Vital Signs: The Columbia-Suicide Severity Rating Scale

Patient suicide is a tragic and relatively frequently reported patient safety event. For the past three years, suicide has been among the top four types of sentinel events reported to The Joint Commission.[1] To help organizations prevent such deaths, The Joint Commission's National Patient Safety Goal (NPSG) **NPSG.15.01.01** requires accredited hospitals and behavioral health care organizations to identify patients at risk for suicide.

Implementing this requirement has been challenging to some organizations. Many suicide risk assessments require that staff have mental health training; at-risk patients can be admitted to the facility via many different departments, not just the emergency department (ED) or behavioral health care department (and may be admitted for a seemingly unrelated health reason); and departments may use different assessments, hindering care continuity as patients move throughout a facility.

The Columbia-Suicide Severity Rating Scale (C-SSRS) is a structured, evidence-based tool that has been used to successfully screen patients for suicide risk in a variety of health care and research settings. Developed by Columbia University, New York, by a team led by Kelly Posner, PhD, the tool is part of a national and international public health initiative involving the assessment of suicidality to reduce unnecessary hospitalizations. The tool is available in more than 100 languages and for a variety of care settings. (*See* the tool on pages 5–6.)

The full version of the C-SSRS assesses the severity and intensity of suicidal thoughts and behaviors and allows caregivers to document the behaviors and their severity. The tool is two pages long and takes only a few minutes to administer. One edition includes two columns, to document a patient's suicidal thoughts or behaviors recently (the past month for ideation and the past three months for behavior—the time frames determined to be most clinically meaningful) as well as over his or her lifetime. Another version includes a column for thoughts or behaviors since the patient's last visit to the facility. The tool also comes in a "screener" version, with fewer questions, to be used in triage situations.

Since its inception, the C-SSRS has been administered to several million individuals and has demonstrated excellent feasibility and success in helping health care organizations prevent patient suicide. One large behavioral health system reported a reduction from 3.1 per 10,000 patients to 1.1, in less than two years.[2] After training community counselors, chaplains, victims' advocates, and attorneys in use of the C-SSRS, the US Marine Corps saw a 22% reduction in suicides in the first year.[3]

"Suicide isn't a high-frequency occurrence, but it is high impact," says Anne Bauer, MD, field director, Accreditation and Certification Operations, The Joint Commission. "The research shows that this tool will help organizations focus on folks who are at highest risk."

Standardize Assessment Throughout an Organization

"I do a lot of surveying and see what hospitals and health care systems are using," Bauer says. "They've either developed something themselves or they're using a piecemeal approach, with different tools in different departments: What may appear to be a person at risk in one area may not appear to be at risk in another. When the ED is asking their set

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A patient at risk for suicide may come to a hospital or other health care setting for a medical condition that is unrelated to his or her psychological state.

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of questions, and then the social worker asks another set, then the psychiatrist asks another, you're reducing the signal strength. You're not honing in on the needle in the haystack."

By adopting the C-SSRS, organizations ensure that one tool is being used by all caregivers, who can then use the same terminology when communicating with other caregivers. This can be particularly valuable when transferring patients within the organization to other facilities. Using the same language helps all caregivers understand what the patient needs.

Build Patient Trust

The C-SSRS tool asks the questions in a direct manner, without euphemisms. For example: "Have you wished you were dead or wished you could go to sleep and not wake up?" This approach avoids confusion and miscommunication but may make some users without behavioral health care experience uncomfortable.

However, Bauer says, some patients report that they were grateful when asked the direct questions about suicide because they had never been asked before and didn't know how to bring up the topic. They wanted help, and the questions gave them the opportunity to ask for it and know that their answers were understood.

Conserve Resources

By identifying at-risk patients more accurately, the C-SSRS allows organizations to focus their resources on those who need them most and reduce unnecessary interventions.

"It's costly to have a one-to-one caregiver keeping someone safe," Bauer notes. "You absolutely want to do that when the patient needs it, but if the patient isn't really at risk, you're pulling resources away from other areas where they're needed."

In New York City, middle school nurses used the C-SSRS to identify at-risk children who would have otherwise been missed, while also dramatically reducing unnecessary referrals (which are not only costly but also can be extremely distressing for young patients). One district determined that 60% to 90% of their referrals were unnecessary.[4]

Training

The C-SSRS does not require that the person administering it have mental health training. Any caregiver may use it, and it can be used in non-behavioral health care settings, including schools, the military, substance abuse treatment centers, prisons, juvenile justice systems, and community organizations.

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However, caregivers should be trained in how to administer the tool effectively, how to score it, and how to communicate the results. In addition, if a patient is positive for suicide risk, the caregiver must know what to do to set up a safety plan and refer the patient for appropriate treatment.

Training is free, available in many languages, and easily adapted based on the needs of the caregiver or organization. Currently, two videotaped trainings are available; one for the full C-SSRS and another for the screener version. These taped trainings can be accessed on the training campus website, downloaded, or obtained on DVD. A new Web-based interactive training for the full C-SSRS is also available in multiple languages. Organizations may add these materials to their internal information networks or training programs.

"The Columbia tool helps organizations to focus their efforts across a wide span of programs," Bauer says. "When adopting it, organizations should take a thoughtful team-oriented approach. People from different parts of the system should be brought together to evaluate how this tool could impact the organization and its patients."

Regular evaluation of the effects of the assessment are also recommended. "It's important to evaluate how well the tool is working for your organization and whether changes are needed to make it more effective. As time goes on, the needs of an organization, its staff, and its patients are going to change, so any assessment tool should be periodically reevaluated." TS

References

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