

Screening for Suicide Risk

Goal 3: All children and adults served within the public mental health system will be screened for suicide risk using the Columbia Suicide Severity Rating Scale by providers trained in its use.

Rationale

The most effective method to identify individuals at risk for suicide is to screen those individuals in higher risk populations, which includes individuals with mental health and substance use disorders. Standardized screening protocols have the following advantages:

- Effective screening identifies those individuals in need of more extensive risk assessment with a time and cost efficient approach.
- Best practice screening protocols ensure agencies are meeting their obligations for high standards of care and reducing liability.
- The use of common definitions of suicide-related behaviors can lead to better provider communication and service planning.
- Effective screening within health care settings has led to reduced expenses through more efficient allocation of crisis response staff.

The Child and Adolescent Needs and Strengths Assessment

DSHS is utilizing the Child and Adolescent Needs and Strengths (CANS; Lyons, 1999) assessment or the Adult Needs and Strengths Assessment (ANSA; Lyons and Anderson, 1999) as the universal suicide screening measure, meaning questions about suicidal risk are asked of all individuals having contact with the public mental health system, either through crisis services or outpatient care. Providers have some flexibility in the interview questions that are asked of individuals to determine a rating on the CANS or ANSA Suicide Risk item, but the following two questions taken from the evidence-based Columbia Suicide Severity Rating Scale are recommended:

- Have you wished you were dead or wished you could go to sleep and not wake up?
- Have you actually had any thought of killing yourself?

Individuals scoring greater than 0 on the CANS/ANSA Suicide Risk Scale are required to gather additional information on the Suicide Risk Module (or subscale). On the ANSA, this includes Ideation, Intent, Planning, Suicide History, History of Family/Friend Suicide. On the CANS, this includes History of Attempts, History of Family/Friend Suicide, Access to Firearm/Lethal Medication. Web-based training on the CANS and ANSA is available through DSHS and manuals are available at

<http://www.dshs.state.tx.us/mhsa/trr/ansa> or
<http://www.dshs.state.tx.us/mhsa/trr/cans>.

Description of the Columbia Suicide Severity Rating Scale

All individuals who receive a rating of 2 or 3 on the CANS or ANSA Suicide Risk scale will receive a secondary screening with the Columbia Suicide Severity Rating Scale (C-SSRS; Posner et al, 2011). The C-SSRS was developed with guidance from the Federal Drug Administration to provide further definitional clarity around the reporting of suicide related events. The scale is available in over one hundred languages, has been used in mental and public health settings across the globe, and exhibits strong feasibility, requiring no mental health training for implementation. The lifetime/recent version addresses suicidal thoughts and behaviors across the individual's lifetime and the past 30 days and should be used at the initiation of an episode of care, at required reassessments, or when historical information is not available to the provider. The Since Last Visit version briefly assesses suicidal ideation, behaviors, intent and method since the previous contact and should be used when for those deemed moderate or high risk (See Frequency below). Both versions are available at <http://www.cssrs.columbia.edu/> or included in Attachment X.

Training in the Columbia Suicide Severity Rating Scale

Web-based training on the Assessment of Suicide Risk Using the C-SSRS is available at http://zerosuicide.actionallianceforsuicideprevention.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/cssrs_web/course.htm. The training is interactive and takes approximately 30 minutes to complete. All behavioral health providers should participate in training on the C-SSRS. This should include staff providing hotline and crisis services, clinical assessments and medication management, rehabilitation and skills training, mental health or substance abuse counseling, peer support services, and case management. Supervisors should assess staff competency in the use of the C-SSRS and provide additional coaching as needed.

Scoring of the Columbia Suicide Severity Rating Scale

Answers on the C-SSRS can be summarized by using the following scales:

Severity of Ideation Subscale – consists of five questions that reflect different types of ideation with increasing severity. Level of risk can be examined based on the last response marked “Yes.” A positive response on Question 3 indicates moderate level of risk. A positive response on either Question 4 or 5 indicates a high level of risk.

Suicidal Behavior Subscale – includes questions about five suicidal behaviors and non-suicidal self-injurious behavior. The presence of ANY suicidal behaviors in the past 3 months indicates a high level of risk.

Intensity of Ideation Subscale – includes five questions about the frequency, duration, controllability, deterrents, and reasons for ideation for the most severe level of ideation on the Severity subscale. The total score ranges from 2 to 25, with a higher number indicating more intense ideation and greater risk.

Suicidal Behavior Lethality – inquires about the level of actual medical damage or potential for it, with greater lethality indicating increased risk.

Guidelines for Referral for or Conduct of Risk Assessment

Individuals who are screened at high risk (see below) should receive further risk assessment by a trained provider. Research has shown that individuals who meet the criteria of “high risk” are almost four times more likely to attempt suicide within the 24-month study period (Posner, et. al, 2011). Individuals with a previous history of suicidal behaviors (prior to 3 months) or a positive response to Question 3 on the ideation scale (but not 4 or 5) should be referred for a risk assessment on a case by case basis.

Indicators of High Risk

- A positive response to either Question 4 or 5 on the Suicidal Ideation section (lifetime severity), OR
- Any suicidal behaviors (e.g. attempts, interrupted, aborted, or preparatory behaviors) during the past 3 months.

Further information on the scoring and protocols for the C-SSRS can be found at http://www.cssrs.columbia.edu/documents/C-SSRS_Triage_Guidelines_000.pdf.

Frequency of Screening

The C-SSRS should be used as a screening tool during crisis assessments, clinical assessments, and assessments in which the CANS or ANSA Suicide Risk scale is elevated. In addition, the C-SSRS should be utilized as a brief measure of risk at every consumer contact for those individuals found to be at moderate or high suicide risk (up to once daily). There is no activity more critical than identifying increases in suicide risk for individuals at risk of suicide.

Screening should occur at:

- Crisis assessments or clinical assessments with elevated Suicide Risk on CANS/ANSA
- All consumer contacts for individuals with moderate to high risk

Future Goals

The C-SSRS can be used most efficiently by embedding it into the Electronic Health Record (EHR). Completion of the C-SSRS should be triggered in the EHR in the intake and update assessment documentation, crisis notes, and all progress notes for individuals at elevated risk. The EHR should contain an indicator (e.g., red flag) that is prominently displayed on each EHR screen for individuals at moderate or high suicide risk. The operationality of the IT system could occur at a local agency level within the local EHR system.

Moving Beyond – Community Expansion

The effectiveness of these screening activities can be further enhanced by expansion to additional systems in which the use of the C-SSRS is warranted. The community mental health system can support this effort by providing leadership to community suicide prevention efforts, encouraging community partners to consider the use of the tool within their system, providing training in the use of the C-SSRS to staff within other systems, and serving as suicide prevention experts within the community. In addition, data sharing agreements and electronic data portals that allow for the communication of the results of suicide risk screening across partners (e.g., emergency medical staff) will increase the impact of these activities.

Examples of community partners who could strengthen the Suicide Safe Community through the use of the C-SSRS include:

- Emergency Departments
- Law Enforcement
- Emergency Medical Transport
- Primary Care Clinics/Federally Qualified Health Centers
- Jails or Detention Facilities
- Community Behavioral Health Providers
- Homeless or Runaway Shelters