The Columbia Protocol: Reducing Suicide, Redirecting Scarce Resources and Protecting Against Liability

A Universal Policy Tool Across States and Nations, a Whole Community Solution

A Vital Part of Health and Wellness
for Employees, Families, and Communities

Just Ask. You Can Save a Life.

Kelly Posner Gerstenhaber, Ph.D.
Professor, *Columbia Psychiatry*
Recipient, *Secretary of Defense Medal for Exceptional Public Service*
Founder and Director, *The Columbia Lighthouse Project*

Suicide is a Problem of Humanity, But It is Preventable! It is the Tragic Paradox That Takes…

More Fire Fighters than Fire

More Police Officers than Crime

More Soldiers than Combat

More Teenage Girls than All Other Causes

More People than Car Accidents

…More Lives than Natural Disasters, War and Homicide

But the Great News:

Suicide rate decreased 2% in 2019 for the first time in 2 decades, and fell another 6% in 2020 amid the pandemic

ss Generations

THE COLUMBIA LIGHTHOUSE PROJECT
IDENTIFY RISK. PREVENT SUICIDE.

Why National Agencies, Regulatory Bodies, States and Nations Have Clarified the Critical Need for a Common Method

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The Importance of a National & Global Common Language

Increases Knowledge and Improve Standard of Care

Adopted by CDC: "The Need for Consistent Definitions"

"The C-SSRS is changing the paradigm in suicide risk assessment in the US and worldwide" – Alex Crosby

From the HHS National Strategy for Suicide Prevention full report:

Suicide attempt	A nonfatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

SOURCE: Crosby A, Ortega L, Melanson C. *Self-directed violence surveillance: Uniform definitions and recommended data elements*, Version 1.0. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2011. Available at www.cdc.gov/ViolencePrevention/pub/selfdirected_violence.html.

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•Suicide gesture

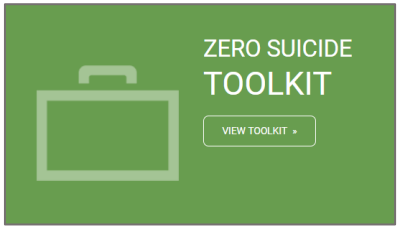
From the ICE Health Service Corps Suicide Prevention and Intervention policy document:

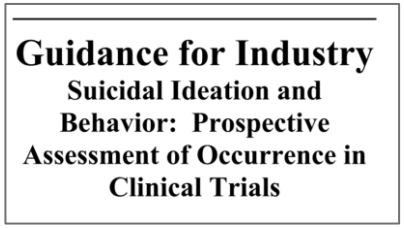
8-9. Suicide attempt – Any non-fatal, self-directed, potentially injurious behavior with any intent to die because of the behavior. A suicide attempt may or may not result in injury (see U.S. Department of Health and Human Services (HHS) Office of the Surgeon General Report).

"Playing from the same sheet of music"

National and International Agencies Identify Need for Common Method in Order to Increase Knowledge and Improve Standard of Care

- Prominent Research Agendas Speak about Uniformity
- Measurement imprecision is *particularly problematic* in dealing with events with low incidence.
- **Common language ensures comparisons and pooling of** data across studies, increases the scientific impact of each study, and helps accrue knowledge.
- **National Action Alliance for Suicide Prevention (2014):** A prioritized research agenda for suicide prevention in healthcare systems
- **FDA Guidance to the Industry (2012)**
- **PhenX Project (Phenotypes and eXposures)** funded by the National Human Genome Research Institute (NHGRI) and the National Institute on Drug Abuse (NIDA) to integrate genetics and epidemiologic research.





Moving away from a single instrument inherently degrades the precision of the signal, compounding imprecision when combining data.

"It should be noted that the **use of different instruments is likely to increase measurement variability…decreasing the opportunity to identify potential signals in future meta-analyses**…this type of imprecision is particularly problematic in dealing with events that have a low incidence, as is the case for suicidal ideation and behavior occurring in clinical trials." –FDA Guidance

The impact of ***imprecision grows when incidence rates are low*** : 1% vs. 3% or misclassification of 1 or 2 cases can profoundly change conclusions about drug effects.

National Research Agenda: Common Goal, Method and Data Elements: Inconsistency in definitions and lack of uniformity in method of detection is one of the major impediments to prevention (US National Suicide Prevention Strategy 2012, National Academy of Medicine 2002).

From Congress to Regulatory Bodies – Medical and Beyond

Joint Commission: *Vital Signs*

The U.S. National Regulatory Body Says this Needs to be a Vital Sign and Every Part of an Organization Needs to Ask the Same Questions

C-SSRS presented to Congress:

Services learning from each other

DoD: "Central to National Strategy"

https://www.youtube.com/watch?v=wnoAMC4voLI

Joint Commission: *Vital Signs*

"By adopting the C-SSRS, organizations ensure that **one tool is being used by all caregivers** … Using **the same language helps all caregivers** understand what the patient needs" … "**focus on folks who are at highest risk.**"

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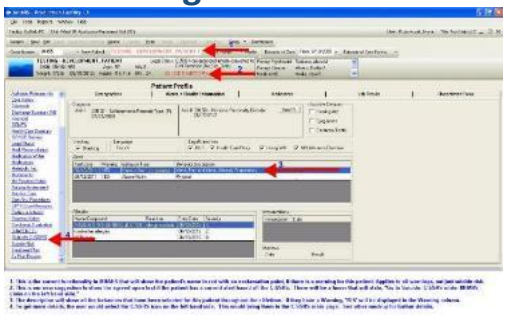
High-Risk Tracking and Alerting Across a State

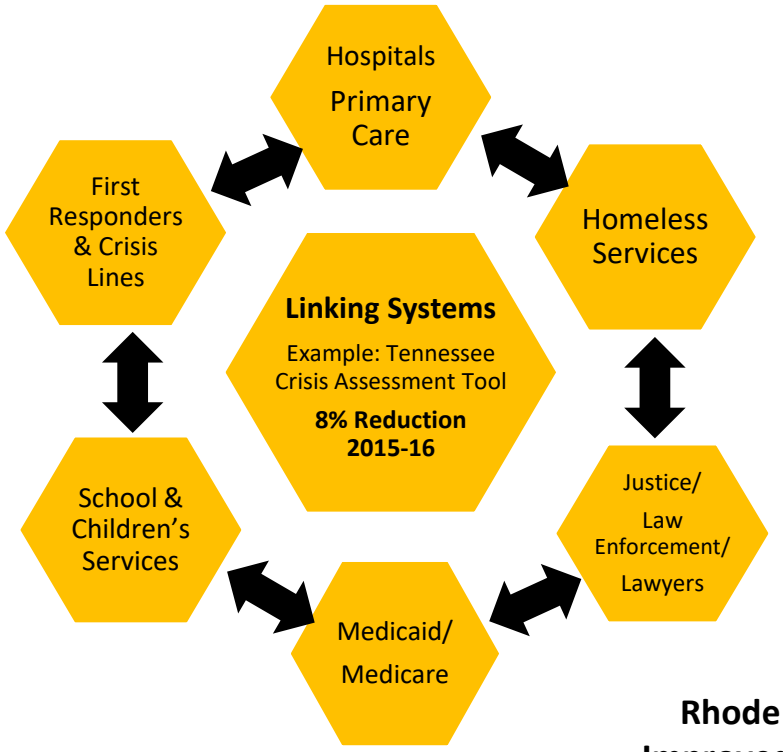


Quickening Care Delivery through Linking of Systems Across All Agencies, States, and Systems Across a Nation

Provider by Provider	All Services	Between Services	All Systems of Care

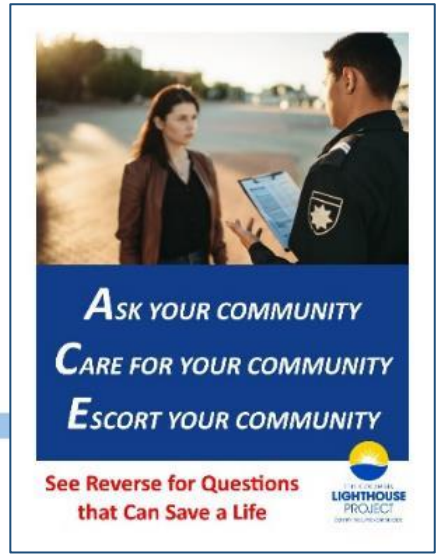
(The statewide adoption of the C-SSRS as the crisis assessment tool) "has **catapulted a transformation of practices** in TN by insuring professionals and family members who come in contact with an individual who may have thoughts of taking their own life **receive the help they need before it is too late**"

- Melissa Sparks, Director of Crisis Services and Suicide Prevention, Tennessee Department of Mental Health and Substance Abuse Services



"Over the past 8 years Nevada has implemented the C-SSRS in suicide prevention gatekeeper trainings across the state. From its initial use in First Responder trainings to Community and Health/ Behavioral Health professions, now it is moving into school systems and military professions throughout our community." *-Richard Egan, Nevada*

Rhode Island: Improved youth suicide and ED Holds



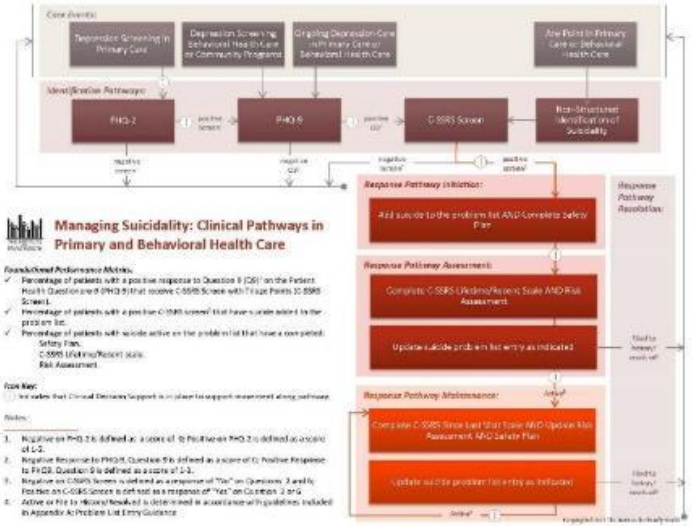
Used throughout government agencies including DHS, HHS, VA, DoD, SAMHSA, and the Office of Refugee Resettlement (HHS Administration for Children and Families)

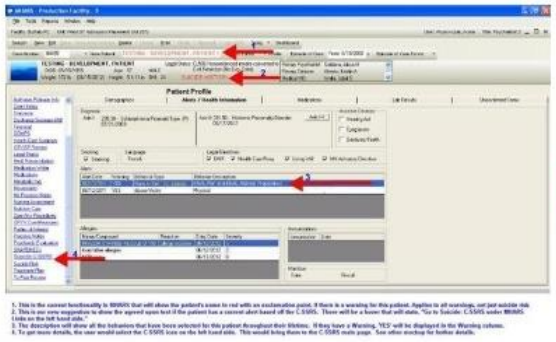
Well Delineated Streamlined Big System Alerting Policies:

Optimizing Identification of Those at High Risk

"With so many patients it's like mining for gold and **the Columbia is the sifter"**

Alerting System… suicide reduction in primary care





Risk
Info
Travels

New York State Electronic Medical Record

CENTERSTONE

Clinical Pathway for Suicide Prevention

Intake	Therapy Appointment	Case Management	Medical Provider
Lifetime/Recent Screening Questions	Since Last Visit Screening Questions	Since Last Visit Screening Questions	Since Last Visit Screening Questions

Positive Screen above results in full C-SSRS and placement in Clinical Pathway
4 or 5—past month
6—past 3 months

- Populate in EHR in purple
- Weekly Therapy
- Crisis Management Plan with Means Restriction Education

No-show results in placement on **Suicide Pathway Referral Follow-up Report** where specialists continuously reach out to client to assess with C-SSRS and re-engage which **never shuts down**

Alert and Monitoring System

The Electronic Health Record (EHR) is designed to offer assistance to providers assessing service recipients for high suicide risk. Based on information collected in the applicable Columbia SSRS tool, a service recipient can be identified as being at high risk for suicide. Those who will be considered at high risk for suicide will have a positive endorsement of **either** of the following (research found these to be highly predictive of completed suicides):

A positive endorsement, relative to the past 30 days, in the "Suicidal Thoughts" section of item # 4 (Have you had these thoughts and had some intention of acting on them?) or item # 5 (Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?).

A positive endorsement, relative to the past 90 days, in the "Suicide Behavior" section of item # 6 (Have you ever done anything, started to do anything, or prepared to do anything to end your life?).

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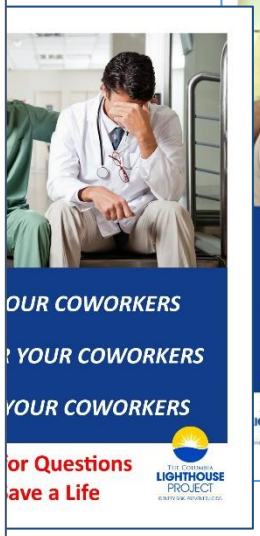
Touches Everyone… Vital Part of Health and Wellness for Employees and Their Families

Need to Screen Everywhere and Care for the Caregivers

In a company of 100,000 employees:

- **Every 6 days,** one employee or family member will die by suicide



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Since Asking with an **"Everyone, Everywhere"** **Approach Utah Achieves Decrease in Suicide**

Reversed an alarming increasing trend over the past 10 years

Medicaid Improvement Plan

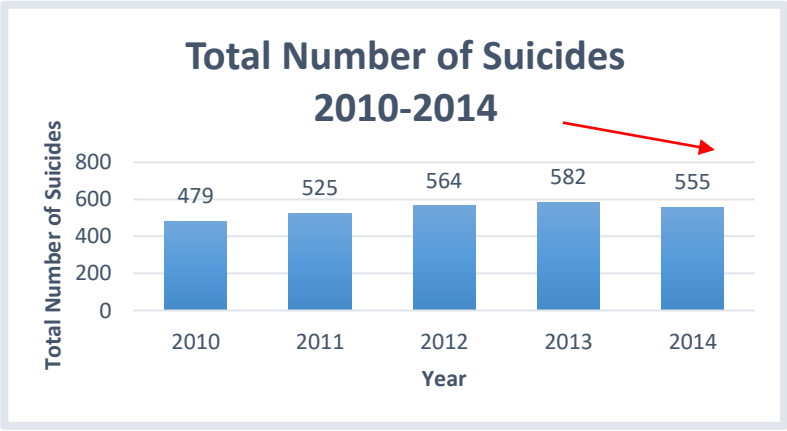
In their legislative suicide prevention report they state "we are committed to becoming a **Zero Suicide System of Care"**

"**Screening and assessment using the C-SSRS had been an important piece to this comprehensive multi system approach.** We are on year 2 of a state-wide Medicaid improvement project that **highlights the use of the C-SSRS and subsequent interventions**… Another step in our "all-in" adoption of shared tools and language"

State Suicide Prevention Plan: Planned Legislation

utah department of human services
SUBSTANCE ABUSE AND MENTAL HEALTH

State Suicide Prevention Programs
FY 2015 Report



A Nevada State Senator grappling with her state's high suicide rate looked to progress made in Utah for hope, saying, "Utah recently reversed an upward trend in suicides and experts are citing the implementation of the Columbia Suicide Severity Rating Scale."

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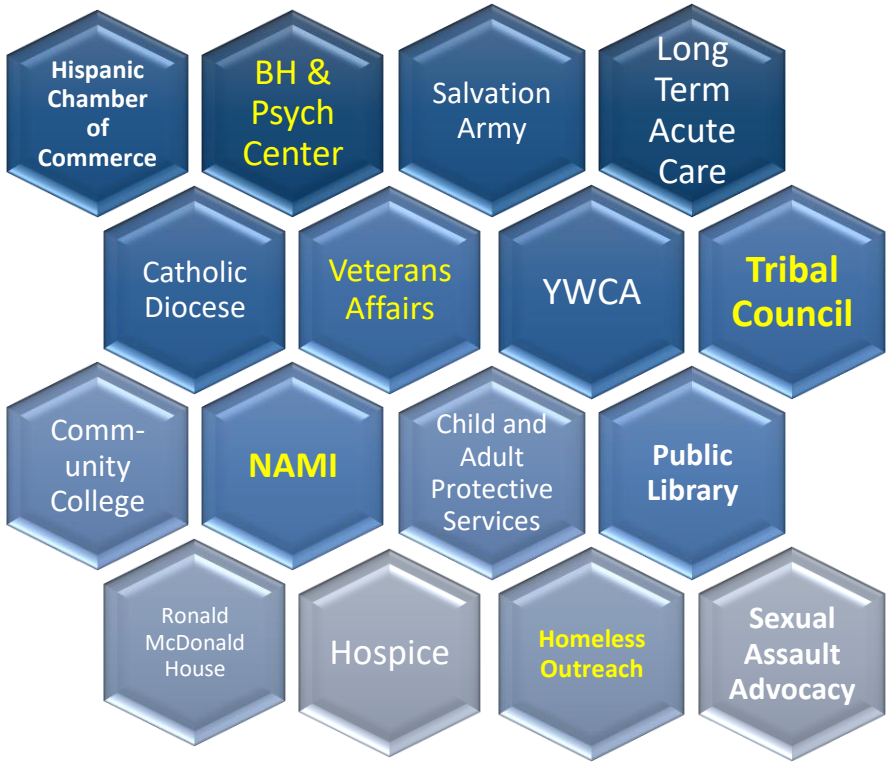
Texas

Statewide Top-Down Implementation

- **C-SSRS recommended tool for "suicide safer care"** endorsement from state for local mental health authorities
- Universal assessment process for access to the public mental health system (**embedding C-SSRS in existing tools)** – Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA)
- Mobile crisis units and hotlines
- Psychiatric emergency walk in centers
- Physical Health/ Behavioral Health integration projects
- Suicide Safer Schools Model system

El Paso: Bottom-Up Whole Community Implementation



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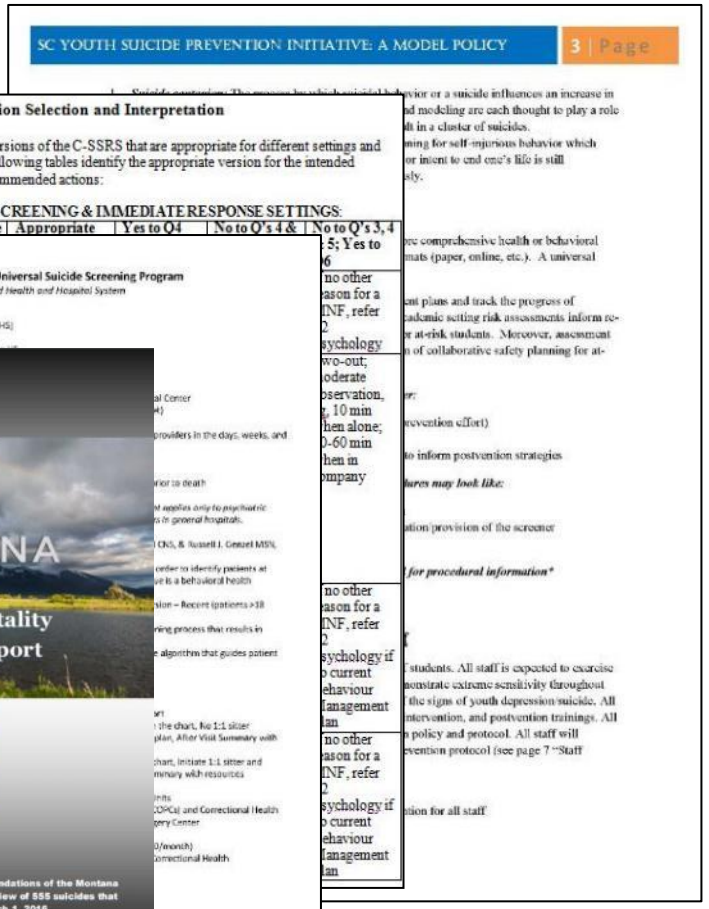
Global Policy Toolkit: Guidance for Every Part of a Community

USAF Clergy

Israel Schools

South Carolina Schools



New Zealand Corrections

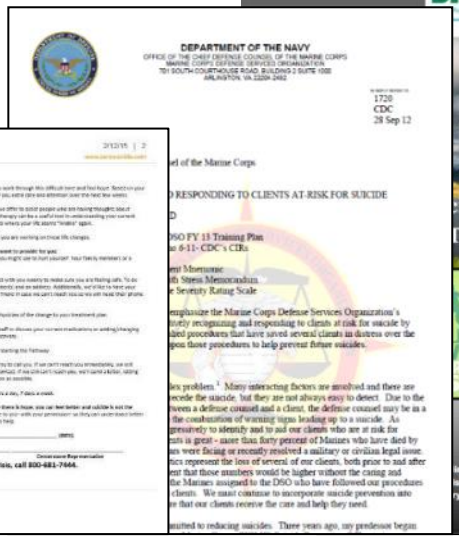
Hospital Systems

States

Saudi Arabia

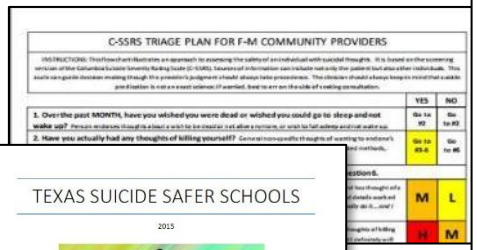
جامعة الأميرة نورة بنت عبدالرحمن
Princess Nourah bint Abdulrahman University

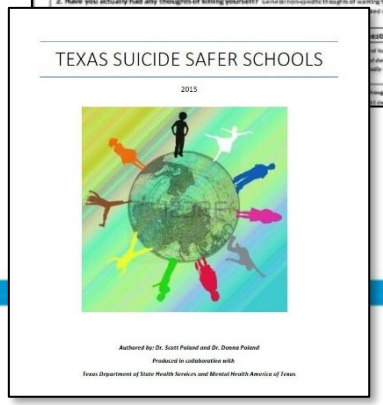
Military



Behavioral Health

First Responders





Texas Schools

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Whole-Community Approach in Schools and Universities: In Everyone's Hands

Veterans on Campus Program



Umatter for Schools: Suicide Prevention Training Puzzle Piece Activity

Columbia-Suicide Severity Rating Scale

Suicide Ideation Definitions And Prompts In The Past Month — Ask Questions that are bolded and underlined

Ask Questions 1 and 2

1) Wish to be Dead:
Yes / No
Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up
Have you wished you were dead or wished you could go to sleep and not wake up?

2) Suicidal Thoughts
Yes / No
General non-specific thoughts of wanting to end one's life/commit suicide, "I've thougth about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan
Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6

3) Suicidal Thoughts With Method (Without Specific Plan Or Intent To Act)
Yes / No
Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time. place or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when or where or how I would actually do it....and I would never go through with it."
Have you been thinking about how you might kill yourself?

4) Suicidal Intent (Without Specific Plan)
Yes / No
Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them."
Have you had these thoughts and had some intention of acting on them?

5) Suicide Intent With Specific Plan
Yes / No
Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out
Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

6) Suicide Behavior Question
Have you ever done anything, started to do anything, or prepared to do anything to end your life?
Yes / No
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

HSACCC
Health Services Association - California Community Colleges

Membership ▾ Annual Conference ▾ About Us ▾

2018 Annual Conference: Pathways to Healing and Sustainability

Was Held on: February 20-23, 2018
Location: Asilomar Conference Center
800 Asilomar Ave Pacific Grove, CA 93950

2018 Conference Brochure

Taking Care of Each Other: Giving Veterans a **Renewed Sense of Purpose**

When A Community Comes Together There is Hope: Linking of Systems Within Systems

U.S. Department of Veterans Services

VHA Policy
Primary Care, Psychiatric Care, ERs
Substance abuse clinics

- **First Responders**
- Law enforcement
- Crisis Lines

Benefits Officers

- Parole officers
- Local Courts and Jails
- Wardens, Guards
- **Case Workers**
- Probation officers
- Counsellors

Department of Veterans Services

- **Lawyers**
- **Legal assistants**

HUD/Homeless Services

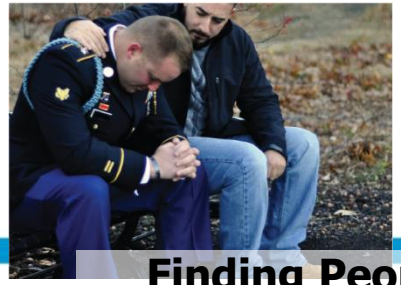
- **Peer support networks**
- Family & friends

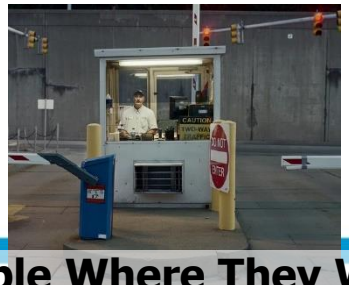
- HR Directors
- Job Corps

- Support staff
- Front desk workers
- Janitors/maintenance
- Parking lot attendants

After a VA attorney used the Columbia to help save the life of a suicidal client, the OGC decided to make Columbia policy **sustainable and scalable:**

Now it's been put it in the hands of all attorneys, legal aids and volunteer attorneys throughout the VA nationwide… *on the heels of a life saved.*





Finding People Where They Work, Live, and Thrive:
Army Suicide Decrease is Steeper in Active Duty Than Reserves
60% of veterans don't get care at the VA

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Uniformity in Public Health: "Complete Blanket Coverage"

Particularly Important in Rural Communities where there is less access to primary care

State-Wide Dissemination in Montana

- School counselors nurses, and administrators
- Human Resource Directors
- Job Corp staff
- Managers at government agencies and local businesses
- Staff of a local theater that works with high-risk youth
- Hospital chaplains
- **First responders:** *EMT, Fire Dept, law enforcement cadets, etc.*

County-Wide Dissemination in Lapeer County, Michigan

- Court workers
- Mental health workers
- K-12 school staff: teachers, bus drivers, cafeteria workers, etc.
- Clergy
- Law enforcement
- Child welfare workers
- Police Officers, Sheriff, Road Patrol, Village & State Troopers
- **First responders:** *EMT, Fire Dept, officers, etc.*

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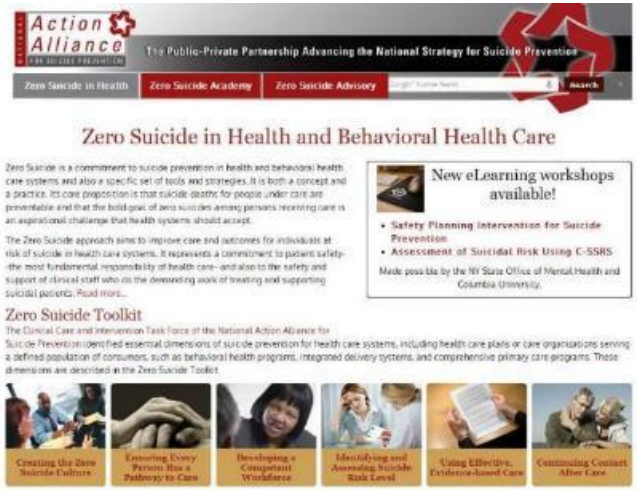
How Do We Get to Zero Suicide? Asking is Only the First Step

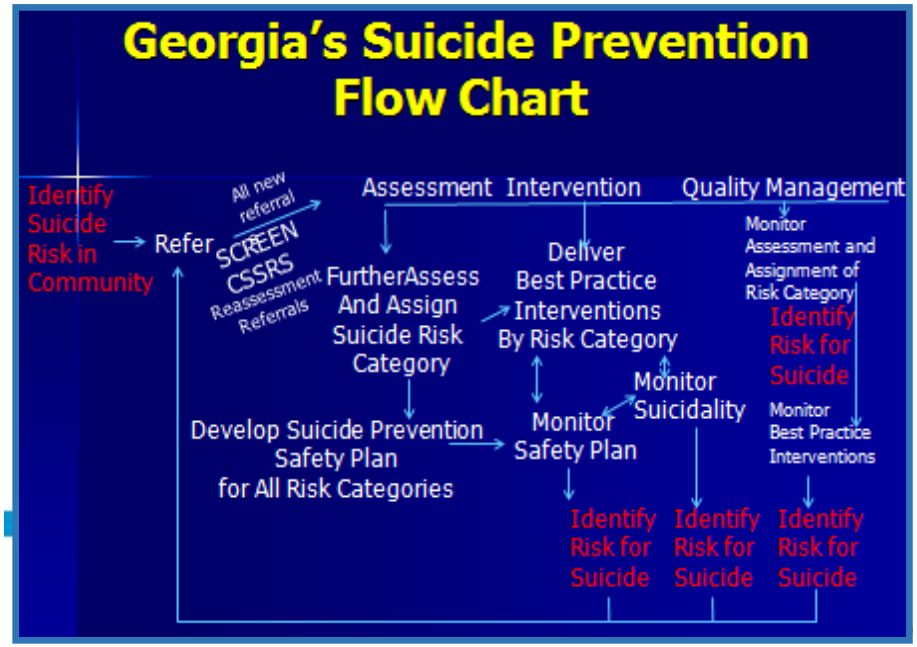
Statewide Policy: "AIM" Assessment, Intervention and Monitoring



- NY – Evaluation of recent suicides All same picture: *No good risk assessment, no safety plan, and no warm hand-off*
- Organizational vision of **Zero Suicides**
- C-SSRS and Safety Planning to be **used in training <u>all</u> staff to screen *all patients* statewide**

Georgia DBHDD Implementation Plan

1. Introduced Statewide
2. Overview by region and regional support
3. Policy development at state level for **<u>all Medicaid providers</u>**
4. Lifeline Crisis Call Center
5. <u>Provider by Provider</u> implementation in all services and systems



The Power of Asking Beyond the Doctor's Office: Look at the Effect This Has Already Had in Largest Community BH System in US

Reduced their suicide rate 65% over 20 months

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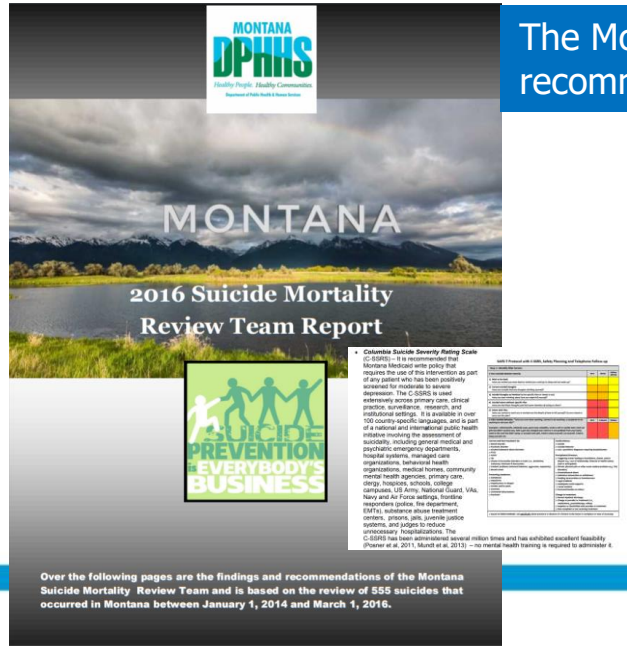
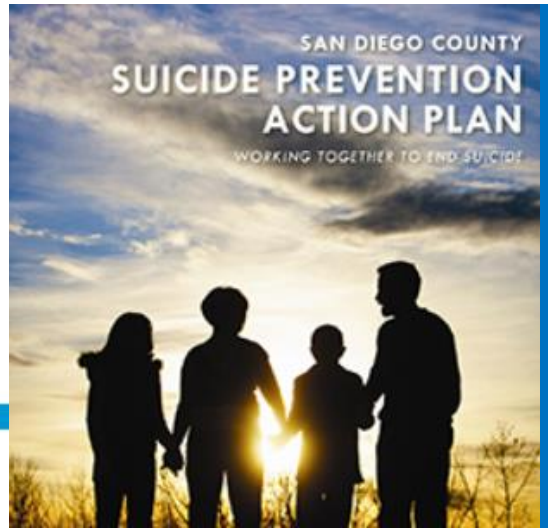
Columbia's Large Screening Data Not Only an Intervention But Helps Prioritize Resources for Prevention Efforts

- **Data helps prioritize needs and resources** for preventing suicide
  - Screening All Coast Cadets led to resources for improved prevention training and treatment (and engagement: several Cadets coming forward to ask for help)
- Collecting data on where, when, and by whom the C-SSRS is used ***allows us to see how systems can be improved***
- Adoption of screening and tracking across all public settings – we collect data that **informs broader prevention efforts**



The Montana 2016 Suicide Mortality Review Team Report recommended that Medicaid policy require C-SSRS



San Diego County

- C-SSRS included in the San Diego County Suicide Prevention Action Plan.
- A data-driven program evaluation report facilitated a 5-year grant from San Diego County Health and Human Serves Agency to implement county-wide standardized risk assessment procedures and expand crisis intervention.

Barriers to Screening: Stigma, Fear and Liability

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 give them the idea?"

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

Protects Against Liability: Internal and External

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

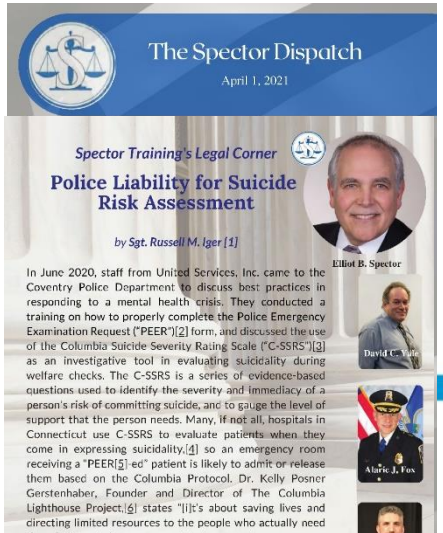
REPRESENTATIVE PUBLICATIONS FOR C-SSRS USE: POPULATIONS, SETTINGS, TREATM

PEDIATRIC POPULATIONS BY AGE GROUP

MEDICAL SPECIALTIES
Neurology
Oncology
PSYCHIATRIC CONDITIONS
Alzheimer's
Autism
Bipolar Depression
Complicated Grief
Psychosis
PTSD
HEALTHCARE SYSTEMS
OUTPATIENT SETTINGS
Outpatient Psychiatry
Juvenile Justice
Integrated Primary Care
Veterans

Columbia is "A Game Changer"

This [C-SSRS] changes the game to the extent that now they have something to hang their hat on."
- Fargo MN Police Department Article



The Spector Dispatch
April 1, 2021

Spector Training's Legal Corner

Police Liability for Suicide Risk Assessment

by Sgt. Russell M. Iger [1]

Elliot B. Spector

In June 2020, staff from United Services, Inc. came to the Coventry Police Department to discuss best practices in responding to a mental health crisis. They conducted a training on how to properly complete the Police Emergency Examination Request ("PEER")[2] form, and discussed the use of the Columbia Suicide Severity Rating Scale ("C-SSRS")[3] as an investigative tool in evaluating suicidality during welfare checks. The C-SSRS is a series of evidence-based questions used to identify the severity and immediacy of a person's risk of committing suicide, and to gauge the level of support that the person needs. Many, if not all, hospitals in Connecticut use C-SSRS to evaluate patients when they come in expressing suicidality.[4] so an emergency room receiving a "PEER[5]-ed" patient is likely to admit or release them based on the Columbia Protocol. Dr. Kelly Posner Gerstenhaber, Founder and Director of The Columbia Lighthouse Project,[6] states "[i]t's about saving lives and directing limited resources to the people who actually need

- **Over 100 studies supporting across cultures, properties and sub-populations**
- **Well over 1000 that reference it**
- **A 2020 paper from Sweden showed the C-SSRS ability to predict death by suicide**

Breaking Down Barriers:
Asking These Questions Protects 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 medical malpractice insurance company, 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.

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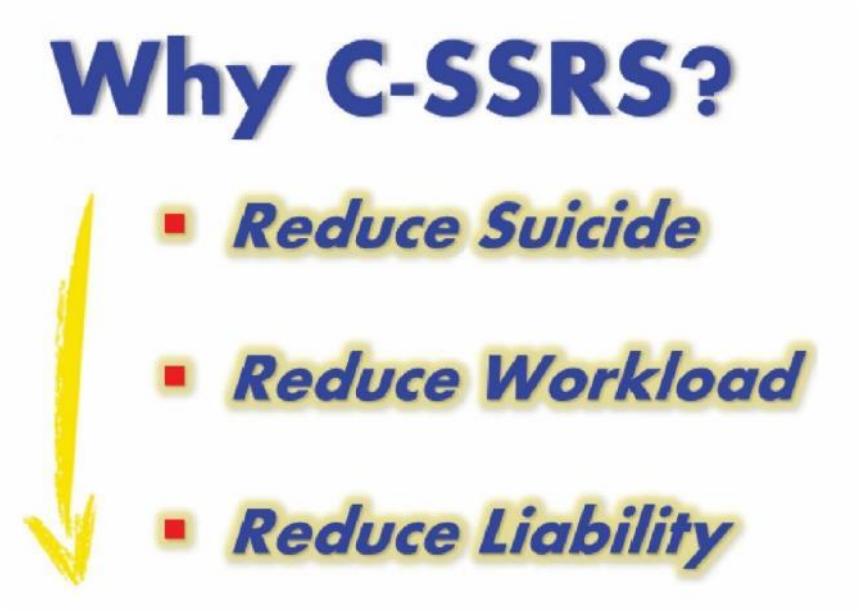
Just Ask, You Can Save a Life:

Columbia-Suicide Severity Rating Scale (C-SSRS)



- **Developed in a NIMH effort**
- **100s of millions of administrations**
- **Over 140 languages**
- **Endorsed, Recommended, Adopted or Mandated by National and International Agencies (CDC, FDA, DOD, NIMH)**

FDA PhenX consensus measures for Phenotypes and eXposures

NIMH National Institute of Mental Health

CDC Centers for Disease Control and Prevention

The Columbia Lighthouse Project
Identify Risk. Prevent Suicide.

DATA ON REDUCING BURDEN AND REDIRECTING RESOURCES VIA EVIDENCE-SUPPORTED THRESHOLDS FOR IMMINENT RISK

- **Largest provider of outpatient community behavioral healthcare - Centerstone**
  - *REDUCED EMERGENCY DEPARTMENT RECIVIDISM from over 40% to approximately 7%*
  - Saved approximately $750,000 for 250 patients
  - Reduced suicide 65% in 20 months in one state
  - EHR algorithm to place in or remove from clinical pathway. Every visit including multiple times per day and still only approximately 1% positives
- **Detroit VA Medical Center**
  - *Only 5 of 3,000 high-risk vets* (ones going to see psychiatrist) needed more acute care
- **Of approximately 50,000 administrations to depressed patients, *less than 1% of 50,000 contacts, 327 patients deemed high-risk, requiring follow-up***
- **First ever *UNIVERSAL SCREENING* hospital at Parkland Hospital in Dallas:**
  - *Only 1.8% of approximately 100k* patients required next steps
  - Specialized algorithm in electronic health record that triggers appropriate clinical intervention based on patient answers to C-SSRS questions
  - "When suicidal behaviors are detected early, lives can be saved…. even within the first few days of implementing the screening program, we were able to intervene with patients at high risk." - Dr. Celeste Johnson, Director of Nursing
- **Connecticut National Guard:**
  - In 38,000 screenings in the Periodic Health Assessment only 17 identified as high risk
- **Cleveland Clinic:**
  - Improved Identification with Decreased False Positives
  - *Reduced false positives from PHQ-9 by 75%* while identifying high risk patients that were missed

REDUCTION OF 1:1, PSYCHIATRIC CONSULTS and ED HOLDS

- ***Med/surg hospital reduces 1:1 and psychiatric consultations***
  - C-SSRS criteria used for placing on and removing from 1:1 (see the C-SSRS version for 1:1 with response protocols)
- **Northwest Community Hospital – 25% reduction in ED holds**

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Why C-SSRS?

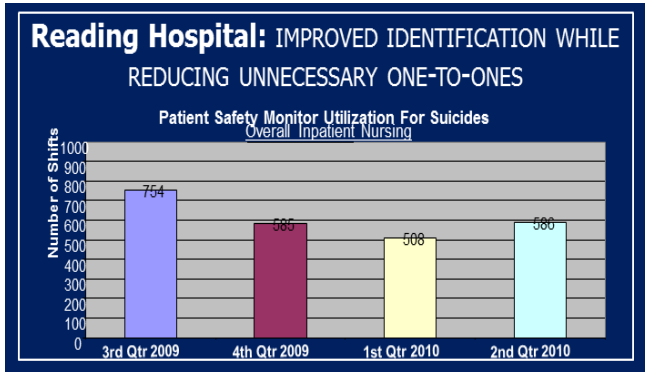
- *Reduce Suicide*
- *Reduce Workload*
- *Reduce Liability*

Finally Knowing Who to Worry About:

Screening with Evidence Supported Thresholds for Imminent Risk: Reduction of Workload, Reduction of False Positives

In Schools: No one knew who to worry about or who to refer

Rhode Island:
Reduced Suicide and ED Holds



Suicide watch goes down and police ***do not have to hospitalize***

Indicates Need for Next Step

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Emergency Department - Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month YES	NO
Ask questions that are bolded and underlined.		
Ask Questions 1 and 2		
1) Wish to be Dead: *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) Suicidal Thoughts: *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): 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.*" *Have you been thinking about how you might do this?*		
4) Suicidal Intent (without Specific Plan): As opposed to "*I have the thoughts but I definitely will not do anything about them.*" *Have you had these thoughts and had some intention of acting on them?*		
5) Suicide Intent with Specific Plan: *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) Suicide Behavior Question: *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. If YES, ask: *Was this within the past three months?*	Lifetime / Past 3 Months	

Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

Only approx 1% require a next step **Implications:** Determining if able to return "fit for duty."

Dramatically reducing unnecessary interventions

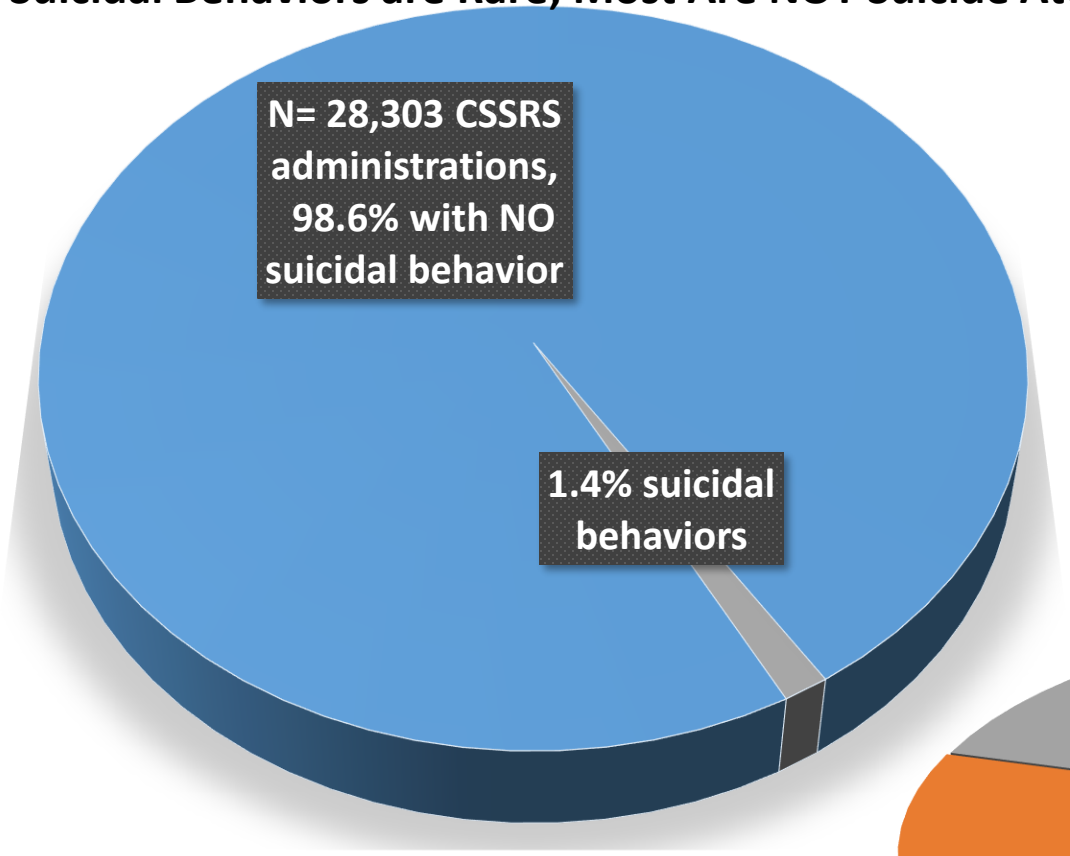
NEXT STEPS

Recent study from Sweden – C-SSRS Screen Version: initial screening for suicide risk in a psychiatric emergency department – Predicted death by suicide (Bjureberg 2021)

Why Are These Questions Different?

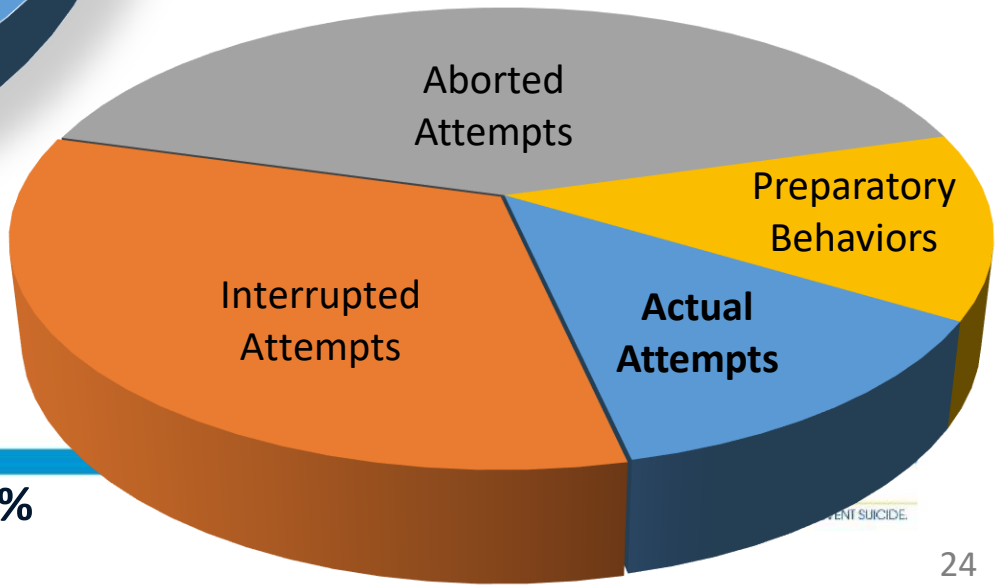
Highlights from the Science:

Suicidal Behaviors are Rare; Most 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 predictive

Multiple behaviors = greater risk

When you get to a 4 or 5, risk jumps 100%

Preparatory Behaviors

Zero Suicide with Gatekeeper Training:

A **front desk staff member** noticed a patient in the waiting room who did not appear well. Because she had undergone training to know **it's okay to ask**, she had the knowledge and courage to ask the suicide question, which revealed high risk and **disclosure of a suicide note** which led to him being transported to the hospital.

By asking about all types of ideation and behaviors maybe we can find kids like Dylan Klebold (Columbine) who mentioned suicide more than 5x 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 and then kill himself

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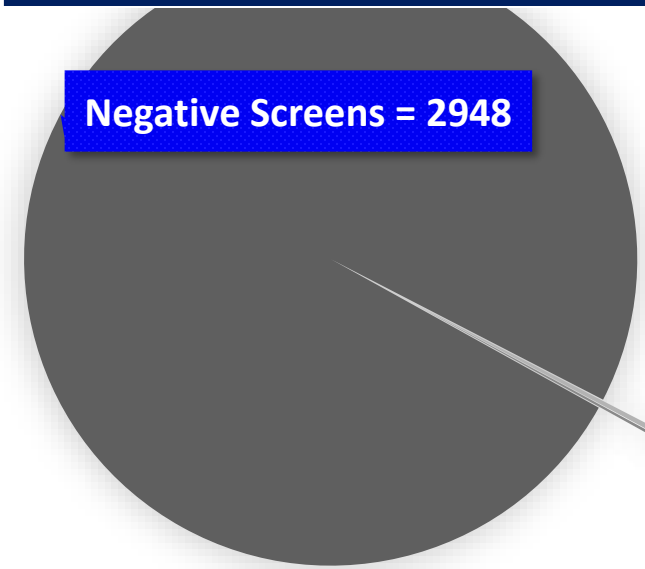
Screening Vets with C-SSRS: Only 5 out of 3000 High-Risk Veterans Required More Acute Care

Now we need to extend into the community to save more veterans' lives

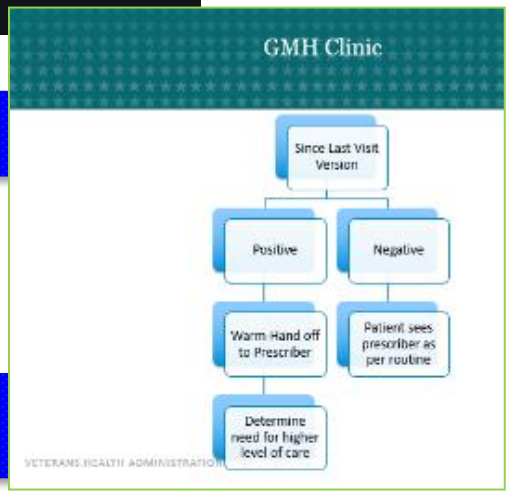
Only 14 out of 2962 screened positive (.47%)

Only 5 (.17%) required more acute care



Hospitalization = 5 (0.17%)

No Hospital =9 (0.3%)



VA SAFE-VET demonstration project – First large-scale study of C-SSRS in the VA Bridget Matarazo and Lisa Brenner Severity, Intensity and Behavior subscales predict suicidal behavior 6 months later

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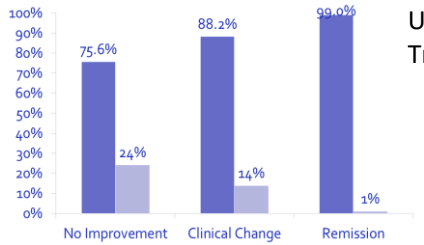
Normalizing Screening and Reducing Stigma Saves Lives in the US Army

Millions of Screens



U.S. Army PTSD Treatment Outcome

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 is no longer at a stigmatizing outpost
- Mental health questions (including C-SSRS) were integrated into care
- **Inpatient overnights reduced 41%, saving $30-40 million since 2012**
- Decrease in suicide

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

Nearly 50% of people who die by suicide saw their primary care doctor the month before they die

2/3 of adolescent attempters in ER are not typically present for psychiatric reasons

Screen more at times of higher risk, e.g. transition from active duty to veteran status, relocation, anxiety about in-person school/work

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.*

Universal screening in an Ohio school system: Hundreds of students screened electronically – just 5% requiring a next step. Reports were sent to school admin so counselors could follow-up right away with appropriate care.

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The High Cost of NOT Screening:

What Not Identifying High Risk Costs Society

- US (2010): **$91 billion in lost wages and work productivity**
- **Worldwide: $300 billion** in years of life disabled or lost

Look What Happens When You Do:

The Power of Asking, Even Beyond the Doctor's Office

CENTERSTONE **the largest provider of outpatient community behavioral healthcare in the U.S., reduced ED recidivism from 40% to 7% and reduced suicide rate 65% in the first 20 months.**

Atrium Health **acute care facilities saw a 50% reduction in suicide since implementing C-SSRS in April 2019. Atrium Health Behavioral Health Service Line saw an 86% reduction!**

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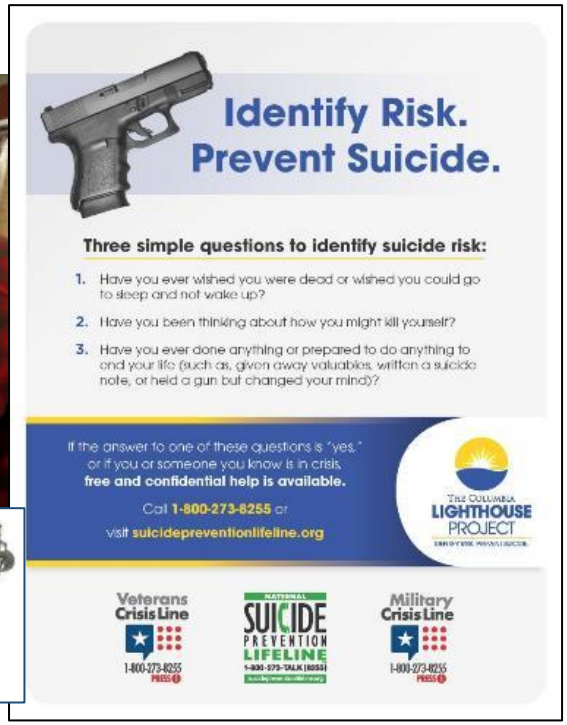
The Gun Death Crisis and the Need to Go Beyond the Hospital: Most Gun Deaths are Suicides

About 2/3 are Suicides (~20,000 per year)

Thousands of Mass Shootings in the US Since Sandy Hook

90% of school shooters have a history of suicidal issues



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

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The Power of Asking to Help Reduce Gun Deaths and Their Traumatic Aftermath:

Former Deputy Secretary of Education Said The Columbia Can Help Keep our 64 Million Children Safe

After the Navy Yard shooting…

"What is it going to take to make this ubiquitous?"

"…**The Columbia has the potential to keep the 64 million children in our schools safe physically and mentally** by helping prevent school violence."

- James Shelton, Former Deputy Secretary US Dept. of Education

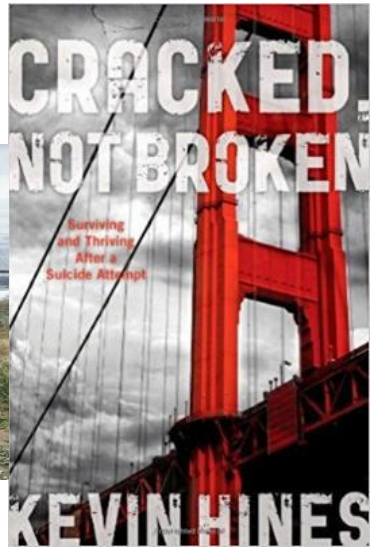
Early Identification & Prevention Through Public Health Outreach

"I want every parent in our community to hold each other accountable. We should ask ourselves on social media and at the grocery store, have you asked the questions, right?" - Ryan Petty on CNN

Dr. Kelly Posner, Ryan Petty, and Senator Marco Rubio at the U.S. Senate forum on school safety, April 2018.

People Want to Be Saved and Need to Be Asked

If Just One Person Had Asked…



"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*

<u>Restricting lethal means</u> wherever available: Gun shops, Pharmacies, Transit, Pesticides

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Everyone, Everywhere Can Ask and Needs to Ask: Needs to be Policy

Policy recommendation for school janitors in VT

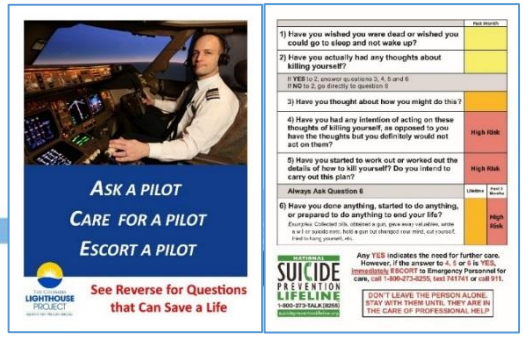
Community workshops for custodians and receptionists

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

VA attorneys and legal partners, VA parking lot attendants

"This is prevention for the masses now, not just the educated, the wealthy or those in the medical field. **It is available and accessible for all of humanity**."

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



Must Go Beyond the Medical Model Towards a Public Health Approach:

Marines reduced suicide by 22% while at the same time there was a reduction in domestic violence, alcohol incidents & sexual assault

Undersecretary of Defense Urgent Memo

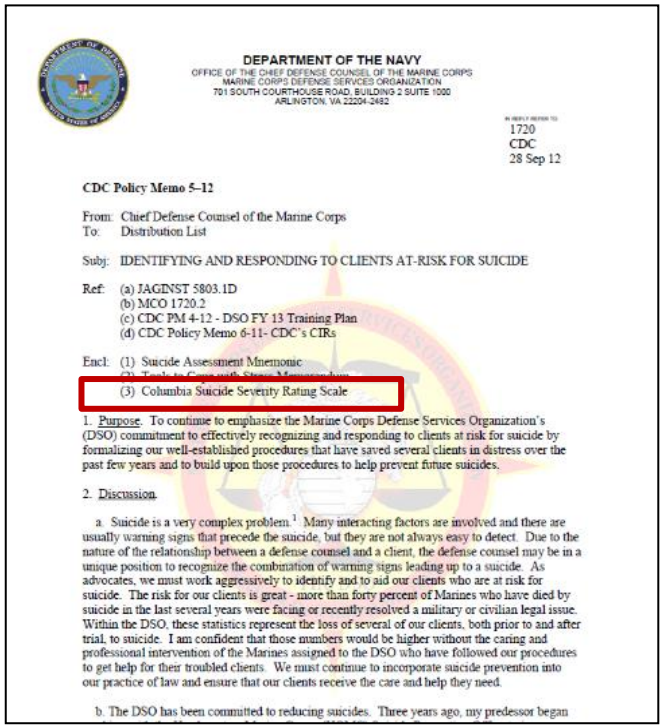
OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

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

- **Total force roll-out**, in the hands of whole community
- **ALL support workers including lawyers**, financial aid counselors, chaplains, family advocacy workers, substance abuse specialists, advocates



DEPARTMENT OF THE NAVY
OFFICE OF THE CHIEF DEFENSE COUNSEL OF THE MARINE CORPS
MARINE CORPS DEFENSE SERVICES ORGANIZATION
701 SOUTH COURTHOUSE ROAD, BUILDING 2 SUITE 1000
ARLINGTON, VA 22204-2482

1720
CDC
28 Sep 12

CDC Policy Memo 5-12

From: Chief Defense Counsel of the Marine Corps
To: Distribution List

Subj: IDENTIFYING AND RESPONDING TO CLIENTS AT-RISK FOR SUICIDE

Ref: (a) JAGINST 5803.1D
(b) MCO 1720.2
(c) CDC PM 4-12 - DSO FY 13 Training Plan
(d) CDC Policy Memo 6-11- CDC's CIRs

Encl: (1) Suicide Assessment Mnemonic
(3) Columbia Suicide Severity Rating Scale

1. Purpose. To continue to emphasize the Marine Corps Defense Services Organization's (DSO) commitment to effectively recognizing and responding to clients at risk for suicide by formalizing our well-established procedures that have saved several clients in distress over the past few years and to build upon those procedures to help prevent future suicides.

2. Discussion.

a. Suicide is a very complex problem.[1] Many interacting factors are involved and there are usually warning signs that precede the suicide, but they are not always easy to detect. Due to the nature of the relationship between a defense counsel and a client, the defense counsel may be in a unique position to recognize the combination of warning signs leading up to a suicide. As advocates, we must work aggressively to identify and to aid our clients who are at risk for suicide. The risk for our clients is great - more than forty percent of Marines who have died by suicide in the last several years were facing or recently resolved a military or civilian legal issue. Within the DSO, these statistics represent the loss of several of our clients, both prior to and after trial, to suicide. I am confident that those numbers would be higher without the caring and professional intervention of the Marines assigned to the DSO who have followed our procedures to get help for their troubled clients. We must continue to incorporate suicide prevention into our practice of law and ensure that our clients receive the care and help they need.

b. The DSO has been committed to reducing suicides. Three years ago, my predessor began

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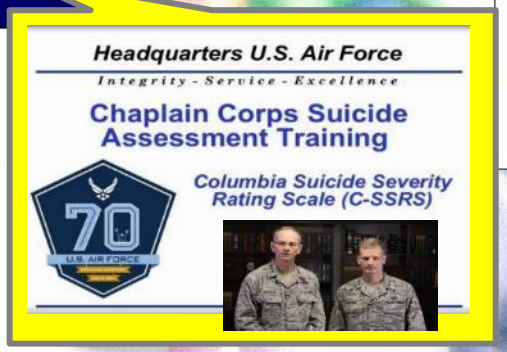
Suicide Rate in Air Force Decreases with Everyone Asking

Zero Suicide: Whole-Community Systems Approach in the Air Force

Airman, Clergy, Dentist, Spouse etc

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

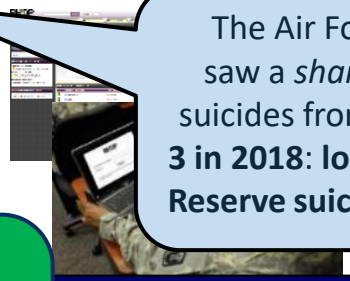
Schools, Child & Family Services



Peers & Leadership

Security/Safety
- Overnights
- Explosive Ordinance Disposal
- Military Police

Spouses



Behavioral Health

The Air Force Reserves saw a *sharp decrease* in suicides from **11 in 2017** to **3 in 2018**: **lowest number of Reserve suicides since 2012.**

"If I had the Columbia Scale, I never would have left him alone in that hotel that day." - Kim Ruocco

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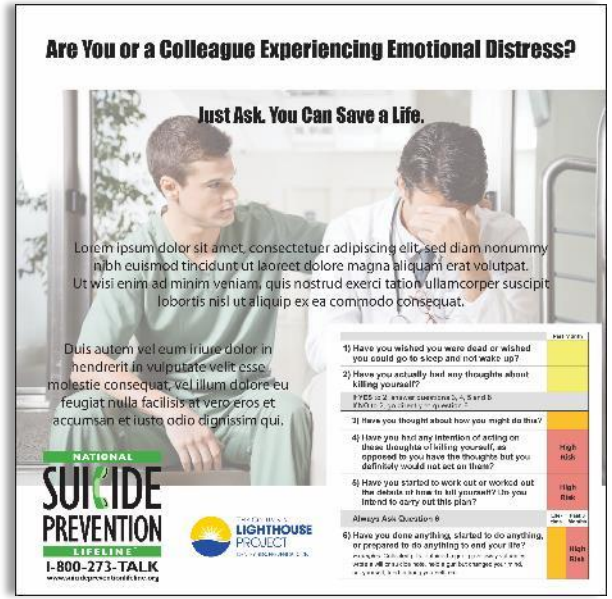
Just as Important to have Flexible and Innovative Delivery as to Have the Right Questions



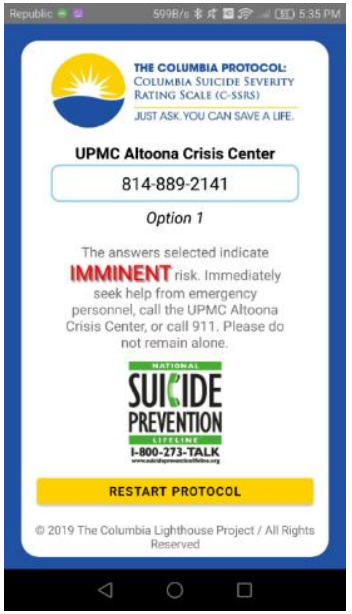
Posters in Workplaces

Electronic delivery, automatic risk notification

sticky pads

University of Tennessee Chattanooga "Badge Buddies"

The Columbia Mobile App:
With Individualized Community Crisis Information



Search the app store for Columbia protocol

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

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Breaking the Silence and Helping Communities Heal

At one point in history, **learning to wash hands** began saving lives. Now, just asking and **being there for each other** gives us permission to connect and build a **path of openness and resilience** that spans generations and is helping us save lives today.

"This is not only saving millions of lives, it is literally changing the way we live our lives, breaking down barriers that have been built over thousands of years. But we are just one nation and every nation deserves this lifesaving tool."

- Israeli official

"The beauty of the Columbia Protocol is that anyone can be involved. **So, as a community, we don't have to sit back and feel powerless. We can feel like we're part of a solution.**
It really does help in our own personal trauma and healing"

- Ryan Petty

Memorial events or other positive gatherings led by students or the community are known to be particularly healing after a traumatic event

For questions and other inquiries,

email: *kelly.posner@nyspi.columbia.edu*

Website for more information and downloads:

cssrs.columbia.edu

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Improving Suicide Screening at the Cleveland Clinic through Electronic Self-Reports: PHQ-9 and the Columbia-Suicide Severity Rating Scale (C-SSRS)

Irene L. Katzan[1], M.D.; Adele C. Viguera[1], M.D., M.P.H; Taylor Burke[2], B.A.; Jacqueline Buchanan[2], A.B.; Kelly Posner[2], Ph.D.
[1]Cleveland Clinic [2]Columbia University Medical Center

Improved Identification with Decreased False Positives

PHQ-9 Suicide Item: Thoughts that you would be ***better off dead*** or of ***hurting yourself*** in some way

NIMH TOOLKIT

asQ Suicide Risk **Screening Tool**

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

C-SSRS-PHQ9: Reduce False Positives and Workload While Finding the Right People

Air Force Zero Suicide: Increased sensitivity with C-SSRS across mental health clinics

at risk (intake) **16% PHQ9 vs 6.5% C-SSRS**

at risk (follow-up) **13% PHQ9 vs 1.3% C-SSRS**

- ASQ does not include any questions about intent to act on suicidal thoughts
- ASQ's risk criteria are narrow in timeframe (only *current* risk), non-specific in severity
- Most ASQ research was done in pediatric emergency departments
- ASQ assesses only passive and active ideation and actual suicide attempts