The Adoption & Implementation of the Columbia-Suicide Severity Rating Scale (C-SSRS) in a Psychiatric Emergency Service: Utilizing Roger's Diffusion of Innovations Model

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Background

- Suicide is in the top 20 leading causes of death worldwide for all ages.
- **In the US, on average 1 suicide occurs every 13.7 minutes** (1).
- Suicide has now become a major public health problem and the most dreaded patient outcome in psychiatry.
- Patient suicides are one of the top 5 most common sentinel events in health care.
- **Within 2 months of discharge from an ER; 1 in 10 patients will commit suicide** (2).
- Risk assessments in acute care settings are often completed without the use of a clinical instrument to measure future suicide risk.
- Assessment practices vary across institutions and currently there is no universally accepted instrument.

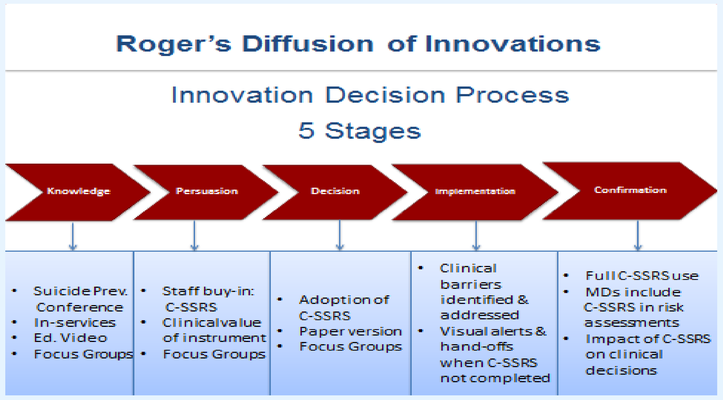
Purpose

The purpose of this Quality Improvement project was to evaluate the adoption and implementation of the C-SSRS in a suburban, tertiary care, psychiatric emergency service using Roger's Diffusion of Innovations model as a framework.

Theoretical Framework

Roger's Diffusion of Innovations:

- Provides a context for facilitating an evidenced-based practice change throughout the culture of a clinical unit/organization.
- Assists in transformative practices geared towards a process change involving both clinical staff and an innovation.
- Five Stages: Knowledge, Persuasion, Decision, Implementation & Confirmation



Instrument

Columbia-Suicide Severity Rating Scale (C-SSRS)

- Gold standard for suicide assessment.
- Evidence-based; brief, valid, reliable measure.
  - ❖ Prediction of attempts during treatment: odds ratio = 1.45, 95% CI [1.07, 1.98], p = 0.02.
- Semi structured clinician-administered, consists of 11 items which measures 4 constructs: suicidal ideation, the intensity of the suicidal ideation, suicidal behavior and lethality.
- Each item includes operational definitions with standardized questions to assist the clinician.

SUICIDAL IDEATION	Lifetime: Time He/She Felt Most Suicidal
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.	
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 ☐
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. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐ No ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g. thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it.....and I would never go through with it".* ***Have you been thinking about how you might do this?*** If yes, describe:	Yes ☐ No ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them".* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	Yes ☐ No ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you 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 ☐

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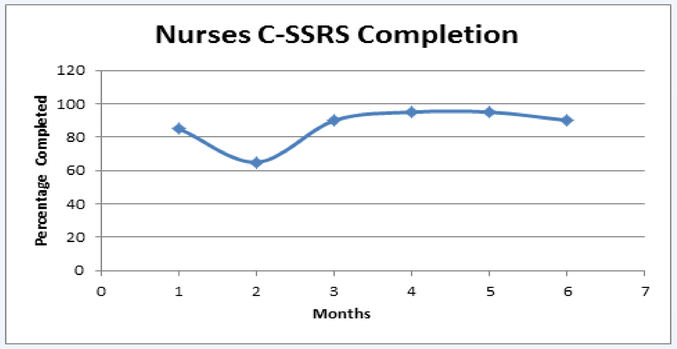
Methods

- Quality Improvement Design
- Setting
  - Academic medical center; tertiary care, Level 1 Trauma Center; 603 beds.
  - Comprehensive Psychiatric Emergency Program
    - ➢ New York State, Office of Mental Health licensed
    - ➢ Hospital-based, emergency psychiatric service open 24 hours/day, 7days/week.
    - ➢ More than 6,800 patient visits/annually
- IRB approval was attained.
- Registered Nurses completed the C-SSRS on patients who presented to the psychiatric emergency service.
- Educational Activities:
  - Suicide Prevention Training Conference
  - Educational Video/Training
  - Focus Groups
- Convenience sample of 120 charts were reviewed over a 6 month period to assess the uptake of the C-SSRS instrument.

Results



- Data was aggregated at monthly intervals (*N=20*) and at the onset, Nurses demonstrated an 85% completion rate of the C-SSRS.
- Findings in the 2nd month revealed a completion rate of 65% and educational initiatives yielded higher completion rates in subsequent months.
- Results indicated a 90% uptake of the intervention was achieved and sustained over 6 months following the implementation.

Implications

- Strategies to mitigate the variations in the assessment of suicide risk through utilizing the evidenced-based C-SSRS offer the potential to foster a culture of safety, patient-centered care and best practices.
- Future studies could address :
  - Accuracy of the recorded C-SSRS data entries across multiple patient visits
  - Impact of the C-SSRS on patient outcomes
  - How C-SSRS data relates to decisions regarding in-patient hospitalizations

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