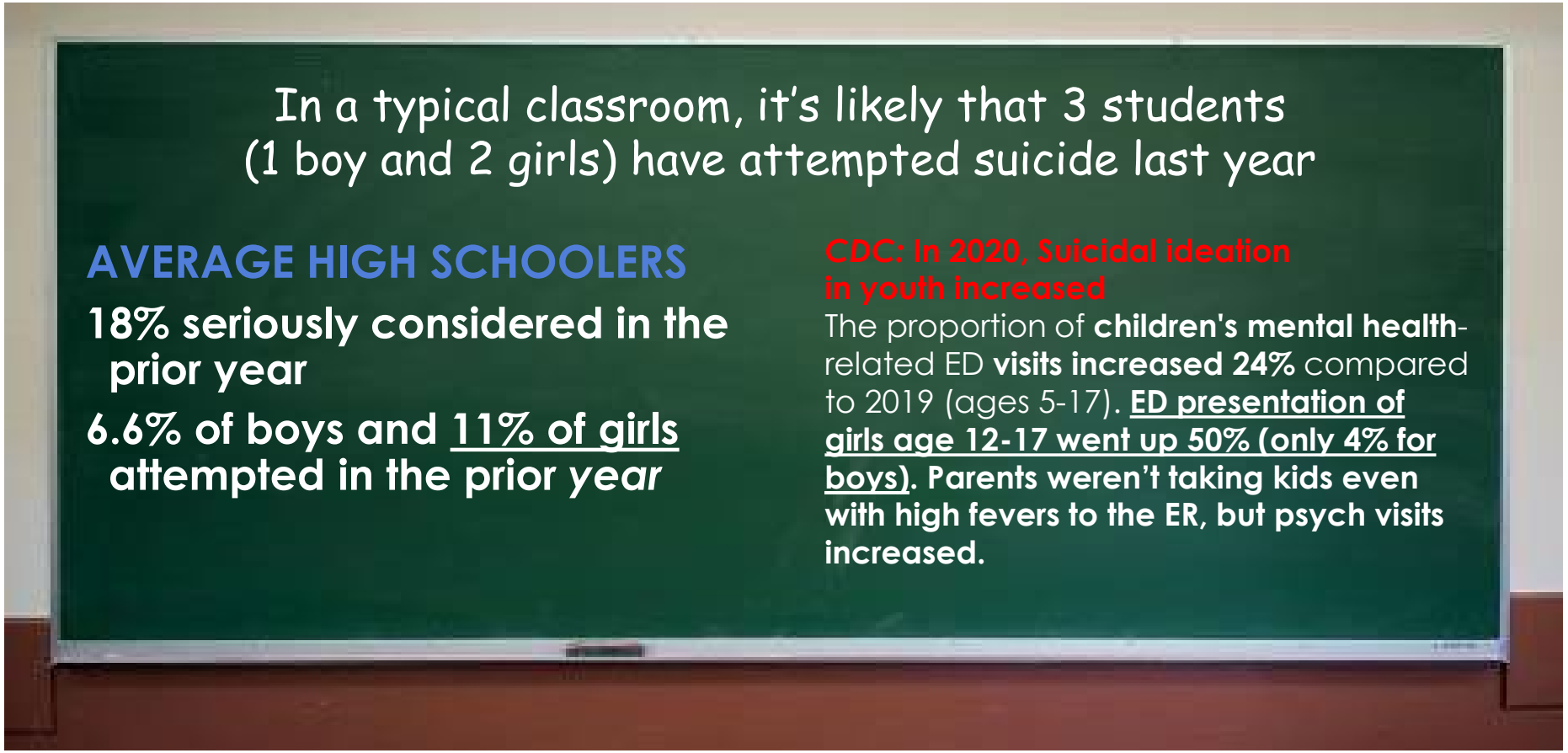
Pyramid of Suicidal Behaviors (Adults)



Source: * National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2022). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Available from: **www.cdc.gov/injury/wisqars/index.html.**

Why Asking Our Kids Routinely is Critical

Whether You're a Parent, Coach, Teacher or Peer



Suicide attempts by Black adolescents rose 73% (compared to 18% rise among white adolescents)

Chronic Medical Illness and Suicide

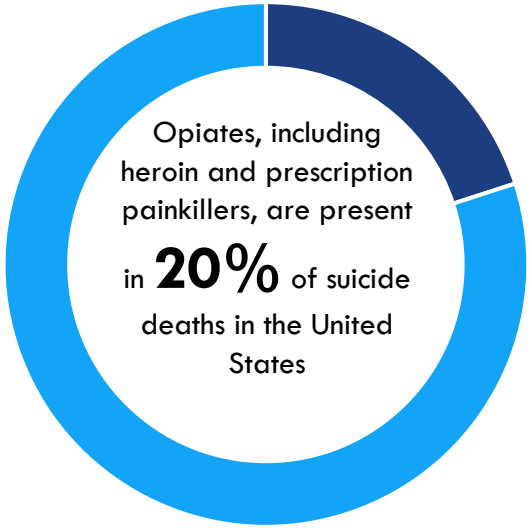
Studies indicate at least 10% suicide deaths connected to chronic medical conditions

Young people 15-30 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)

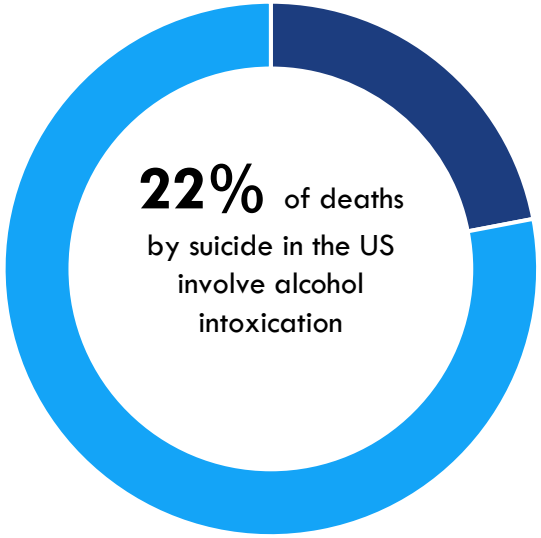
17 chronic medical conditions linked to increased risk for suicide (back pain, brain injury, cancer, CHF, COPD, Epilepsy, HIV/AIDS, migraine, sleep disorders) (Ahmedani 2017)

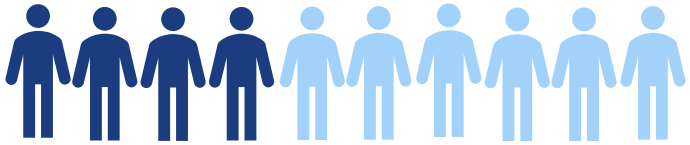
In cancer, suicide most common in first 3 months after diagnosis. Overall risk twice that of the general population, this risk can be as much as 13 times the average suicide risk in those newly diagnosed with cancer. (Saad 2019)

Addictions



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





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

(Rizk 2021)

Desperately Self-Medicating in Lieu of Proper Treatment:
Large Portion of Overdoses Are Suicides

NIH National Institute on Drug Abuse
Advancing Addiction Science

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Opioid Use Disorders and Suicide: A Hidden Tragedy (Guest Blog)

Share

April 20, 2017

*At a Congressional briefing on April 6, the **President of the American Psychiatric Association, Dr. Maria Oquendo**, presented startling data about the opioid overdose epidemic and the role suicide is playing in many of these deaths. I invited her to write a blog on this important topic. More research needs to be done on this hidden aspect of the crisis, including whether there may be a link between pain and suicide. —Nora*

In 2015, over 33,000 Americans died from opioids—either prescription drugs or heroin or, in many cases, more powerful synthetic opioids like fentanyl. Hidden behind the terrible epidemic of opioid overdose deaths looms the fact that many of these deaths are far from accidental. They are suicides.

About This Blog

Welcome to my blog, here I highlight important work being done at NIDA and other news related to the science of drug abuse and addiction.

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The Magnitude… U.S. Life Expectancy Decreased: Suicide Deaths Play a Role

Health & Science

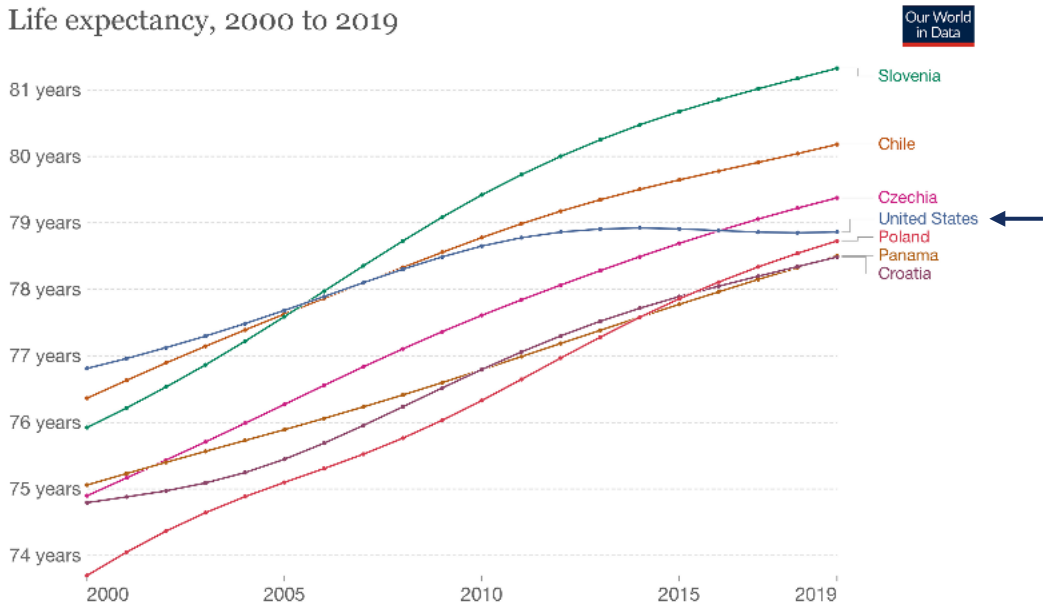
U.S. life expectancy declines for the first time since 1993

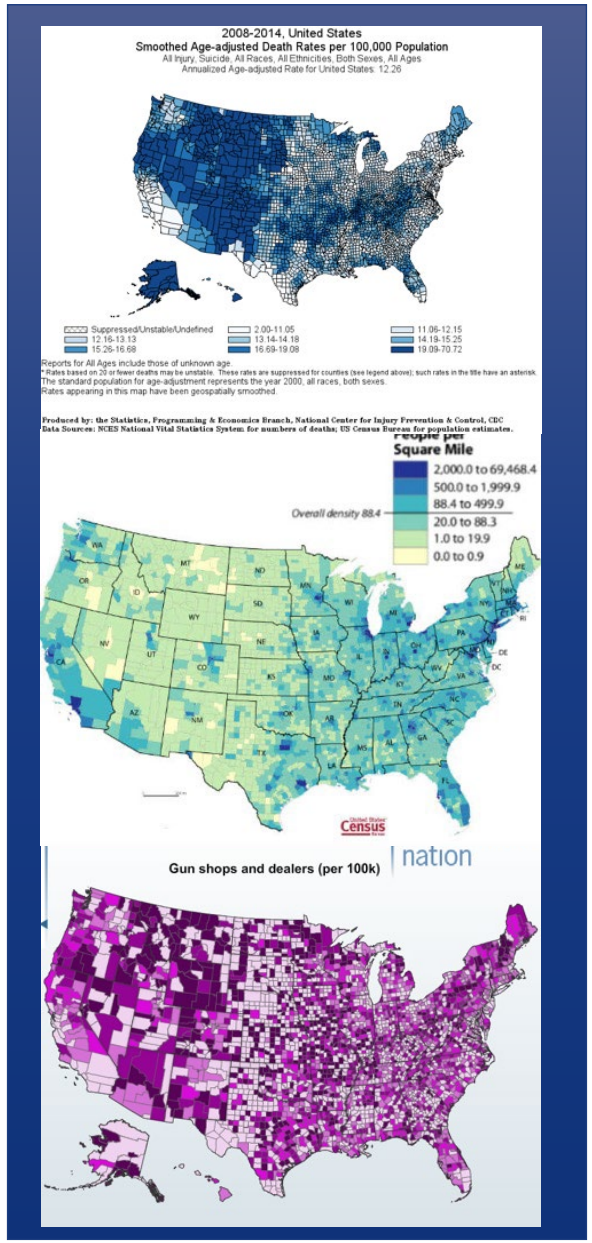
By Lenny Bernstein December 8, 2016

The Post's Lenny Bernstein explains a report that shows life expectancy for Americans has declined in 2015 for the first time since 1993. (Monica Akhtar, Gillian Brockell/The Washington Post)

For the first time in more than two decades, life expectancy for Americans declined last year — a troubling development linked to a panoply of worsening health problems in the United States.

Anomaly Among Developed Nations





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)

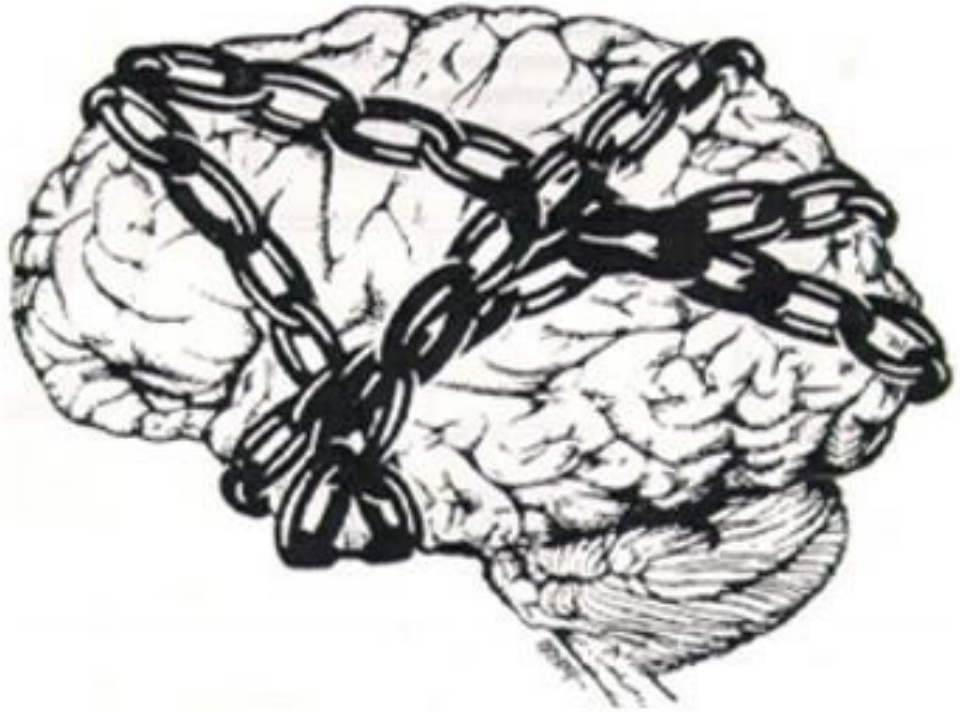
Data on 2016-2020 Suicides in States with the Highest and Lowest Rates of Gun Ownership

	High Gun Ownership	Low Gun Ownership	Ratio
Percent of households with guns	~50%	~20%	
Suicide Rate per 100,000	18.17	9.02	2.0
Male			
Non-firearm Suicides	9042	9121	1.0
Firearm Suicides	17779	3909	4.5
Female			
Non-firearm Suicides	3851	3655	1.1
Firearm Suicides	3286	342	9.6

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

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 (Meza 2022)**
- 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 (Hoffmann 2016)**
- Limited access to community support and lack of in-school counseling has also **disproportionately impacted LGBTQ youth**, especially if their family is unsupportive
- Unemployment results in loss of health insurance and often medications are unaffordable



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***

Columbia University Department of Psychiatry
Vagelos College of Physicians and Surgeons | Division of Child & Adolescent Psychiatry

NewYork-Presbyterian

Touches Everyone… Vital Part of Health & Wellness for Employees & Their Families

Need to Screen Everywhere and Care for the Caregivers

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

Healthy Employees = Improved Earnings

58% of teachers report high stress and/or depression. But have one of the lowest rates of suicide deaths among professions.

Firefighters utilize the C-SSRS in 3 ways:

1) To **screen civilians in the community** who are potentially suicidal to determine what treatment is appropriate.

2) To **identify members in the Department** who are in need of assistance.

3) To **recognize family members** of firefighters who may be at risk of suicide.

Why Is Screening So Important for Everyone? Stigma and Misunderstanding Can be Lethal

The Culture that Defines the Protectors

"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."

"I'm an ER doctor. I've seen a therapist & have been on antidepressants. Our system considers this a red flag, instead of a positive signal that I'm taking the best care of myself possible. **This needs to change."**

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 to the psychologist or whatever, just 'cause that becomes your weakness." - *MLB Player*

It's a Sign of Strength to Ask for Help

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.

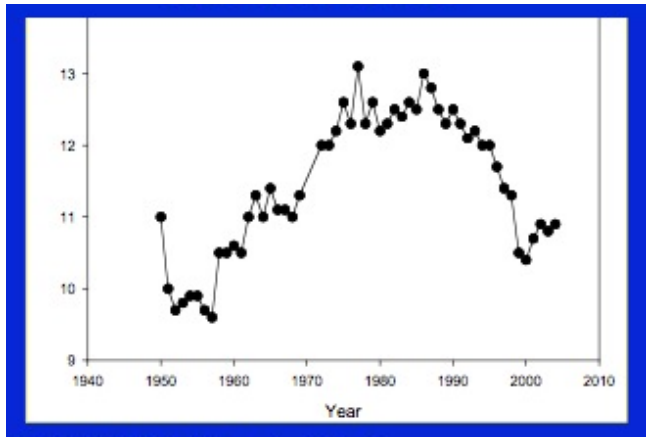
Especially in adolescents and young adults

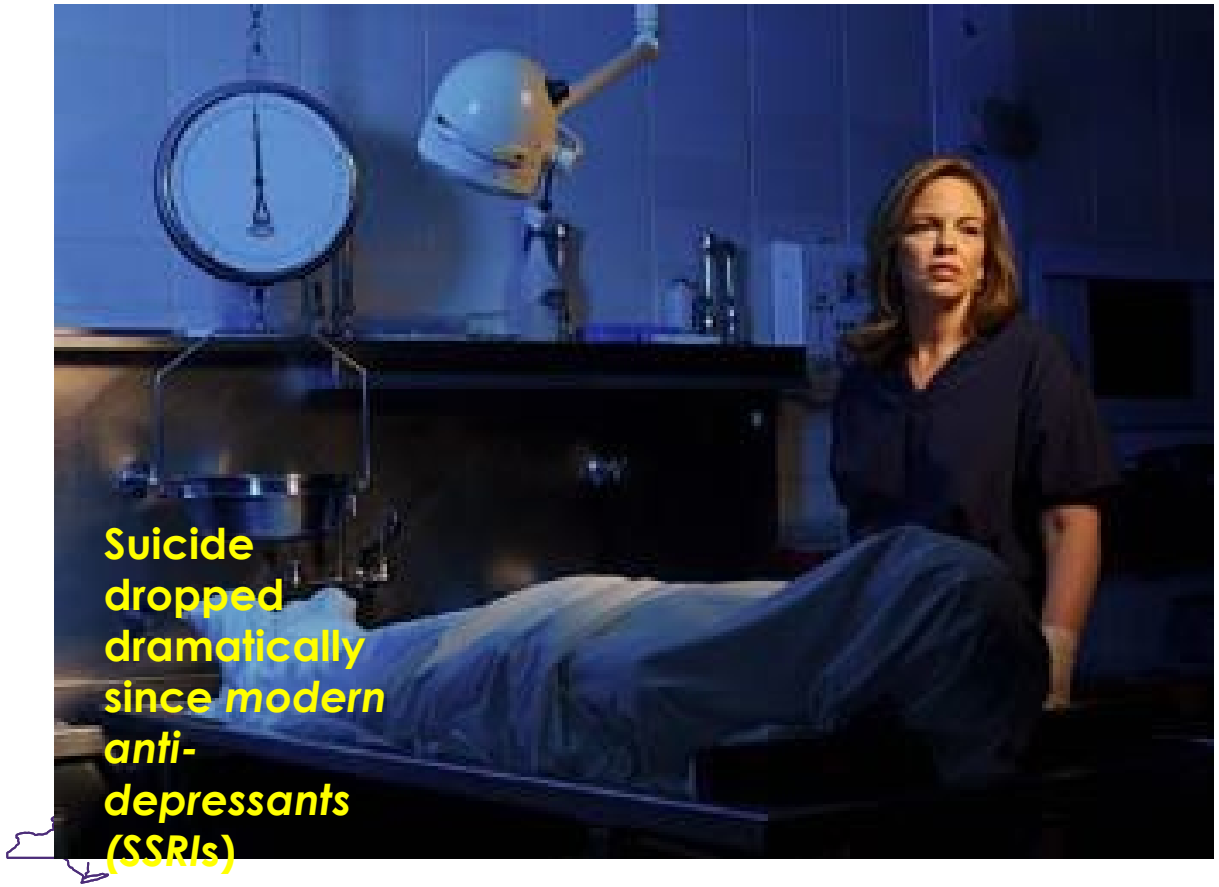
(Niederkrotenthaler, 2019)

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."**





Unfortunately…
Those Who Need Treatment Do Not Get It

The scandal of common mental illnesses left untreated

Would we tolerate a situation in which the majority of those suffering from diabetes, heart disease, or arthritis were left to fend for themselves, or asked to make do with inferior therapies?

▲ Mental illness is common and debilitating, yet most people receive no medical help. Photograph: Alamy

The Guardian

Under-treatment of mental illness is pervasive:

- 50-75% of those in need receive no or inadequate treatment (Iometsa 1994)
- Over 80% of adolescents and college students who die by suicide never received any consistent treatment prior to their death
- In LTC 63% of residents who died from suicide and were diagnosed with depression not on medication

MYTHS ABOUT SUICIDE

"If someone is really suicidal, they are probably going to kill themselves at some point no matter what you do."

- 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."

- 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."

- 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

"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

Method	Lethality
Firearm	**85%**
Suffocation	69%
Fall	31%
Poisoning/overdose	2%
Cuts	1%

Means Safety Works
Very Little Method Substitution in All Cases

- **England 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)

Kevin Hines Survived Jumping Off the Golden Gate Bridge: If Just One Person Had Asked...

All Survivors Wanted to Be Saved

"Most people considering suicide *want someone to save them.* What we need is a culture in which no one is afraid to ask. What we needed were the questions people could use to help save us. That's why the pioneering change the C-SSRS is enabling is so essential to our humanity." - *Kevin Hines, Survivor*

People Want to Be Saved & Need to be Asked

Everywhere People Acquire Means: A Life Can Be Saved Up Until the Last Minute

- Transit Workers
- Pharmacies
- Gun shops
- Pesticide Suppliers
- Parks
- Bathrooms







'I wasn't thinking about anything except wanting to hurt myself.' Teen suicide attempts soar

JUMPING OFF SCHOOL BUILDINGS

Columbia University Department of Psychiatry
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Division of Child & Adolescent Psychiatry
NewYork-Presbyterian

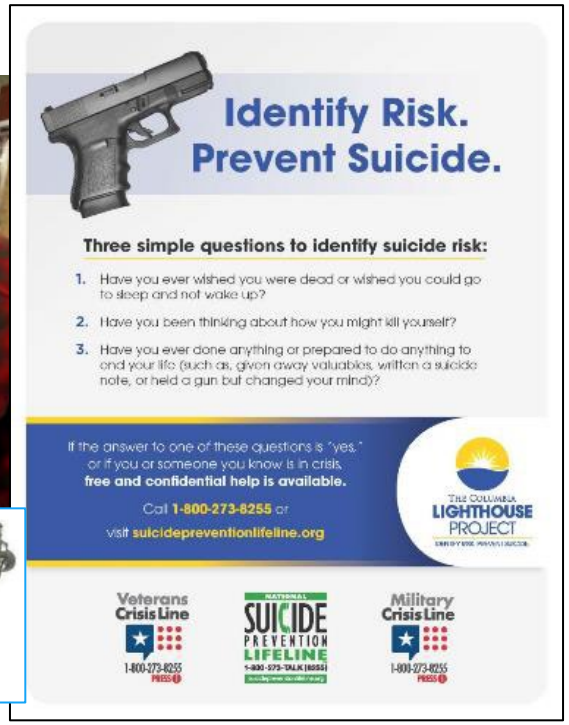
The Gun Death Crisis and the Need to Go Beyond the Hospital: Most Gun Deaths are Suicides

Nearly 2/3 are Suicides (20,000-25,000 per year)

Over 2000 Mass Shootings in the US Since Sandy Hook

80% of school shooters have a history of suicidal issues

The Gun Buyer Wants to be



"The Highest Form of 'See Something Say Something'"

The Importance of Screening Beyond Medicine:
Life Saving Synergistic Partnership of the Medical Model and the Public Health Approach

Medical Model

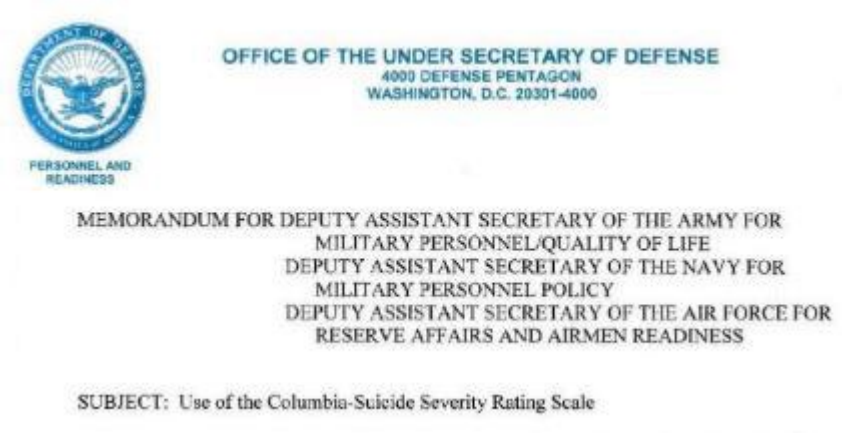
- Narrow approach
- Mental health treatment by clinicians in hospitals & clinics
- Most people at risk do not seek specialized treatment

Public Health Model

- Broad approach
- Target: whole community
- Training of all gatekeepers
- Across all health services

Must Go Beyond the Medical Model: Marines Reduce Suicide by 22%

Undersecretary of Defense Urgent Memo



OFFICE OF THE UNDER SECRETARY OF DEFENSE
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WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

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

Marine Corps Times
A GANNETT COMPANY

- Total force roll-out
- In the hands of whole community
- ALL support workers: lawyers, financial aid counselors, chaplains

We Must Find People Where they Work, Live, Learn and Thrive:
People Don't Necessarily Have the Will to Come to You

VT Policy recommendation and role play for school janitors

Zero Suicide community workshop for custodians and receptionists

Future VA stand-down: From canteen worker to cemetery worker

75% of those who die by suicide die at home – for ages 5-11, it's 95%

Always ask questions 1 and 2.	Past Month
1) Have you wished you were dead or wished you could go to sleep and not wake up?	
2) Have you actually had any thoughts about killing yourself?	
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.	
3) Have you been thinking about how you might do this?	
4) Have you had these thoughts and had some intention of acting on them?	High Risk
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk
Always Ask Question 6	Life-time / Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples:* Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, 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, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. **If yes, was this within the past 3 months?**	High Risk

988 SUICIDE & CRISIS LIFELINE

If YES to 2 or 3, seek behavioral healthcare for further evaluation.
If the answer to 4, 5 or 6 is YES, get immediate help: Call or text 988, call 911 or go to the emergency room.
STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

"Screening normalizes the conversation. We need to change the culture so that it becomes like taking your blood pressure – everybody gets asked."

Community Cards

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
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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

ASK YOUR RESIDENTS
CARE FOR YOUR RESIDENTS
ESCORT YOUR RESIDENTS

See Reverse for Questions that Can Save a Life

Suicide Rate in Air Force Decreases with Everyone Asking

Zero Suicide: Whole-Community Systems Approach in the Air Force
Airman, Clergy, Dentist, Spouse, etc.

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

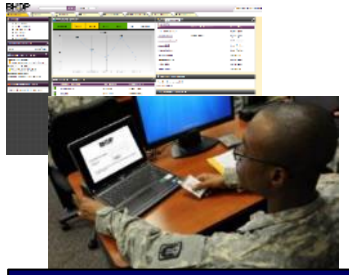
Schools, Child & Family Services

Primary Care, Dentistry

Spouses

Peers & Leadership

Security/Safety
- Overnights
- Explosive Ordinance Disposal



Behavioral Health

When A Community Comes Together There is Hope

Air Force Chaplains Peer-to-Peer

https://youtu.be/MfBXroY5doo

PREVENTING SUICIDE REQUIRES ACCURATE IDENTIFICATION: THE COLUMBIA TOOLS

Columbia University Department of Psychiatry
Vagelos College of Physicians and Surgeons
Division of Child & Adolescent Psychiatry
NewYork-Presbyterian

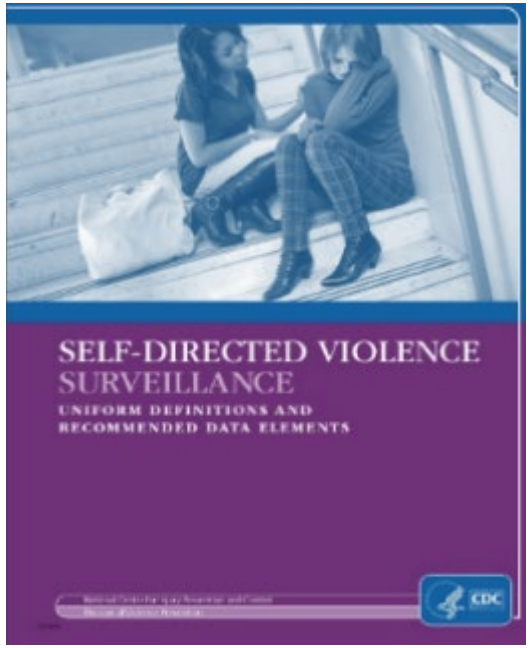
Just Ask, You Can Save a Life:

Columbia-Suicide Severity Rating Scale (C-SSRS)

- Developed in NIMH effort
- Thousands of studies using it
- 130 languages
- Endorsed, Recommended, Adopted or Mandated by National and International Agencies (CDC, FDA, DOD, NIMH)

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

Source: Posner K, Oquendo MA, Gould M, Stanley B, Davies M. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of Antidepressants. Am J Psychiatry. 2007; 164:1035-1043. http://cssrs.columbia.edu/

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 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 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)

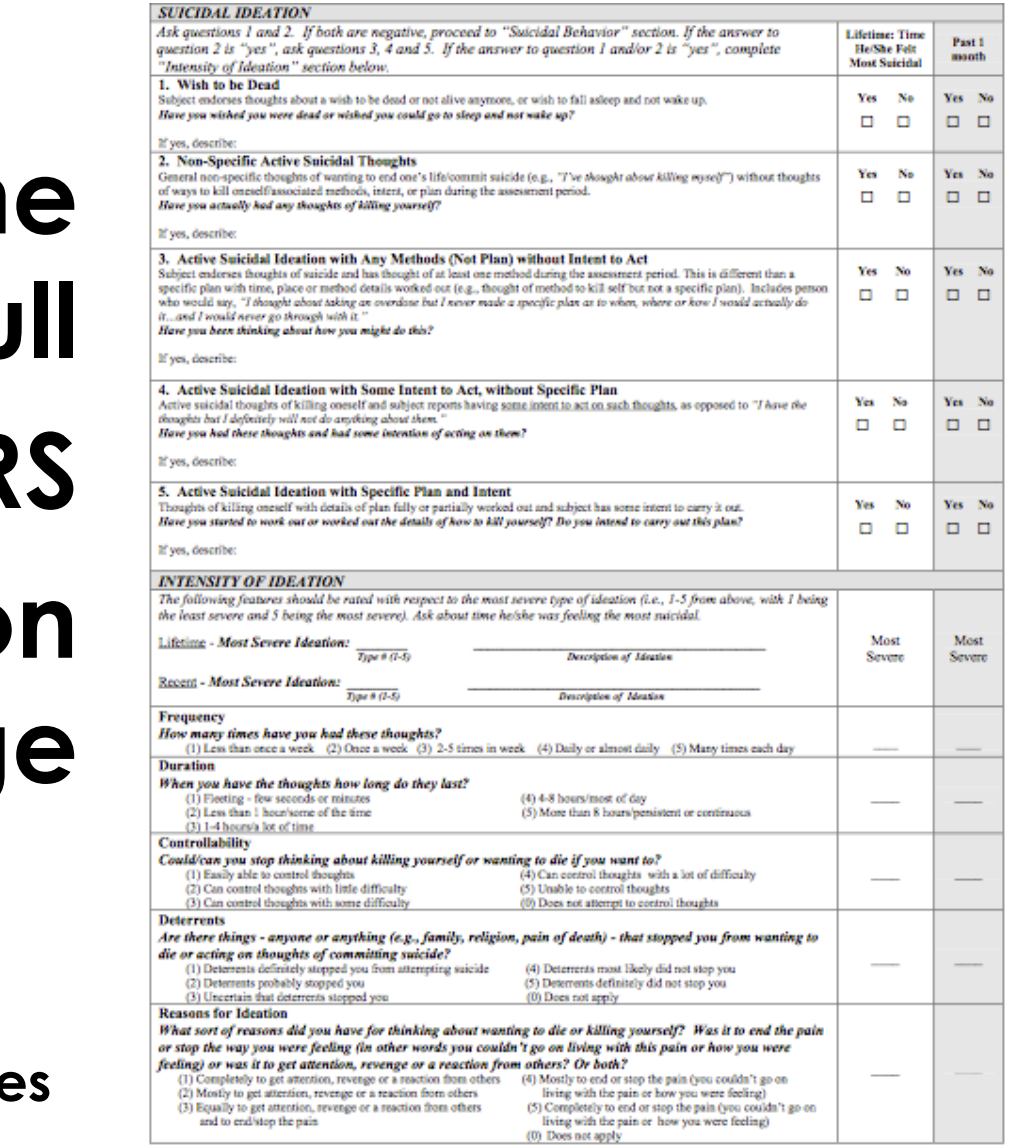
- Behaviors - All relevant behaviors assessed and all items include definitions for each term and standardized questions for each category are included to guide the interviewer for facilitating improved identification (Full and Screener C-SSRS)
- Lethality of Actual Suicide Attempts (Full C-SSRS Only)

SUICIDAL IDEATION

Columbia University Department of Psychiatry
Vagelos College of Physicians and Surgeons
Division of Child & Adolescent Psychiatry
NewYork-Presbyterian

This is the Full C-SSRS Ideation Page

Typical Administration Time=Few Minutes



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 wished you were dead or wished you could go to sleep and not wake up?*** 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 actually had any thoughts of 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 been thinking about how you might do this?*** 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."* ***Have you had these thoughts and had some intention of acting on them?*** 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 started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐

INTENSITY OF IDEATION

The following features 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). Ask about time he/she was feeling the most suicidal.

Lifetime - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*)

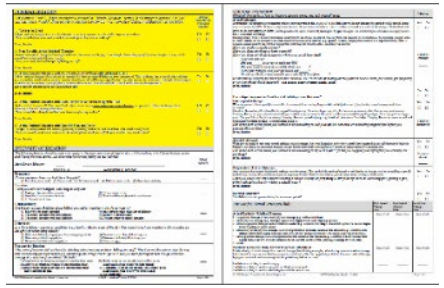
Recent - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*)

	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

C-SSRS Full & Screener Ideation Questions

	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *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) *Have you been thinking about how you might do this?* 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.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*		

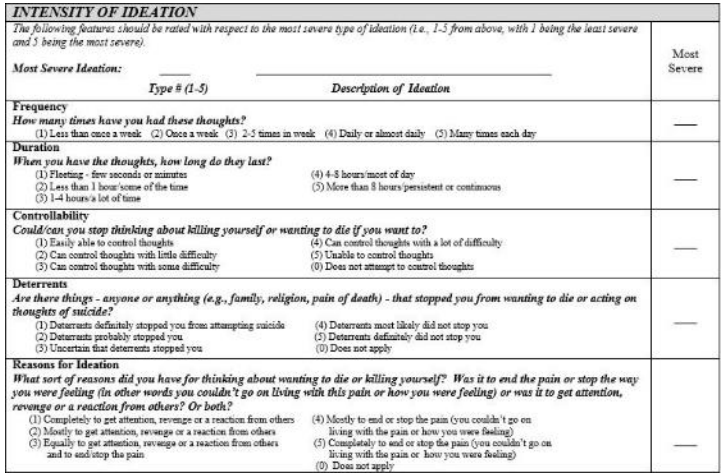
Psychosis: Auditory hallucinations count as suicidal ideation



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)



INTENSITY OF IDEATION

The following features 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

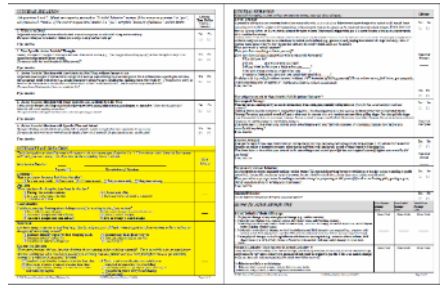
Frequency
How many times have you had these thoughts?
(1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day ____

Duration
When you have the thoughts, how long do they last?
(1) Fleeting - few seconds or minutes
(2) Less than 1 hour/some of the time
(3) 1-4 hours/a lot of time
(4) 4-8 hours/most of day
(5) More than 8 hours/persistent or continuous ____

Controllability
Could/can you stop thinking about killing yourself or wanting to die if you want to?
(1) Easily able to control thoughts
(2) Can control thoughts with little difficulty
(3) Can control thoughts with some difficulty
(4) Can control thoughts with a lot of difficulty
(5) Unable to control thoughts
(0) Does not attempt to control thoughts ____

Deterrents
Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?
(1) Deterrents definitely stopped you from attempting suicide
(2) Deterrents probably stopped you
(3) Uncertain that deterrents stopped you
(4) Deterrents most likely did not stop you
(5) Deterrents definitely did not stop you
(0) Does not apply ____

Reasons for Ideation
What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?
(1) Completely to get attention, revenge or a reaction from others
(2) Mostly to get attention, revenge or a reaction from others
(3) Equally to get attention, revenge or a reaction from others and to end/stop the pain
(4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling)
(5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling)
(0) Does not apply ____

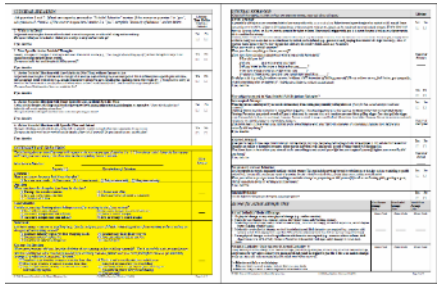


Clinical Guidance

For Intensity of Ideation, risk is greater when:

- Thoughts are more frequent
- Thoughts are of longer duration
- Thoughts are less controllable
- Fewer deterrents 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)**

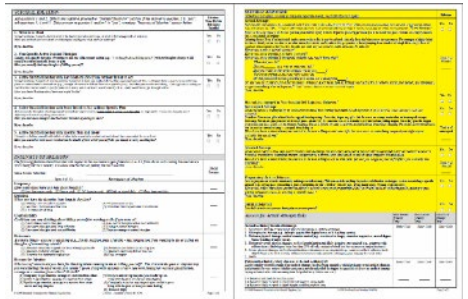


Ideation Demo

SUICIDAL BEHAVIOR

Full C-SSRS Suicidal Behavior Section

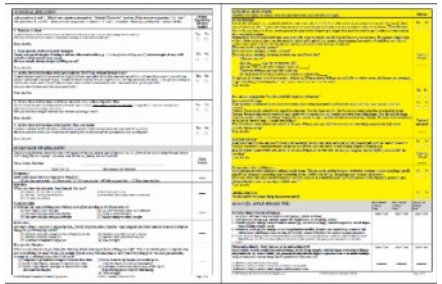
SUICIDAL BEHAVIOR *(Check all that apply; so long as these are separate events; must ask about all types)*	Lifetime	Past 3 months
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of* act. Behavior was in part thought of as method to kill oneself. 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. *Have you made a suicide attempt?* *Have you done anything to harm yourself?* *Have you done anything dangerous where you could have died?* *What did you do?* *Did you_____ as a way to end your life?* *Did you want to die (even a little) when you_____?* *Were you trying to end your life when you_____?* *Or Did you think it was possible you could have died from_____?* *Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, 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 ☐ ☐
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 end your life but someone or something stopped you before you actually did anything?* 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 try to end your life but you stopped yourself before you actually did anything?* 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 taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?* If yes, describe:	Yes No ☐ ☐ Total # of preparatory acts ____	Yes No ☐ ☐ Total # of preparatory acts ____



Suicide Attempt Definition

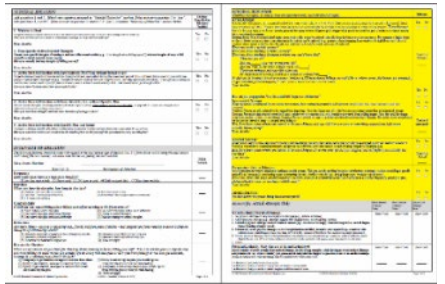
A self-injurious **act** undertaken with at least **some** intent to die, **as a result of** the act

- There does not have to be any injury or harm, just the **potential** for injury or harm (e.g., gun failing to fire, first pill swallowed, scratch with a knife)
- 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)

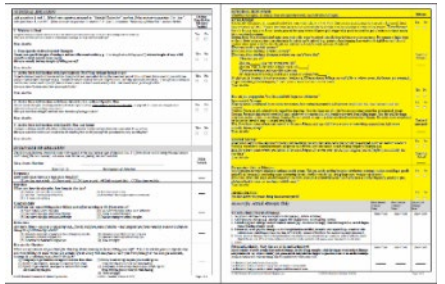


As Opposed To Non-suicidal Self-injurious Behavior

- 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:	Examples
• When person starts to take steps to end their life but someone or something stops them	• Bottle of pills or gun in hand but someone grabs it • On ledge poised to jump

Aborted/Self-Interrupted Attempt

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

Lethality

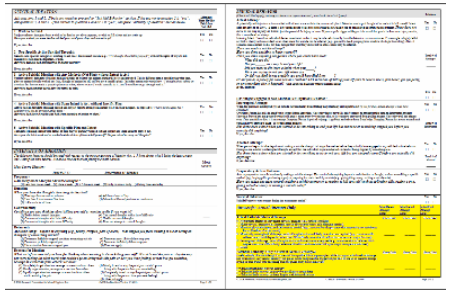
(Compilation of Beck Medical Lethality Rating Scale)

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

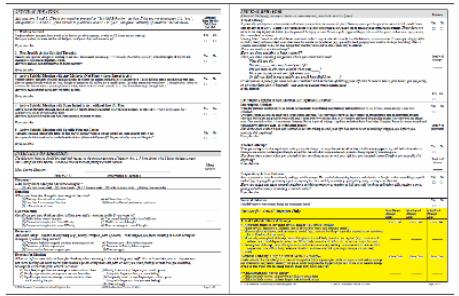
Likely lethality of attempt if no medical damage. Examples of why this is important are cases in which there was no actual medical damage but the potential for very serious lethality

- **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

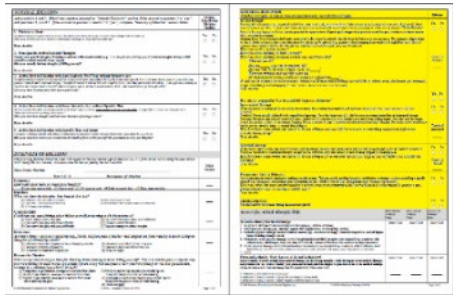


Behavior Demo

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

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***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) ***Have you been thinking about how you might do this?*** 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.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?***		

6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Took pills, tried to shoot yourself, cut yourself, or hang yourself, 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, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. **If YES, ask:** ***Was this within the past three months?***	**YES**	**NO**

- Low Risk
- Moderate Risk
- High Risk

If 2 yes, ask 3-6

If 2 is no, go to 6

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)

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 wished you were dead or wished you could go to sleep and not wake up?*** 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	Yes ☐ No ☐	Yes ☐ No ☐

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. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, 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 ☐

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 anything, started to do anything or prepared to do anything to end your life?"

Recommended **EVERY** visit

- ***You don't want the time you didn't ask to be the time you needed to ask***

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Frequent Screener

Ask questions that are bold and underlined	Since Last Contact	
Ask Question 2*	**YES**	**NO**
2) ***Have you had thoughts about killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) ***Have you been thinking about how you might do this?***		
4) ***Have you had these thoughts and had some intention of acting on them?*** 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.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
6) ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Took pills, tried to shoot yourself, cut yourself, or hang yourself, 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, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc.		

*** Note – for frequent assessment purposes, Question 1 has been omitted**

Low Risk
Moderate Risk
High Risk

Flexible Toolkit: Youth Screener

Columbia Suicide Severity Rating Scale (C-SSRS) - Screener – Recent - Child

	PAST MONTH
Ask questions 1 and 2.	
1. Have you wished that you could go to sleep and never wake up or that you were dead?	
2. Have you thought about killing yourself?	
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.	
3. Did you think about ways you could kill yourself?	
4. Some people think about killing themselves but know they would NEVER do it. Others think about killing themselves and think that they might do something. **Was there a time when you thought about killing yourself and it was something you MIGHT do, even if you weren't completely sure?**	
5. Did you make a plan for how you would kill yourself (things like when, how, and where) and, even if you weren't completely sure when you made this plan, was it something that you thought you MIGHT do?	
Always ask question 6	
6. Have you EVER tried to kill yourself, started to do something to kill yourself or done anything to get ready to kill yourself?	
If YES, was this in the past 3 months?	
Examples: took pills, tried to shoot yourself, cut yourself or hang yourself, 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, wrote, or sent a goodbye message, did research on the internet about killing yourself, or got what you needed to kill yourself, etc.	

- Risk Assessment page and screener for all crisis evaluations

Flexible Toolkit – *Tennessee Crisis Assessment Tool*

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***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) ***Have you been thinking about how you might do this?*** 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.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Took pills, tried to shoot yourself, cut yourself, or hang yourself, 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, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. **If YES, ask:** ***Was this within the past three months?***	**YES**	**NO**

Low Risk
Moderate Risk
High Risk

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.

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

Past 3 Months	Suicidal and Self-Injurious Behavior (from C-SSRS)	Lifetime	Clinical Status (Recent)
*☐	Actual suicide attempt	☐	☐ Hopelessness
*☐	Interrupted attempt	☐	☐ Major depressive episode
*☐	Aborted or Self-Interrupted attempt	☐	☐ Mixed affective episode
*☐	Other preparatory acts to kill self	☐	☐ Command hallucinations to hurt self
Suicidal Ideation (from C-SSRS) Check Most Severe in Past Month			☐ Highly impulsive behavior
☐	Wish to be dead (1)		☐ Substance abuse or dependence
☐	Suicidal thoughts (2)		☐ Agitation or severe anxiety
☐	Suicidal thoughts with method (but without specific plan or intent to act) (3)		☐ Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
*☐	Suicidal intent (without specific plan) (4)		☐ Perceived burden on family or others
*☐	Suicidal intent with specific plan (5)		☐ Homicidal ideation
Activating Events (Recent)			☐ Aggressive behavior towards others
☐	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)		☐ Method for suicide available (gun, pills, etc.)
Describe:			☐ Refuses or feels unable to agree to safety plan
			☐ Sexual abuse (lifetime)
☐	Pending incarceration or homelessness		☐ Family history of suicide (lifetime)
☐	Current or pending isolation or feeling alone		☐ Self-injurious behavior without suicidal intent
Treatment History			**Protective Factors (Recent)**
☐	Previous psychiatric diagnoses and treatments		☐ Identifies reasons for living
☐	Hopeless or dissatisfied with treatment		☐ Responsibility to family or others; living with family
☐	Non-compliant with treatment		☐ Supportive social network or family
☐	Not receiving treatment		☐ Fear of death or dying due to pain and suffering
Other Risk Factors			☐ Belief that suicide is immoral; high spirituality
☐			☐ Engaged in work or school
☐			**Other Protective Factors**
☐			☐
Describe any suicidal, self-injurious or aggressive behavior (include dates)			

SAFE-T with C-SSRS

SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors) Lifetime/Recent

Step 1: Identify Risk Factors		
C-SSCS Suicidal Ideation Severity	**Month**	**Lifetime (Worst)**
1) Wish to be dead *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*		
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might kill yourself?*		
4) Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?*		
5) Intent with Plan *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*		
C-SSRS Suicidal Behavior: *"Have you ever 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.	**3 Months**	**Lifetime**

Activating Events:
- ☐ Recent losses or other significant negative event(s) (legal, financial, relationship, etc.)
- ☐ Pending incarceration or homelessness
- ☐ Current or pending isolation or feeling alone

Treatment History:
- ☐ Previous psychiatric diagnosis and treatments
- ☐ Hopeless or dissatisfied with treatment
- ☐ Non-compliant with treatment
- ☐ Not receiving treatment
- ☐ Insomnia

Other:
- ☐ _____
- ☐ _____
- ☐ _____

Clinical Status:
- ☐ Hopelessness
- ☐ Major depressive episode
- ☐ Mixed affect episode (e.g. Bipolar)
- ☐ Command Hallucinations to hurt self
- ☐ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- ☐ Highly impulsive behavior
- ☐ Substance abuse or dependence
- ☐ Agitation or severe anxiety
- ☐ Perceived burden on family or others
- ☐ Homicidal Ideation
- ☐ Aggressive behavior towards others
- ☐ Refuses or feels unable to agree to safety plan
- ☐ Sexual abuse (lifetime)
- ☐ Family history of suicide

☐ **Access to lethal methods:** Ask specifically about presence or absence of a firearm in the home or workplace or ease of accessing

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

Internal:
- ☐ Fear of death or dying due to pain and suffering
- ☐ Identifies reasons for living
- ☐ _____
- ☐ _____

External:
- ☐ Belief that suicide is immoral; high spirituality
- ☐ Responsibility to family or others; living with family
- ☐ Supportive social network of family or friends
- ☐ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent (see Step 1 for Ideation Severity and Behavior)

C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation identified above)	**Month**	**Lifetime (Worst)**
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day		
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous		
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts		
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply		
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply		
Total Score		

Notes:

Behaviors:
- ☐ Preparatory Acts (e.g., buying pills, purchasing a gun, giving things away, writing a suicide note)
- ☐ Aborted/self-interrupted attempts,
- ☐ Interrupted attempts and
- ☐ Actual attempts

☐ **Assess for the presence of non-suicidal self-injurious behavior** (e.g. cutting, hair pulling, cuticle biting, skin picking) particularly among adolescents and young adults, and especially among those with a history of mood or externalizing disorders

☐ **For Youths:** ask parents/guardian about evidence of suicidal thoughts, plans or behaviors and changes in mood, behaviors or disposition

☐ **Assess for homicidal ideation, plan behavior and intent** particularly in:
- ☐ character disordered males dealing with separation, especially if paranoid, or impulsivity disorders

SAFE-T with C-SSRS Triage

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE
High Risk ☐ Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) **Or** ☐ Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	☐ **Initiate local psychiatric admission process** ☐ **Stay with patient until transfer to higher level of care is complete** ☐ **Follow-up and document outcome of emergency psychiatric evaluation**
Moderate Risk ☐ Suicidal ideation with method **WITHOUT plan, intent or behavior in past month** (C-SSRS screen #3) **Or** ☐ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior) **Or** ☐ Multiple risk factors and few protective factors	☐ **Directly address suicide risk, implementing suicide prevention strategies** ☐ **Develop Safety Plan**
Low Risk ☐ Wish to die or suicidal thoughts (C-SSRS Suicidal Ideation #1 and/or #2) **no method, plan, intent or behavior** **Or** ☐ Suicidal ideation more than 1 month ago (C-SSRS screen #1-5) **Or** ☐ Modifiable risk factors and strong protective factors **Or** ☐ No reported history of Suicidal Ideation or Behavior	☐ **Discretionary Outpatient Referral**

Step 5: Document Level of Risk, Rationale for Risk Assignment, Intervention and Structured Follow Up Plan (to be developed)

Risk Level :

[ ] High Risk [ ] Moderate Risk [ ] Low Risk Suicidal

Clinical Note:

- ☐ Your Clinical Observation
- ☐ Relevant Mental Status Information
- ☐ Methods of Suicide Risk Evaluation
- ☐ Brief Evaluation Summary
  - ☐ Warning Signs
  - ☐ Risk Indicators
  - ☐ Protective Factors
  - ☐ Access to Lethal Means
  - ☐ Collateral Sources Used and Relevant Information Obtained
  - ☐ Specific Assessment Data to Support Risk Determination
  - ☐ Rationale for Actions Taken and Not Taken
- ☐ Provision of Crisis Line 1-800-273-TALK(8255)
- ☐ Implementation of Safety Plan (If Applicable)

THE SCIENCE

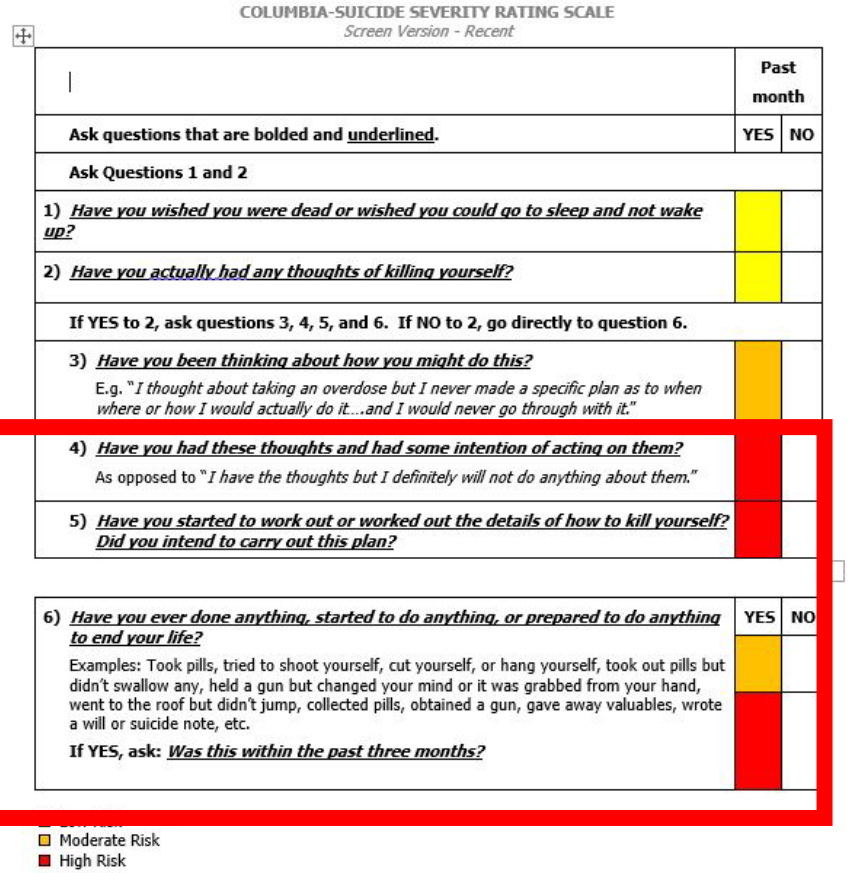
Research Supported Thresholds for Imminent Risk Identification

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



COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***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) ***Have you been thinking about how you might do this?*** 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.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Took pills, tried to shoot yourself, cut yourself, or hang yourself, 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, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. **If YES, ask:** ***Was this within the past three months?***	**YES**	**NO**

Moderate Risk
High Risk

The Full Lifetime/Recent C-SSRS

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	
	Y	N	Y	N
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:				
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 actually had any thoughts of killing yourself?*** If yes, describe:				
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 been thinking about how you might do this?*** If yes, describe:				
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."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:				
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 started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:				

The following features 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). Ask about time he/she was feeling the most suicidal. Lifetime - *Most Severe Ideation:* ____ (Type # (1-5)) ____ (Description of Ideation) Past Month - *Most Severe Ideation:* ____ (Type # (1-5)) ____ (Description of Ideation)	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	Lifetime		Past 3 months	
	Y	N	Y	N
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. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you_____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe:				
Has subject engaged in Non-Suicidal Self-Injurious Behavior?				
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 end your life but someone or something stopped you before you actually did anything?*** If yes, describe:				
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 try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:				
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 taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:				

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: Physical damage or very minor physical damage (e.g., surface scratches). Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 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). 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*

Questions Used to Facilitate Appropriate Care: Officer Demo

http://youtu.be/fx3N3uDUQbo

Police Asking
is Critical to
Optimizing
Scarce Resources,
and Decreasing
Unnecessary ED Holds

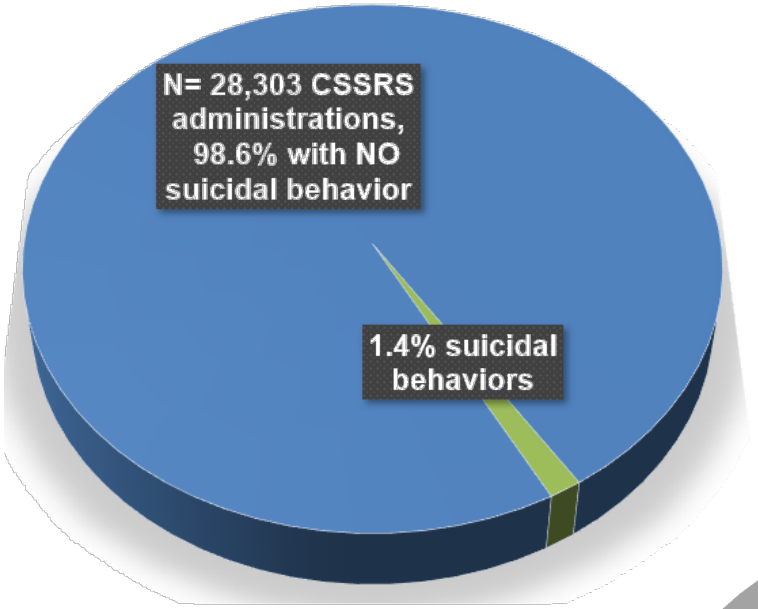
Magellan PA Study
EMS use of the
Columbia resulted in
increased rates of
voluntary
hospitalization

Improved mental health follow-up and treatment engagement following C-SSRS screening in the Veterans Health Administration

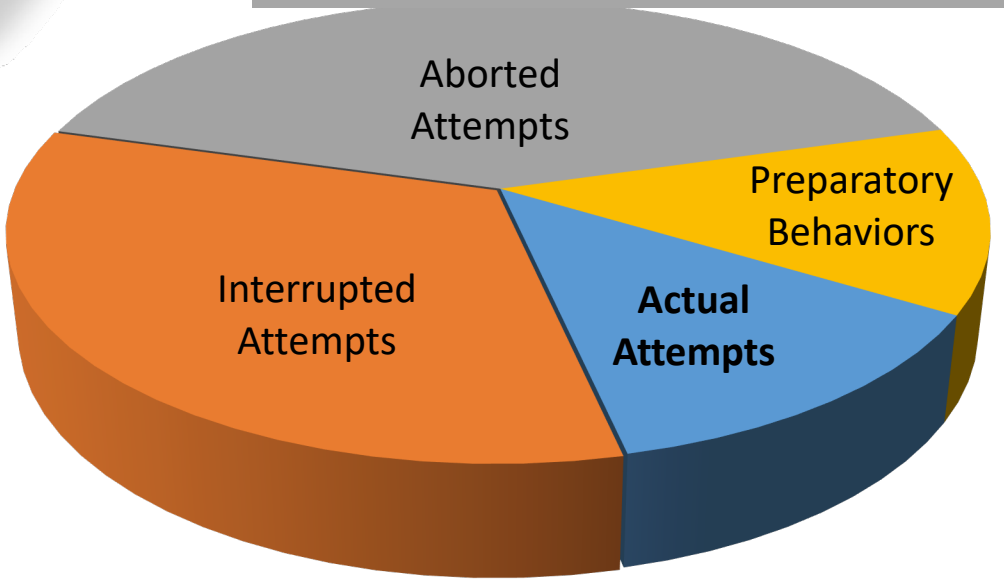
Highlights from the Science:

Suicidal Behaviors are Rare; Mst Are NOT Suicide Attempts

We used to only ask about a suicide attempt, and **missed the person who bought the gun, or wrote the suicide note, or put a noose around their neck and changed their mind.**



Of the 1.4% suicidal behaviors:
87% (472) = interrupted + aborted + preparatory
vs.
13% (70) actual attempts



Each type of suicidal behavior is equally OR MORE predictive
An interrupted attempt (e.g. officer grabbing someone from jumping) was 4x as potent in identifying who would go on to end their life

Multiple behaviors = greater risk
When you get to a 4 or 5, risk jumps 100%

Why C-SSRS is Common Data Element?

Evidence-based Thresholds for Imminent Risk: Full Range of Behavior, Precision on Passive Suicidal Thoughts

Risk increases with each step and utilization predicted death by suicide imminently (Bjureberg 2021)

Q1	Wish to die	• Increases risk of suicidal behavior 5-6x (Beck 2000)	ASQ/PHQ "better off dead" is NOT suicidal ideation	Increases false positives
Q2	Thoughts of killing self			
Q3	Thoughts with methods	• Risk increases 45%	ASQ ideation stops here	ASQ "In the past week, have you been having thoughts about killing yourself?"
Q4	Thoughts with any intent to act	• Evidence-based threshold for imminent risk • Risk of suicidal behavior increases 100% with intent to act (Greist 2014) 4 or 5 times more likely	NOT on the ASQ or PHQ9	
Q5	Thoughts with any intent and plan			
Q6	Actual attempt, interrupted attempt, aborted attempt, preparatory behavior	• ALL behaviors equally or more predictive as an attempt • Almost 90% of suicidal behaviors are not actual attempts	ASQ/P4 has only actual attempts PHQ9 has NO behaviors	ASQ only "Have you ever tried to kill yourself?"

IMPACT ON CARE

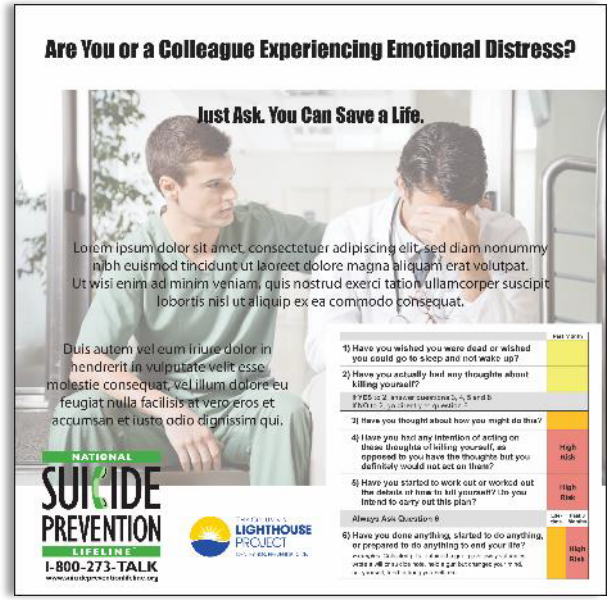
The National Action Alliance Toolkit for Zero SuicideCenterstone Care Pathway

"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 documents phone-call
5. If unable to contact, referred to Follow-Up Specialist who attempts to contact for risk assessment and encouragement to re-engage
6. **Crisis line never shuts down** until they are tracked down

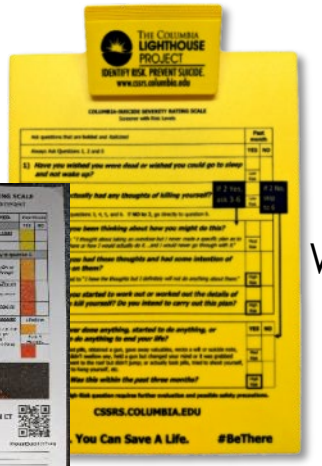
Reduced their suicide rate 65% over 20 months. Also reduced hospital recidivism from 40% to 7%

Just as Important to have Flexible and Innovative Delivery as to Have the Right Questions

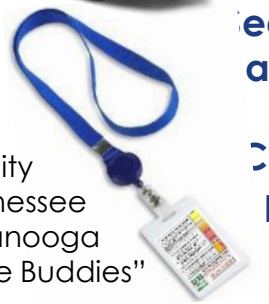


Posters in Workplaces

Electronic delivery, automatic risk notification



sticky pads

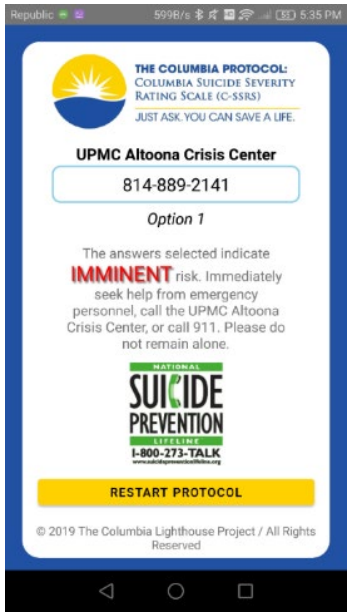


University of Tennessee Chattanooga "Badge Buddies"

Search the app store for Columbia protocol

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

The Columbia Mobile App:
With Individualized Community Crisis Information



SCREENING

Vital Part of Saving Lives: Need to Ask Like Blood Pressure to Find People Suffering in Silence

Over 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

Part of daily safety checks

Screen more at times of higher risk, e.g. transition from active duty to veteran status, problems happening at home, injury, relocation, wartime, etc

VITAL OPPORTUNITIES FOR PREVENTION:

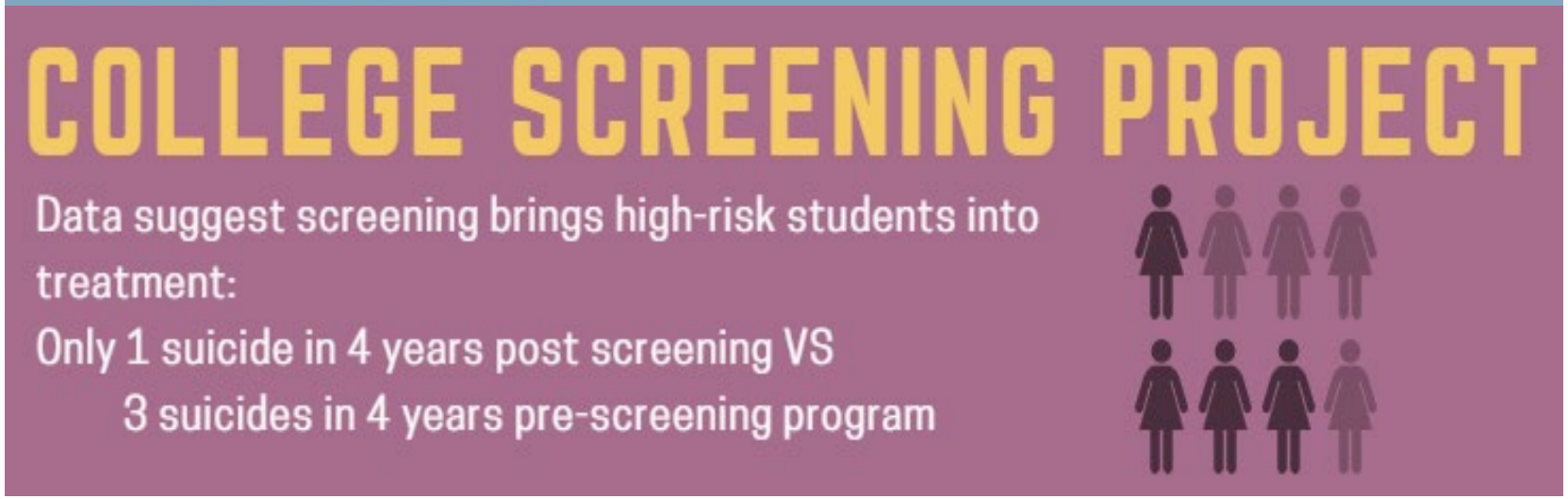
Imagine every school nurse, physical therapist or EAP asking about mental health alongside physical checkups.
If we ask, we can find those suffering in silence.

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

Scott et al., 2009



Haas et al., 2008

Barriers to Screening: Stigma, Fear and Liability

The Data Supports the Public Health Approach, Getting the Highest Risk People to Care

"I'm afraid to ask because I don't know what to do with the answer."
"If I ask, will I put the idea in their head?"

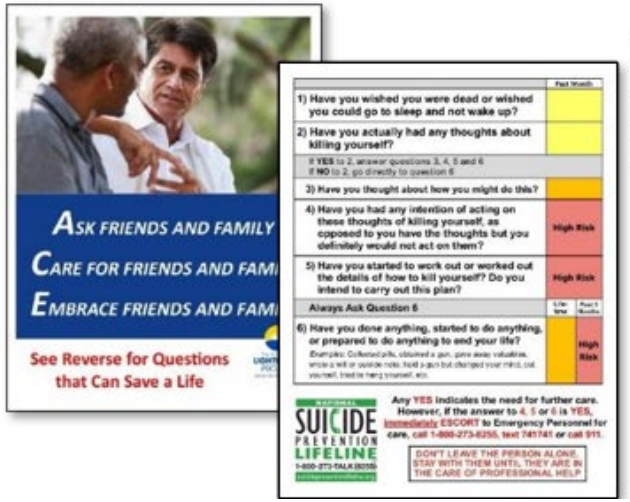
Asking actually relieves distress — people who are suffering want help but don't necessarily have the will to come to you

The Columbia Lighthouse Project/Center for Suicide Risk Assessment

The Columbia Suicide Severity Rating Scale (C-SSRS)

Supporting Evidence

Last Revised
2-2-2017



Protects Against Liability: Internal and External

"If a practitioner asked the questions...
It would provide some legal protection"
– Mental Health Attorney, Crain's NY

- Over 100 studies supporting across cultures, properties and sub-populations
- Over 1000 published studies in last 5 years
- Brand new study from Sweden Emergency Departments proves the C-SSRS's robust ability to predict imminent risk

Breaking Down Barriers:
Asking These Questions <u>Protects</u> Against Liability

"If a practitioner asked the questions... **It would provide some legal protection"**

–Bruce Hillowe, mental health attorney specializing in malpractice litigation (Crain's NY, 11/8/11)

Implemented by national risk managers of *The Doctor's Company*, a <u>medical malpractice insurance company</u>, to be used by physician members

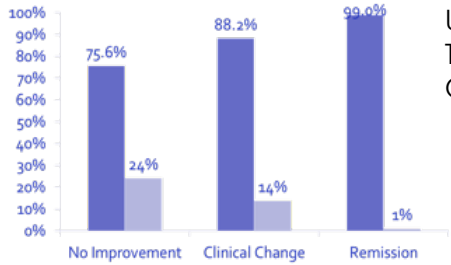
"I believe it sets the standard…we take a proactive position in patient safety" – Patient Safety Risk Manager

"People don't get sued for something bad happening, they get sued for negligence."

52. At 3:18 a.m. Matt was triaged by a registered nurse and scored as "high risk" by the Columbia-Suicide Severity Rating Scale ("C-SSRS") screening and was immediately placed on suicide precautions. It was noted that Matt was "suicidal with a specific plan." An order was entered for an ER Counselor consult, and Matt was visually observed every fifteen minutes.

Normalizing Screening and Reducing Stigma Saves Lives in the US Army

Millions of Screens



Data leads to additional funding

Military, highest risk post-hospitalization – struggle to reintegrate into unit, stigma, false sense of recovery so this prevents post-hospitalization risk sequelae

Elevated risk for 2 years after discharge

- Treatment no longer at a stigmatizing outpost
- Mental health questions integrated into other care
- Inpatient overnights reduced **41%, saving 30-40 million dollars since 2012**
- Decrease in suicide

How To Ask The Questions: Delivery Matters!

Effective Communication: Key to Building Trust and Collecting Accurate Information

- Stay in this Moment = Clear your mind and free yourself of as many distractions as possible
- Positive Body Language= arms loosely at your side, head up, eyes connecting to the person in front of you
- Stay Attentive and Responsive, but Calm
- Voice is Steady and Clear
- Listen Carefully
- Do not Judge
- Paraphrase/Reflect back important details

The Power of Empathy

https://www.youtube.com/watch?v=HznVuCVQd10&list=PPSV

What Do I Do?

- Don't be afraid to ask the questions directly
- Listen to their story
- Tell them you are worried about them
- Ask them to come with you to get help
- Show you care, be patient but don't take no for an answer
- Avoid minimizing feelings, trying to talk them out of it or giving advice
- Create safe and supportive family, community and school environments

A Common Language is an Intervention In and of Itself: Asking Can Literally Be Medicine Because it Shows You Care

Huge Study Showed Biggest Impact in Stopping Kids From Trying to Take Their Own Lives is Peers Helping Each Other

- "Just Ask" is much more than a screening intervention
- **Study in 10 EU countries with >11,000 students: peer-to-peer component** is most effective
- Common language develops **Connectedness** which saves lives

- Even if you are lucky enough to see a professional it's likely only once a week, so **we all need to check on our friends, coworkers and neighbors** more consistently

- We also help kids by helping ourselves, just like putting on your own **oxygen mask** first

Schools offer students the opportunity to **build their resilience by developing caring relationships with teachers, and school staff**. The presence of a trusted caring adult is often considered one of the most **critical protective factors** in a young person's life.

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.

(Klineberg 2018)

For questions and other inquiries,
email: kelly.posner@nyspi.columbia.edu

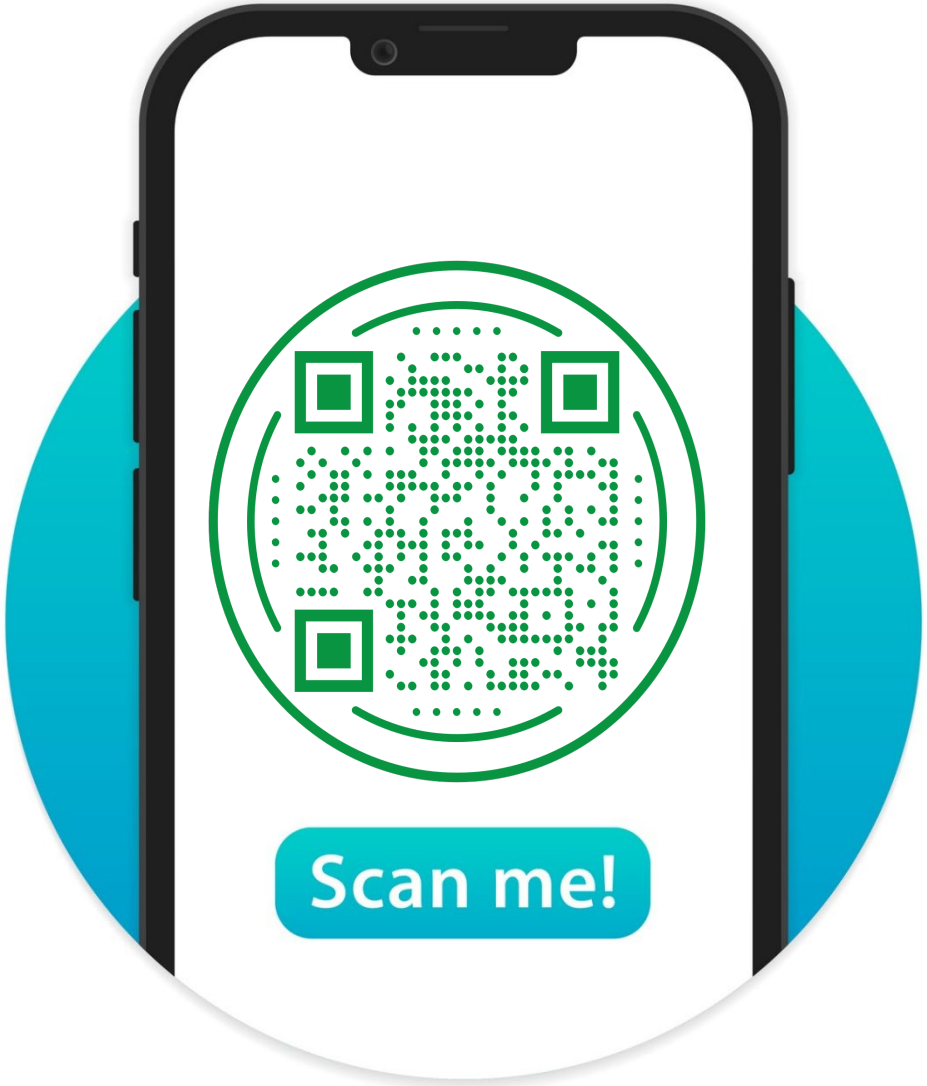
Website address for more information:
cssrs.columbia.edu

The Columbia Lighthouse Project
Identify Risk. Prevent Suicide.

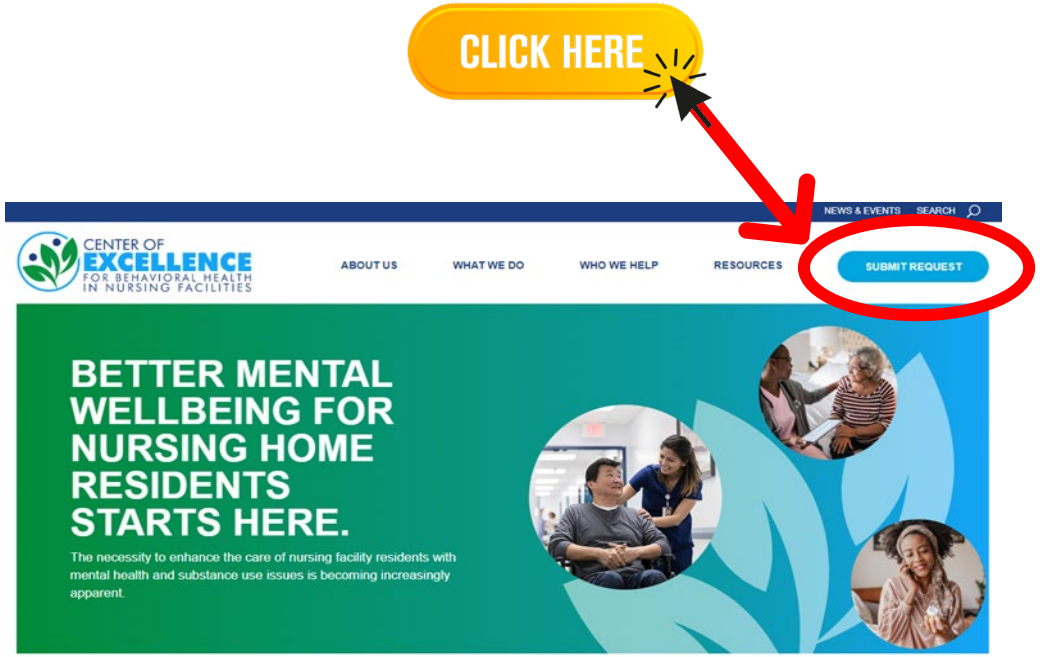
CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

Questions?

Request Assistance



<u>To submit a request for assistance, scan the QR code</u>.



Contact us:
For more information or to request assistance, we can be reached by phone at **1-844-314-1433** or by email at coeinfo@allianthealth.org.

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Thank You!

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